

## PA Criteria

### **Prior Authorization Group**

#### **Drug Names**

#### **PA Indication Indicator**

#### **Off-label Uses**

ABIRATERONE

ABIRATERONE ACETATE, ABIRTEGA

All FDA-approved Indications, Some Medically-accepted Indications

Node-positive (N1), non-metastatic (M0) prostate cancer, very-high-risk prostate cancer, non-metastatic high-risk prostate cancer, non-metastatic prostate cancer with prostate-specific antigen (PSA) persistence/recurrence after radical prostatectomy, salivary gland tumors

#### **Exclusion Criteria**

#### **Required Medical Information**

-  
For all indications: the requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy. For salivary gland tumors: the requested drug is being used for the treatment of recurrent androgen receptor positive disease.

#### **Age Restrictions**

#### **Prescriber Restrictions**

#### **Coverage Duration**

#### **Other Criteria**

#### **Prerequisite Therapy Required**

-  
-  
Plan Year

-  
No

### **Prior Authorization Group**

#### **Drug Names**

#### **PA Indication Indicator**

#### **Off-label Uses**

#### **Exclusion Criteria**

#### **Required Medical Information**

ABRYSVO

ABRYSVO

All FDA-approved Indications

-

-

For the prevention of lower respiratory tract disease (LRTD) and severe LRTD caused by respiratory syncytial virus (RSV): The patient has not previously received an RSV vaccine (i.e., Abrysvo, Arexvy, Mresvia).

#### **Age Restrictions**

#### **Prescriber Restrictions**

#### **Coverage Duration**

#### **Other Criteria**

#### **Prerequisite Therapy Required**

-  
-  
3 months

-

No

|                                      |                                                                                                                                                      |
|--------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | ACITRETIN                                                                                                                                            |
| <b>Drug Names</b>                    | ACITRETIN                                                                                                                                            |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                    |
| <b>Off-label Uses</b>                | Prevention of non-melanoma skin cancers in high risk individuals, Lichen planus, Keratosis follicularis (Darier Disease)                             |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                    |
| <b>Required Medical Information</b>  | For psoriasis: The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to methotrexate or cyclosporine. |
| <b>Age Restrictions</b>              | -                                                                                                                                                    |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                    |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                            |
| <b>Other Criteria</b>                | -                                                                                                                                                    |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                  |
| <b>Prior Authorization Group</b>     | ACTIMMUNE                                                                                                                                            |
| <b>Drug Names</b>                    | ACTIMMUNE                                                                                                                                            |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                    |
| <b>Off-label Uses</b>                | Mycosis fungoides, Sezary syndrome                                                                                                                   |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                    |
| <b>Required Medical Information</b>  | -                                                                                                                                                    |
| <b>Age Restrictions</b>              | -                                                                                                                                                    |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                    |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                            |
| <b>Other Criteria</b>                | -                                                                                                                                                    |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                   |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|--------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | ADEMPAS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Drug Names</b>                    | ADEMPAS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Required Medical Information</b>  | For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For PAH new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units. For chronic thromboembolic pulmonary hypertension (CTEPH) (WHO Group 4): 1) Patient has persistent or recurrent CTEPH after pulmonary endarterectomy (PEA), OR 2) Patient has inoperable CTEPH with the diagnosis confirmed by right heart catheterization AND by computed tomography (CT), magnetic resonance imaging (MRI), or pulmonary angiography. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Prior Authorization Group</b>     | AIMOVIG                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Drug Names</b>                    | AIMOVIG                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Required Medical Information</b>  | For preventative treatment of migraine: The requested drug will not be used concurrently with another calcitonin gene-related peptide (CGRP) receptor antagonist. For preventive treatment of migraine, continuation: The patient received at least 3 months of treatment with the requested drug and had a reduction in migraine days per month from baseline.                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Coverage Duration</b>             | Initial: 3 months, Continuation: Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |

|                                      |                                                                                                                                                                                                                                                                        |
|--------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | AKEEGA                                                                                                                                                                                                                                                                 |
| <b>Drug Names</b>                    | AKEEGA                                                                                                                                                                                                                                                                 |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                           |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                      |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                      |
| <b>Required Medical Information</b>  | The requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy.                                                                                                                                     |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                      |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                      |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                              |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                      |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                     |
| <b>Prior Authorization Group</b>     | ALBENDAZOLE                                                                                                                                                                                                                                                            |
| <b>Drug Names</b>                    | ALBENDAZOLE                                                                                                                                                                                                                                                            |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                      |
| <b>Off-label Uses</b>                | Ascariasis, trichuriasis, microsporidiosis                                                                                                                                                                                                                             |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                      |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                      |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                      |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                      |
| <b>Coverage Duration</b>             | Hydatid disease, Microsporidiosis: 6 months, All other indications: 1 month                                                                                                                                                                                            |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                      |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                     |
| <b>Prior Authorization Group</b>     | ALDURAZYME                                                                                                                                                                                                                                                             |
| <b>Drug Names</b>                    | ALDURAZYME                                                                                                                                                                                                                                                             |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                           |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                      |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                      |
| <b>Required Medical Information</b>  | For mucopolysaccharidosis I (MPS I): Diagnosis was confirmed by an enzyme assay demonstrating a deficiency of alpha-L-iduronidase enzyme activity and/or by genetic testing. Patients with Scheie form (i.e., attenuated MPS I) must have moderate to severe symptoms. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                      |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                      |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                              |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                      |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                     |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|--------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | ALECENSA                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Drug Names</b>                    | ALECENSA                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Off-label Uses</b>                | Recurrent anaplastic lymphoma kinase (ALK)-positive non-small cell lung cancer (NSCLC), brain metastases from ALK-positive NSCLC, ALK-positive anaplastic large cell lymphoma (ALCL), Erdheim-Chester Disease (ECD) with ALK-fusion, inflammatory myofibroblastic tumors (IMT) with ALK translocation (including advanced, recurrent/metastatic, or inoperable uterine sarcoma for IMT with ALK translocation), ALK-positive large B-cell lymphoma |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Required Medical Information</b>  | For non-small cell lung cancer (NSCLC): 1) the patient meets either of the following: a) the disease is recurrent, advanced, or metastatic OR b) the requested drug will be used as adjuvant treatment following tumor resection, AND 2) the disease is anaplastic lymphoma kinase (ALK)-positive.                                                                                                                                                 |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prior Authorization Group</b>     | ALOSETRON                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Drug Names</b>                    | ALOSETRON HYDROCHLORIDE                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Required Medical Information</b>  | For severe diarrhea-predominant irritable bowel syndrome (IBS): 1) The requested drug is being prescribed for a biological female or a person that self-identifies as a female, 2) chronic IBS symptoms lasting at least 6 months, 3) gastrointestinal tract abnormalities have been ruled out, AND 4) inadequate treatment response to one conventional therapy (e.g., antispasmodics, antidepressants, antidiarrheals).                          |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                |
|--------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | ALPHA1-PROTEINASE INHIBITOR                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Drug Names</b>                    | ARALAST NP, PROLASTIN-C, ZEMAIRA                                                                                                                                                                                                                                                                                                                                                                               |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Required Medical Information</b>  | For alpha1-proteinase inhibitor deficiency: Patient must have 1) clinically evident emphysema, AND 2) pretreatment serum alpha1-proteinase inhibitor level less than 11 micromol/L (80 milligrams per deciliter [mg/dL] by radial immunodiffusion or 50 mg/dL by nephelometry).                                                                                                                                |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Prior Authorization Group</b>     | ALUNBRIG                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Drug Names</b>                    | ALUNBRIG                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                              |
| <b>Off-label Uses</b>                | Recurrent anaplastic lymphoma kinase (ALK)-positive non-small cell lung cancer (NSCLC), brain metastases from ALK-positive NSCLC, ALK-positive anaplastic large cell lymphoma (ALCL), inflammatory myofibroblastic tumors (IMT) with ALK translocation (including advanced, recurrent/metastatic, or inoperable uterine sarcoma for IMT with ALK translocation), Erdheim-Chester disease (ECD) with ALK-fusion |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Required Medical Information</b>  | For non-small cell lung cancer (NSCLC): 1) the disease is recurrent, advanced, or metastatic, AND 2) the disease is anaplastic lymphoma kinase (ALK)-positive.                                                                                                                                                                                                                                                 |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                             |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|--------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | ALVAIZ                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Drug Names</b>                    | ALVAIZ                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Required Medical Information</b>  | For chronic or persistent immune thrombocytopenia (ITP) (new starts): 1) Patient (pt) has experienced an inadequate treatment response or is intolerant to a prior therapy such as corticosteroids or immunoglobulins, AND 2) Untransfused platelet (plt) count at any point prior to the initiation of the requested medication is less than 30,000/mcL OR 30,000-50,000/mcL with symptomatic bleeding or risk factor(s) for bleeding (e.g., undergoing a medical or dental procedure where blood loss is anticipated, comorbidities such as peptic ulcer disease, anticoagulation therapy, profession or lifestyle that predisposes pt to trauma). For ITP (continuation): plt count response to the requested drug: 1) Current plt count is less than or equal to 200,000/mcL, OR 2) Current plt count is greater than 200,000/mcL to less than or equal to 400,000/mcL and dosing will be adjusted to a plt count sufficient to avoid clinically important bleeding. For thrombocytopenia associated with chronic hepatitis C (new starts): the requested drug is used for initiation and maintenance of interferon-based therapy. For thrombocytopenia associated with chronic hepatitis C (continuation): pt is receiving interferon-based therapy. For severe aplastic anemia (AA) (new starts): Pt had an insufficient response to immunosuppressive therapy. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Coverage Duration</b>             | HCV: 6mo, ITP/AA initial: 6mo, ITP reauth: Plan Year, AA reauth: APR-Plan Year, IPR-16 wks                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Other Criteria</b>                | For severe AA (continuation): 1) Current plt count is 50,000-200,000/mcL, OR 2) Current plt count is less than 50,000/mcL and pt has not received appropriately titrated therapy for at least 16 weeks, OR 3) Current plt count is less than 50,000/mcL and pt is transfusion-independent, OR 4) Current plt count is greater than 200,000/mcL to less than or equal to 400,000/mcL and dosing will be adjusted to achieve and maintain an appropriate target plt count. APR: adequate platelet response (greater than 50,000/mcL), IPR: inadequate platelet response (less than 50,000/mcL).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                |
|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | ALYFTREK                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Drug Names</b>                    | ALYFTREK                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Required Medical Information</b>  | For cystic fibrosis: the requested drug will not be used in combination with other CFTR (cystic fibrosis transmembrane conductance regulator) potentiating agents (e.g., ivacaftor, deutivacaftor).                                                                                                                                                                                                                            |
| <b>Age Restrictions</b>              | 6 years of age or older                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Prior Authorization Group</b>     | AMBRISANTAN                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Drug Names</b>                    | AMBRISANTAN                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Required Medical Information</b>  | For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For PAH new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                             |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|--------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | AMPHETAMINES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Drug Names</b>                    | AMPHETAMINE/DEXTROAMPHETA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>PA Indication Indicator</b>       | All Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Required Medical Information</b>  | 1) The patient has a diagnosis of Attention-Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) OR 2) The patient has a diagnosis of narcolepsy confirmed by a sleep study.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Prior Authorization Group</b>     | ARCALYST                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Drug Names</b>                    | ARCALYST                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Off-label Uses</b>                | Prevention of gout flares in patients initiating or continuing urate-lowering therapy                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Required Medical Information</b>  | For prevention of gout flares in patients initiating or continuing urate-lowering therapy (e.g., allopurinol) (new starts): 1) two or more gout flares within the previous 12 months, AND 2) inadequate response, intolerance, or contraindication to maximum tolerated doses of a non-steroidal anti-inflammatory drug (NSAID) and colchicine, AND 3) concurrent use with urate-lowering therapy. For prevention of gout flares in patients initiating or continuing urate-lowering therapy (e.g., allopurinol) (continuation): 1) patient must have achieved or maintained a clinical benefit (i.e., a fewer number of gout attacks or fewer flare days) compared to baseline, AND 2) continued use of urate-lowering therapy concurrently with the requested drug. For recurrent pericarditis: patient must have had an inadequate response, intolerance, or contraindication to maximum tolerated doses of a NSAID and colchicine. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |

|                                      |                                                                                                                                                                                                                                                                                                                   |
|--------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | AREXVY                                                                                                                                                                                                                                                                                                            |
| <b>Drug Names</b>                    | AREXVY                                                                                                                                                                                                                                                                                                            |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                      |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                 |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                 |
| <b>Required Medical Information</b>  | For the prevention of lower respiratory tract disease (LRTD) and severe LRTD caused by respiratory syncytial virus (RSV): The patient has not previously received an RSV vaccine (i.e., Abrysvo, Arexvy, Mresvia).                                                                                                |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                 |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                 |
| <b>Coverage Duration</b>             | 3 months                                                                                                                                                                                                                                                                                                          |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                 |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                |
| <b>Prior Authorization Group</b>     | ARIKAYCE                                                                                                                                                                                                                                                                                                          |
| <b>Drug Names</b>                    | ARIKAYCE                                                                                                                                                                                                                                                                                                          |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                      |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                 |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                 |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                 |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                 |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                 |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                         |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                 |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                |
| <b>Prior Authorization Group</b>     | ARMODAFINIL                                                                                                                                                                                                                                                                                                       |
| <b>Drug Names</b>                    | ARMODAFINIL                                                                                                                                                                                                                                                                                                       |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                      |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                 |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                 |
| <b>Required Medical Information</b>  | For excessive sleepiness associated with narcolepsy: The diagnosis has been confirmed by sleep lab evaluation. For excessive sleepiness associated with obstructive sleep apnea (OSA): The diagnosis has been confirmed by polysomnography or home sleep apnea testing (HSAT) with a technically adequate device. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                 |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                 |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                         |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                 |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|--------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | AUGTYRO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Drug Names</b>                    | AUGTYRO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Off-label Uses</b>                | Recurrent ROS1-positive non-small cell lung cancer (NSCLC), recurrent neurotrophic tyrosine receptor kinase (NTRK) gene fusion positive NSCLC, NTRK gene fusion positive solid tumors that are not locally advanced or metastatic                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Required Medical Information</b>  | For ROS1-positive non-small cell lung cancer (NSCLC): the patient has recurrent, advanced, or metastatic disease. For neurotrophic tyrosine receptor kinase (NTRK) gene fusion positive NSCLC: the patient has recurrent, advanced, or metastatic disease. For solid tumors: the tumor is NTRK gene fusion positive.                                                                                                                                                                                                                                                                                                                           |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Prior Authorization Group</b>     | AUSTEDO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Drug Names</b>                    | AUSTEDO, AUSTEDO XR, AUSTEDO XR PATIENT TITRAT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Required Medical Information</b>  | For tardive dyskinesia, initial: patient must meet both of the following: 1) patient exhibits clinical manifestations of the disease, AND 2) patient's disease has been assessed through clinical examination or with a structured evaluative tool (e.g., Abnormal Involuntary Movement Scale [AIMS], Dyskinesia Identification System: Condensed User Scale [DISCUS]). For chorea associated with Huntington's disease, initial: patient demonstrates characteristic motor examination features. For tardive dyskinesia and chorea associated with Huntington's disease, continuation: patient demonstrates a beneficial response to therapy. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Coverage Duration</b>             | Initial: 6 months, continuation: Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |

|                                      |                                                                                                                                                                                                                                                                                                                   |
|--------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | AUVELITY                                                                                                                                                                                                                                                                                                          |
| <b>Drug Names</b>                    | AUVELITY                                                                                                                                                                                                                                                                                                          |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                      |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                 |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                 |
| <b>Required Medical Information</b>  | For Major Depressive Disorder (MDD): The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to TWO of the following: serotonin and norepinephrine reuptake inhibitors (SNRIs), selective serotonin reuptake inhibitors (SSRIs), mirtazapine, bupropion. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                 |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                 |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                         |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                 |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                               |
| <b>Prior Authorization Group</b>     | AVMAPKI-FAKZYNJA                                                                                                                                                                                                                                                                                                  |
| <b>Drug Names</b>                    | AVMAPKI FAKZYNJA CO-PACK                                                                                                                                                                                                                                                                                          |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                      |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                 |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                 |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                 |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                 |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                 |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                         |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                 |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|--------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | AYVAKIT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Drug Names</b>                    | AYVAKIT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Off-label Uses</b>                | Myeloid and lymphoid neoplasms with eosinophilia, gastrointestinal stromal tumor (GIST) for residual, unresectable, tumor rupture, or recurrent/metastatic disease without platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Required Medical Information</b>  | For myeloid and lymphoid neoplasms with eosinophilia, the patient meets all of the following criteria: 1) The disease is FIP1L1- PDGFRA rearrangement-positive, AND 2) The disease harbors a PDGFRA D842V mutation, AND 3) The disease is resistant to imatinib. For GIST, the patient meets either of the following criteria: 1) The disease harbors PDGFRA exon 18 mutation, including a PDGFRA D842V mutation, OR 2) The requested drug will be used after failure on at least two Food and Drug Administration (FDA)-approved therapies in residual, unresectable, tumor rupture, or recurrent/metastatic disease without PDGFRA exon 18 mutation. For systemic mastocytosis: 1) The patient has a diagnosis of indolent systemic mastocytosis or advanced systemic mastocytosis (including aggressive systemic mastocytosis [ASM], systemic mastocytosis with associated hematological neoplasm [SM-AHN], and mast cell leukemia [MCL]) AND 2) The patient has a platelet count of greater than or equal to 50,000/microliter (mCL). |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |

**Prior Authorization Group****Drug Names**

B VS. D

ACETYL CYSTEINE, ACYCLOVIR SODIUM, ADMELOG, ALBUTEROL SULFATE, AMPHOTERICIN B, AMPHOTERICIN B LIPOSOME, APREPITANT, ASTAGRAF XL, AZACITIDINE, AZATHIOPRINE, BENDAMUSTINE HYDROCHLORIDE, BENDEKA, BUDESONIDE, CALCITONIN-SALMON, CALCITRIOL, CARBOPLATIN, CINACALCET HYDROCHLORIDE, CISPLATIN, CLINIMIX 4.25%/DEXTROSE 1, CLINIMIX 4.25%/DEXTROSE 5, CLINIMIX 5%/DEXTROSE 15%, CLINIMIX 5%/DEXTROSE 20%, CLINIMIX 6/5, CLINIMIX 8/10, CLINIMIX 8/14, CLINISOL SF 15%, CLINOLIPID, CROMOLYN SODIUM, CYCLOPHOSPHAMIDE, CYCLOPHOSPHAMIDE MONOHYDR, CYCLOSPORINE, CYCLOSPORINE MODIFIED, CYTARABINE AQUEOUS, DEXTROSE 50%, DEXTROSE 70%, DOCETAXEL, DOCIVYX, DOXORUBICIN HCL, DOXORUBICIN HYDROCHLORIDE, DRONABINOL, ENGERIX-B, ETOPOSIDE, EVEROLIMUS, FIASP, FIASP PUMPCART, FLUOROURACIL, FRINDOVYX, FULVESTRANT, GAMASTAN, GANCICLOVIR, GEMCITABINE HCL, GEMCITABINE HYDROCHLORIDE, GENGRAF, GRANISETRON HYDROCHLORIDE, HEPARIN SODIUM, HEPLISAV-B, HUMULIN R U-500 (CONCENTR, IBANDRONATE SODIUM, IMOVAX RABIES (H.D.C.V.), INTRALIPID, IPRATROPIUM BROMIDE, IPRATROPIUM BROMIDE/ALBUT, IRINOTECAN, IRINOTECAN HYDROCHLORIDE, JYLAMVO, JYNNEOS, KADCYLA, LEUCOVORIN CALCIUM, LEVOCARNITINE, LIDOCAINE HCL, LIDOCAINE HYDROCHLORIDE, LIDOCAINE/PRILOCAINE, METHOTREXATE, METHOTREXATE SODIUM, METHYLPREDNISOLONE, METHYLPREDNISOLONE ACETAT, METHYLPREDNISOLONE SODIUM, MORPHINE SULFATE, MYCOPHENOLATE MOFETIL, MYCOPHENOLIC ACID DR, NOVOLIN R, NOVOLOG, NOVOLOG RELION, NULOJIX, NUTRILIPID, ONDANSETRON HCL, ONDANSETRON HYDROCHLORIDE, ONDANSETRON ODT, OXALIPLATIN, PACLITAXEL, PACLITAXEL PROTEIN-BOUND, PAMIDRONATE DISODIUM, PARICALCITOL, PEMETREXED, PENTAMIDINE ISETHIONATE, PLENAMINE, PREDNISOLONE, PREDNISOLONE SODIUM PHOSP, PREDNISON, PREDNISON INTENSOL, PREMASOL, PROGRAF, PROSOL, RABAVER, RECOMBIVAX HB, SIROLIMUS, TACROLIMUS, TENIVAC, TPN ELECTROLYTES, TRAVASOL, TROPHAMINE, VINCRISTINE SULFATE, VINORELBINE TARTRATE, VIVIMUSTA, XATMEP, ZOLEDRONIC ACID

**PA Indication Indicator**

All Medically-accepted Indications

**Off-label Uses**

-

**Exclusion Criteria**

-

**Required Medical Information**

-

**Age Restrictions**

-

**Prescriber Restrictions**

-

**Coverage Duration**

N/A

**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.

|                                      |                                                                                                                                                                                                                                                                                                                                                                   |
|--------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prior Authorization Group</b>     | BAFIERTAM                                                                                                                                                                                                                                                                                                                                                         |
| <b>Drug Names</b>                    | BAFIERTAM                                                                                                                                                                                                                                                                                                                                                         |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                      |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                         |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prior Authorization Group</b>     | BALVERSA                                                                                                                                                                                                                                                                                                                                                          |
| <b>Drug Names</b>                    | BALVERSA                                                                                                                                                                                                                                                                                                                                                          |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                      |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Required Medical Information</b>  | For urothelial carcinoma: 1) disease has susceptible fibroblast growth factor receptor 3 (FGFR3) genetic alterations, AND 2) the requested drug will be used as subsequent therapy for any of the following: a) locally advanced, recurrent, or metastatic urothelial carcinoma, OR b) stage II-IV, recurrent, or persistent urothelial carcinoma of the bladder. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                         |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prior Authorization Group</b>     | BANZEL                                                                                                                                                                                                                                                                                                                                                            |
| <b>Drug Names</b>                    | RUFINAMIDE                                                                                                                                                                                                                                                                                                                                                        |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                      |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Age Restrictions</b>              | 1 year of age or older                                                                                                                                                                                                                                                                                                                                            |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                         |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|--------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | BENLYSTA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Drug Names</b>                    | BENLYSTA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Exclusion Criteria</b>            | For patients new to therapy: severe active central nervous system lupus.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Required Medical Information</b>  | For systemic lupus erythematosus (SLE): 1) patient is currently receiving a standard therapy regimen for SLE (for example, corticosteroid, antimalarial, or NSAIDs), OR 2) patient has experienced an intolerance or has a contraindication to standard therapy regimen for SLE, AND 3) for initial starts, patient has confirmed diagnosis of SLE from positive autoantibodies relevant to SLE (e.g., antinuclear antibodies [ANA], anti-double stranded DNA [anti-ds DNA], anti-Smith [anti-Sm], antiphospholipid antibodies, complement proteins). For lupus nephritis: 1) patient is currently receiving a standard therapy regimen for lupus nephritis (for example, corticosteroid, cyclophosphamide, mycophenolate mofetil, or azathioprine) OR 2) patient has experienced an intolerance or has a contraindication to standard therapy regimen for lupus nephritis, AND 3) for initial starts, patient has confirmed diagnosis of LN from either of the following: a) kidney biopsy, b) positive for autoantibodies relevant to SLE (e.g., antinuclear antibodies [ANA], anti-double stranded DNA [anti-ds DNA], anti-Smith [anti-Sm], antiphospholipid antibodies, complement proteins). |
| <b>Age Restrictions</b>              | 5 years of age or older                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prior Authorization Group</b>     | BERINERT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Drug Names</b>                    | BERINERT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Required Medical Information</b>  | For treatment of acute angioedema attacks due to hereditary angioedema (HAE): 1) the patient has HAE with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing, OR 2) the patient has HAE with normal C1 inhibitor confirmed by laboratory testing and one of the following: a) the patient tested positive for an F12, angiotensin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation, b) the patient has a family history of angioedema and the angioedema was refractory to a trial of high-dose antihistamine therapy for at least one month.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prescriber Restrictions</b>       | Prescribed by or in consultation with an immunologist, allergist, or rheumatologist                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

|                                      |                                                                                                                                                                                                                |
|--------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | BESREMI                                                                                                                                                                                                        |
| <b>Drug Names</b>                    | BESREMI                                                                                                                                                                                                        |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                   |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                              |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                              |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                              |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                              |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                              |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                      |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                              |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                             |
|                                      |                                                                                                                                                                                                                |
| <b>Prior Authorization Group</b>     | BETASERON                                                                                                                                                                                                      |
| <b>Drug Names</b>                    | BETASERON                                                                                                                                                                                                      |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                   |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                              |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                              |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                              |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                              |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                              |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                      |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                              |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                             |
|                                      |                                                                                                                                                                                                                |
| <b>Prior Authorization Group</b>     | BEXAROTENE                                                                                                                                                                                                     |
| <b>Drug Names</b>                    | BEXAROTENE                                                                                                                                                                                                     |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                              |
| <b>Off-label Uses</b>                | Mycosis fungoides (MF)/Sezary syndrome (SS), CD30-positive primary cutaneous anaplastic large cell lymphoma (ALCL), CD30-positive lymphomatoid papulosis (LyP), subcutaneous panniculitis-like T-cell lymphoma |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                              |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                              |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                              |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                              |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                      |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                              |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                             |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|--------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | BIMZELX                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Drug Names</b>                    | BIMZELX                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Required Medical Information</b>  | For moderate to severe plaque psoriasis (new starts only): 1) Crucial body areas (e.g., hands, feet, face, scalp, neck, genitals/groin, intertriginous areas) are affected at the time of diagnosis, OR 2) Patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of the body surface area is affected), OR 3) At least 3% of body surface area (BSA) is affected and patient meets either of the following: a) Patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) Pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated. For active ankylosing spondylitis and non-radiographic axial spondyloarthritis (new starts only): 1) Patient has experienced an inadequate treatment response or intolerance to a non-steroidal anti-inflammatory drug (NSAID) OR 2) Patient has a contraindication that would prohibit a trial of NSAIDs. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Prior Authorization Group</b>     | BOSENTAN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Drug Names</b>                    | BOSENTAN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Required Medical Information</b>  | For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For PAH new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) if the request is for an adult patient, the patient meets both of the following: a) pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units, and b) the patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to ambrisentan (Letairis).                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|--------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | BOSULIF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Drug Names</b>                    | BOSULIF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Off-label Uses</b>                | Philadelphia chromosome positive B-cell acute lymphoblastic leukemia (Ph+ B-ALL), myeloid and/or lymphoid neoplasms with eosinophilia and ABL1 rearrangement in the chronic phase or blast phase                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Required Medical Information</b>  | For chronic myeloid leukemia (CML), including patients newly diagnosed with CML and patients who have received a hematopoietic stem cell transplant: 1) Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene, AND 2) If patient experienced resistance to an alternative tyrosine kinase inhibitor, patient is negative for all of the following mutations: T315I, G250E, V299L, and F317L, AND 3) Patient has experienced resistance or intolerance to imatinib, dasatinib, or nilotinib. For B-ALL including patients who have received hematopoietic stem cell transplant: 1) Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene, AND 2) If patient experienced resistance to an alternative tyrosine kinase inhibitor, patient is negative for all of the following mutations: T315I, G250E, V299L, and F317L. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|--------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | BRAFTOVI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Drug Names</b>                    | BRAFTOVI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Off-label Uses</b>                | Adjuvant or neoadjuvant systemic therapy for cutaneous melanoma, appendiceal adenocarcinoma, recurrent NSCLC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Required Medical Information</b>  | For colorectal cancer (including appendiceal adenocarcinoma): 1) Tumor is positive for BRAF V600E mutation, AND 2) The patient has either of the following: a) advanced or metastatic disease, b) unresectable metachronous metastases, AND 3) The requested drug will be used in combination with cetuximab or panitumumab. For melanoma: 1) Tumor is positive for BRAF V600 activating mutation (e.g., V600E or V600K), AND 2) The requested drug will be used as a single agent or in combination with binimetinib, AND 3) The requested drug will be used for either of the following: a) unresectable, limited resectable, or metastatic disease, b) adjuvant or neoadjuvant systemic therapy. For non-small cell lung cancer (NSCLC): 1) Tumor is positive for BRAF V600E mutation, AND 2) Disease is advanced, recurrent, or metastatic, AND 3) The requested drug will be used in combination with binimetinib. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Prior Authorization Group</b>     | BRIVIACT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Drug Names</b>                    | BRIVIACT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Required Medical Information</b>  | For treatment of partial-onset seizures (i.e., focal-onset seizures): 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a generic anticonvulsant AND 2) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to any of the following: Aptiom (if 4 years of age or older), Xcopri (if 18 years of age or older), Spritam (if 4 years of age or older).                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Age Restrictions</b>              | 1 month of age or older                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|--------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | BRUKINSA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Drug Names</b>                    | BRUKINSA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Off-label Uses</b>                | Hairy cell leukemia                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Required Medical Information</b>  | For mantle cell lymphoma and chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL): the patient has experienced an intolerable adverse event or has a contraindication to Calquence (acalabrutinib).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Prior Authorization Group</b>     | CABOMETYX                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Drug Names</b>                    | CABOMETYX                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Off-label Uses</b>                | Non-small cell lung cancer, Ewing sarcoma, osteosarcoma, gastrointestinal stromal tumor, endometrial carcinoma, soft tissue sarcoma (alveolar soft part sarcoma and extraskeletal myxoid chondrosarcoma subtypes)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Required Medical Information</b>  | For renal cell carcinoma: The disease is advanced, relapsed, or stage IV (including brain metastases). For non-small cell lung cancer: 1) the disease is rearranged during transfection (RET) positive AND 2) the disease is recurrent, advanced, or metastatic. For hepatocellular carcinoma: the requested drug will be used as subsequent therapy. For gastrointestinal stromal tumor (GIST): 1) the disease is residual, unresectable, recurrent, or metastatic/tumor rupture, AND 2) the disease has progressed after at least two FDA-approved therapies (e.g., imatinib, sunitinib, regorafenib, ripretinib). For Ewing sarcoma and osteosarcoma: the requested drug will be used as subsequent therapy. For differentiated thyroid cancer (DTC) (follicular, papillary, oncocyctic): 1) the disease is locally advanced or metastatic, AND 2) the disease has progressed after a vascular endothelial growth factor receptor (VEGFR)- targeted therapy, AND 3) the patient is refractory to radioactive iodine therapy (RAI) or ineligible for RAI. For endometrial carcinoma: 1) the disease is recurrent, AND 2) the requested drug will be used as subsequent therapy. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |

|                                      |                                                                                                                                                                                                                                                                                                                       |
|--------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | CALCIPOTRIENE                                                                                                                                                                                                                                                                                                         |
| <b>Drug Names</b>                    | CALCIPOTRIENE, CALCITRENE, ENSTILAR                                                                                                                                                                                                                                                                                   |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                          |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                     |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                     |
| <b>Required Medical Information</b>  | For psoriasis: The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a topical steroid.                                                                                                                                                                             |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                     |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                     |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                             |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                     |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                   |
| <b>Prior Authorization Group</b>     | CALQUENCE                                                                                                                                                                                                                                                                                                             |
| <b>Drug Names</b>                    | CALQUENCE                                                                                                                                                                                                                                                                                                             |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                     |
| <b>Off-label Uses</b>                | Waldenstrom macroglobulinemia (lymphoplasmacytic lymphoma), marginal zone lymphoma (including extranodal marginal zone lymphoma of the stomach, extranodal marginal zone lymphoma of nongastric sites, nodal marginal zone lymphoma, splenic marginal zone lymphoma)                                                  |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                     |
| <b>Required Medical Information</b>  | For marginal zone lymphoma (including extranodal marginal zone lymphoma of the stomach, extranodal marginal zone lymphoma of nongastric sites, nodal marginal zone lymphoma, and splenic marginal zone lymphoma): the requested drug is being used for the treatment of relapsed, refractory, or progressive disease. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                     |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                     |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                             |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                     |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                    |
| <b>Prior Authorization Group</b>     | CAPRELSA                                                                                                                                                                                                                                                                                                              |
| <b>Drug Names</b>                    | CAPRELSA                                                                                                                                                                                                                                                                                                              |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                     |
| <b>Off-label Uses</b>                | Thyroid carcinomas (follicular, oncocytic, papillary).                                                                                                                                                                                                                                                                |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                     |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                     |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                     |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                     |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                             |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                     |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                    |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|--------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | CARBAGLU                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Drug Names</b>                    | CARGLUMIC ACID                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Required Medical Information</b>  | For all indications: Diagnosis confirmed by enzymatic, biochemical, or genetic testing.                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Prior Authorization Group</b>     | CAYSTON                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Drug Names</b>                    | CAYSTON                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Required Medical Information</b>  | For treatment of respiratory symptoms in cystic fibrosis patients: 1) Pseudomonas aeruginosa is present in the patient's airway cultures, OR 2) The patient has a history of pseudomonas aeruginosa infection or colonization in the airways.                                                                                                                                                                                                                                                               |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Prior Authorization Group</b>     | CEQUR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Drug Names</b>                    | CEQUR SIMPLICITY 2U, CEQUR SIMPLICITY INSERTER                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Required Medical Information</b>  | Initial: 1) the patient has diabetes requiring insulin management AND 2) the patient is currently self-testing glucose levels, the patient will be counseled on self-testing glucose levels, or the patient is using a continuous glucose monitor AND 3) the patient meets either of the following: a) the patient has tried bolus injections and either did not meet glycemic goals or had difficulties administering multiple insulin injections daily, b) the patient is unable to try bolus injections. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |

|                                      |                                                                                                                                                                                                                                                                                                                                                                               |
|--------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | CERDELGA                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Drug Names</b>                    | CERDELGA                                                                                                                                                                                                                                                                                                                                                                      |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                  |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Required Medical Information</b>  | For type 1 Gaucher disease (GD1): 1) Diagnosis was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing, and 2) Patient's CYP2D6 metabolizer status has been established using an FDA-cleared test, and 3) Patient is a CYP2D6 extensive metabolizer, an intermediate metabolizer, or a poor metabolizer. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Prior Authorization Group</b>     | CEREZYME                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Drug Names</b>                    | CEREZYME                                                                                                                                                                                                                                                                                                                                                                      |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                             |
| <b>Off-label Uses</b>                | Type 2 Gaucher disease, Type 3 Gaucher disease                                                                                                                                                                                                                                                                                                                                |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Required Medical Information</b>  | For Gaucher disease: Diagnosis was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing.                                                                                                                                                                                                                  |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Prior Authorization Group</b>     | CLOBAZAM                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Drug Names</b>                    | CLOBAZAM                                                                                                                                                                                                                                                                                                                                                                      |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                             |
| <b>Off-label Uses</b>                | Seizures associated with Dravet syndrome                                                                                                                                                                                                                                                                                                                                      |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Age Restrictions</b>              | Seizures associated with Lennox-Gastaut syndrome (LGS): 2 years of age or older                                                                                                                                                                                                                                                                                               |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                            |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|--------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | CLOMIPRAMINE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Drug Names</b>                    | CLOMIPRAMINE HYDROCHLORID                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Off-label Uses</b>                | Depression, panic disorder                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Required Medical Information</b>  | For obsessive-compulsive disorder (OCD) and panic disorder: The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to any of the following: a serotonin and norepinephrine reuptake inhibitor (SNRI), a selective serotonin reuptake inhibitor (SSRI). For depression: The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to two of the following: serotonin and norepinephrine reuptake inhibitors (SNRIs), selective serotonin reuptake inhibitors (SSRIs), mirtazapine, bupropion. . For all indications: If the patient is 65 years of age or older AND is using one or more additional anticholinergic medications (e.g., oxybutynin, meclizine, paroxetine, amitriptyline, dicyclomine, hydroxyzine) with the requested drug, the prescriber has determined that taking multiple anticholinergic medications is medically necessary for the patient [Note: Use of multiple anticholinergic medications in older adults is associated with an increased risk of cognitive decline.]. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|--------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | CLORAZEPATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Drug Names</b>                    | CLORAZEPATE DIPOTASSIUM                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Required Medical Information</b>  | For all indications: 1) The prescriber must acknowledge the benefit of therapy with this prescribed medication outweighs the potential risks for the patient(Note: The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.), 2) if the patient is using two or more additional central nervous system (CNS) active medications (e.g., lorazepam, quetiapine, sertraline, clonazepam, escitalopram, alprazolam) with the requested drug, the prescriber has determined that taking multiple central nervous system (CNS) active medications is medically necessary for the patient [Note: Use of multiple central nervous system (CNS) active medications in older adults is associated with an increased risk of falls.] For the management of anxiety disorders: 1) The requested drug is being used concurrently with a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI) until the SSRI/SNRI becomes effective for the symptoms of anxiety, OR 2) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to AT LEAST TWO agents from the following classes: a) selective serotonin reuptake inhibitors (SSRIs), b) serotonin-norepinephrine reuptake inhibitors (SNRIs). |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Coverage Duration</b>             | Short-term relief anxiety-1 month, Anxiety Disorders-4 months, All other Diagnoses-Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Other Criteria</b>                | This Prior Authorization only applies to patients 65 years of age or older.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prior Authorization Group</b>     | CLOZAPINE ODT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Drug Names</b>                    | CLOZAPINE ODT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|--------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | COBENFY                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Drug Names</b>                    | COBENFY, COBENFY STARTER PACK                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Required Medical Information</b>  | For treatment of schizophrenia: 1) The patient experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following generic products: aripiprazole, asenapine, lurasidone, olanzapine, quetiapine, risperidone, ziprasidone, AND 2) The patient experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following brand products: Caplyta, Lybalvi, Rexulti, Secuado, Vraylar. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Prior Authorization Group</b>     | COMETRIQ                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Drug Names</b>                    | COMETRIQ                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Off-label Uses</b>                | Non-small cell lung cancer (NSCLC), thyroid carcinomas (follicular, oncocytic, papillary).                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Required Medical Information</b>  | For non-small cell lung cancer (NSCLC): Disease is positive for rearranged during transfection (RET) rearrangements.                                                                                                                                                                                                                                                                                                                                              |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|--------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | COPIKTRA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Drug Names</b>                    | COPIKTRA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Off-label Uses</b>                | Hepatosplenic T-Cell lymphoma, breast implant-associated anaplastic large cell lymphoma (ALCL), peripheral T-Cell lymphoma                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Required Medical Information</b>  | For chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL), breast implant-associated anaplastic large cell lymphoma (ALCL), and peripheral T-Cell lymphoma: the patient has relapsed or refractory disease. For hepatosplenic T-Cell lymphoma: the patient has refractory disease.                                                                                                                                                                                                                                                                 |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Prior Authorization Group</b>     | COTELLIC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Drug Names</b>                    | COTELLIC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Off-label Uses</b>                | Central nervous system (CNS) cancer (i.e., glioma, glioblastoma), adjuvant or neoadjuvant systemic therapy for cutaneous melanoma.                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Required Medical Information</b>  | For central nervous system (CNS) cancer (i.e., glioma, glioblastoma): 1) The tumor is positive for BRAF V600E activating mutation, AND 2) The requested drug will be used in combination with vemurafenib. For melanoma: 1) The tumor is positive for BRAF V600 activating mutation (e.g., V600E or V600K), AND 2) The requested drug will be used in combination with vemurafenib, AND 3) The requested drug will be used for either of the following: a) unresectable, limited resectable, or metastatic disease, b) adjuvant or neoadjuvant systemic therapy. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |

|                                      |                                                                                                                                                                                                                                                                                                     |
|--------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | CRESEMBA                                                                                                                                                                                                                                                                                            |
| <b>Drug Names</b>                    | CRESEMBA                                                                                                                                                                                                                                                                                            |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                   |
| <b>Off-label Uses</b>                | Fluconazole-refractory esophageal candidiasis in a patient with HIV, fungal peritoneal dialysis-associated peritonitis                                                                                                                                                                              |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                   |
| <b>Required Medical Information</b>  | The requested drug is being used orally. For invasive aspergillosis and fluconazole-refractory esophageal candidiasis in a patient with HIV: the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to voriconazole.                                  |
| <b>Age Restrictions</b>              | 6 years of age or older                                                                                                                                                                                                                                                                             |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                   |
| <b>Coverage Duration</b>             | Invasive Aspergillosis: 3 mo. Invasive Mucormycosis: 6 mo. Esophageal candidiasis, peritonitis: 1 mo                                                                                                                                                                                                |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                   |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                 |
| <b>Prior Authorization Group</b>     | CYSTADROPS                                                                                                                                                                                                                                                                                          |
| <b>Drug Names</b>                    | CYSTADROPS                                                                                                                                                                                                                                                                                          |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                        |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                   |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                   |
| <b>Required Medical Information</b>  | For cystinosis: 1) Diagnosis was confirmed by ANY of the following: a) the presence of increased cystine concentration in leukocytes, OR b) genetic testing, OR c) demonstration of corneal cystine crystals by slit lamp examination, AND 2) the patient has corneal cystine crystal accumulation. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                   |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                   |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                           |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                   |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                  |

|                                      |                                                                                                                                                                                                                                                                                                                |
|--------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | CYSTAGON                                                                                                                                                                                                                                                                                                       |
| <b>Drug Names</b>                    | CYSTAGON                                                                                                                                                                                                                                                                                                       |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                   |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                              |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                              |
| <b>Required Medical Information</b>  | For nephropathic cystinosis: Diagnosis was confirmed by ANY of the following: 1) the presence of increased cystine concentration in leukocytes, OR 2) genetic testing, OR 3) demonstration of corneal cystine crystals by slit lamp examination.                                                               |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                              |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                              |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                      |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                              |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                             |
| <b>Prior Authorization Group</b>     | CYSTARAN                                                                                                                                                                                                                                                                                                       |
| <b>Drug Names</b>                    | CYSTARAN                                                                                                                                                                                                                                                                                                       |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                   |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                              |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                              |
| <b>Required Medical Information</b>  | For cystinosis: 1) Diagnosis was confirmed by ANY of the following: a) the presence of increased cystine concentration in leukocytes, OR b) genetic testing, OR c) demonstration of corneal cystine crystals by slit lamp examination, AND 2) the patient has corneal cystine crystal accumulation.            |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                              |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                              |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                      |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                              |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                             |
| <b>Prior Authorization Group</b>     | DALFAMPRIDINE                                                                                                                                                                                                                                                                                                  |
| <b>Drug Names</b>                    | DALFAMPRIDINE ER                                                                                                                                                                                                                                                                                               |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                   |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                              |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                              |
| <b>Required Medical Information</b>  | For multiple sclerosis (for new starts): prior to initiating therapy, patient demonstrates sustained walking impairment. For multiple sclerosis (continuation): patient must have experienced an improvement in walking speed OR other objective measure of walking ability since starting the requested drug. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                              |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                              |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                      |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                              |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                             |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | DANZITEN - PENDING CMS REVIEW                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Drug Names</b>                    | DANZITEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>PA Indication Indicator</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Coverage Duration</b>             | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prior Authorization Group</b>     | DARAPRIM                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Drug Names</b>                    | PYRIMETHAMINE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Off-label Uses</b>                | Toxoplasmosis prophylaxis, Pneumocystis jirovecii pneumonia prophylaxis, cystoisosporiasis treatment and secondary prophylaxis                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Required Medical Information</b>  | For primary toxoplasmosis prophylaxis, Pneumocystis jirovecii pneumonia (PCP) prophylaxis, and secondary cystoisosporiasis prophylaxis: 1) The patient has experienced an intolerance or has a contraindication to trimethoprim-sulfamethoxazole (TMP-SMX) AND 2) The patient is immunocompromised. For secondary toxoplasmosis prophylaxis: The patient is immunocompromised. For cystoisosporiasis treatment: The patient has experienced an intolerance or has a contraindication to TMP-SMX. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Coverage Duration</b>             | Congen toxo tx: Plan Yr. Acqu toxo tx, prim toxo ppx, PCP ppx: 3mo. Sec toxo ppx, cysto tx/ppx: 6mo                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |

|                                      |                                                                                                                                                                                                                                                                                                                               |
|--------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | DAURISMO                                                                                                                                                                                                                                                                                                                      |
| <b>Drug Names</b>                    | DAURISMO                                                                                                                                                                                                                                                                                                                      |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                             |
| <b>Off-label Uses</b>                | Post-induction therapy/consolidation following response to previous therapy with the same regimen for acute myeloid leukemia (AML)                                                                                                                                                                                            |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                             |
| <b>Required Medical Information</b>  | For acute myeloid leukemia (AML): 1) the requested drug must be used in combination with cytarabine, 2) the patient is 75 years of age or older OR has comorbidities that preclude intensive chemotherapy, AND 3) the requested drug will be used as treatment for induction therapy or post-induction/consolidation therapy. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                             |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                             |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                     |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                             |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                            |
| <b>Prior Authorization Group</b>     | DEFERASIROX                                                                                                                                                                                                                                                                                                                   |
| <b>Drug Names</b>                    | DEFERASIROX                                                                                                                                                                                                                                                                                                                   |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                  |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                             |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                             |
| <b>Required Medical Information</b>  | For chronic iron overload due to blood transfusions: pretreatment serum ferritin level is greater than 1000 mcg/L.                                                                                                                                                                                                            |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                             |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                             |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                     |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                             |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                            |
| <b>Prior Authorization Group</b>     | DEMSEER                                                                                                                                                                                                                                                                                                                       |
| <b>Drug Names</b>                    | METYROSE                                                                                                                                                                                                                                                                                                                      |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                  |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                             |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                             |
| <b>Required Medical Information</b>  | The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to an alpha-adrenergic antagonist.                                                                                                                                                                                       |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                             |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                             |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                     |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                             |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                           |

|                                      |                                                                                                                                                                                                                                                                   |
|--------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | DEXMETHYLPHENIDATE                                                                                                                                                                                                                                                |
| <b>Drug Names</b>                    | DEXMETHYLPHENIDATE HCL, DEXMETHYLPHENIDATE HYDROCHLORIDE                                                                                                                                                                                                          |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                 |
| <b>Off-label Uses</b>                | Cancer-related fatigue                                                                                                                                                                                                                                            |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                 |
| <b>Required Medical Information</b>  | 1) The patient has a diagnosis of Attention-Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) OR 2) The requested drug is being prescribed for the treatment of cancer-related fatigue after other causes of fatigue have been ruled out. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                 |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                 |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                         |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                 |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                |
| <b>Prior Authorization Group</b>     | DHE NASAL                                                                                                                                                                                                                                                         |
| <b>Drug Names</b>                    | DIHYDROERGOTAMINE MESYLATE                                                                                                                                                                                                                                        |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                      |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                 |
| <b>Exclusion Criteria</b>            | Coverage will be denied when used in conjunction with potent CYP3A4 inhibitors (e.g., ritonavir, nelfinavir, indinavir, erythromycin, clarithromycin).                                                                                                            |
| <b>Required Medical Information</b>  | The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least ONE triptan 5-HT <sub>1</sub> receptor agonist.                                                                                                  |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                 |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                 |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                         |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                 |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                               |
| <b>Prior Authorization Group</b>     | DIACOMIT                                                                                                                                                                                                                                                          |
| <b>Drug Names</b>                    | DIACOMIT                                                                                                                                                                                                                                                          |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                      |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                 |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                 |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                 |
| <b>Age Restrictions</b>              | 6 months of age or older                                                                                                                                                                                                                                          |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                 |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                         |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                 |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|--------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | DIAZEPAM                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Drug Names</b>                    | DIAZEPAM, DIAZEPAM INTENSOL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Required Medical Information</b>  | For all indications: 1) The prescriber must acknowledge the benefit of therapy with this prescribed medication outweighs the potential risks for the patient (Note: The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.), 2) if the patient is using two or more additional central nervous system (CNS) active medications (e.g., lorazepam, quetiapine, sertraline, clonazepam, escitalopram, alprazolam) with the requested drug, the prescriber has determined that taking multiple central nervous system (CNS) active medications is medically necessary for the patient [Note: Use of multiple central nervous system (CNS) active medications in older adults is associated with an increased risk of falls.]. For the management of anxiety disorders: 1) The requested drug is being used concurrently with a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI) until the SSRI/SNRI becomes effective for the symptoms of anxiety, OR 2) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to AT LEAST TWO agents from the following classes: a) selective serotonin reuptake inhibitors (SSRIs), b) serotonin-norepinephrine reuptake inhibitors (SNRIs). |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Coverage Duration</b>             | Short-term relief anx-1 mo, skeletal muscle spasm-3 mo, Anx Disorders-4 mo, Other Diagnoses-PlanYR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Other Criteria</b>                | This Prior Authorization only applies to patients 65 years of age or older. Applies to greater than cumulative 5 days of therapy per year.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Prior Authorization Group</b>     | DOPTelet - PENDING CMS REVIEW                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Drug Names</b>                    | DOPTelet                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>PA Indication Indicator</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Coverage Duration</b>             | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|--------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | DRIZALMA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Drug Names</b>                    | DRIZALMA SPRINKLE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Off-label Uses</b>                | Cancer pain, chemotherapy-induced neuropathic pain                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Required Medical Information</b>  | For major depressive disorder (MDD): The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to TWO of the following: serotonin and norepinephrine reuptake inhibitors (SNRIs), selective serotonin reuptake inhibitors (SSRIs), mirtazapine, bupropion. For Generalized Anxiety Disorder, Diabetic Peripheral Neuropathy, Fibromyalgia, Chronic Musculoskeletal pain: 1) The patient has tried duloxetine capsules OR 2) The patient is unable to take duloxetine capsules for any reason (e.g., difficulty swallowing capsules, requires nasogastric administration). |
| <b>Age Restrictions</b>              | Generalized Anxiety Disorder: 7 years of age or older                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Prior Authorization Group</b>     | DUPIXENT - PENDING CMS REVIEW                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Drug Names</b>                    | DUPIXENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>PA Indication Indicator</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Coverage Duration</b>             | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prior Authorization Group</b>     | ELIGARD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Drug Names</b>                    | ELIGARD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Off-label Uses</b>                | Salivary gland tumors                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Required Medical Information</b>  | For salivary gland tumors: 1) the disease is androgen receptor positive AND 2) the disease is recurrent, metastatic, or unresectable.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|--------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | EMGALITY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Drug Names</b>                    | EMGALITY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Required Medical Information</b>  | For preventative treatment of migraine: The requested drug will not be used concurrently with another calcitonin gene-related peptide (CGRP) receptor antagonist. For preventive treatment of migraine, continuation: The patient received at least 3 months of treatment with the requested drug and had a reduction in migraine days per month from baseline. For episodic cluster headache, initial: The patient experienced an inadequate treatment response, intolerance, or contraindication to a triptan 5-HT1 receptor agonist. For episodic cluster headache, continuation: The patient received the requested drug for at least 3 weeks of treatment and had a reduction in weekly cluster headache attack frequency from baseline. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Coverage Duration</b>             | Initial: 3 months, Continuation: Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Prior Authorization Group</b>     | EMSAM                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Drug Names</b>                    | EMSAM                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Required Medical Information</b>  | For Major Depressive Disorder (MDD): 1) The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to TWO of the following: serotonin and norepinephrine reuptake inhibitors (SNRIs), selective serotonin reuptake inhibitors (SSRIs), mirtazapine, bupropion, OR 2) The patient is unable to swallow oral formulations.                                                                                                                                                                                                                                                                                                                                                                |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | ENDARI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Drug Names</b>                    | L-GLUTAMINE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Age Restrictions</b>              | 5 years of age or older                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Prior Authorization Group</b>     | EPCLUSA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Drug Names</b>                    | EPCLUSA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Required Medical Information</b>  | For hepatitis C virus (HCV): Infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of human immunodeficiency virus (HIV) coinfection, presence or absence of resistance-associated substitutions where applicable, transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current American Association for the Study of Liver Diseases and Infectious Diseases Society of America (AASLD-IDSA) treatment guidelines. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Coverage Duration</b>             | Criteria will be applied consistent with current AASLD-IDSA guidance                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Prior Authorization Group</b>     | EPIDIOLEX                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Drug Names</b>                    | EPIDIOLEX                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Age Restrictions</b>              | 1 year of age or older                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | EPRONTIA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Drug Names</b>                    | TOPIRAMATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Required Medical Information</b>  | For treatment of partial-onset seizures (i.e., focal-onset seizures): 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a generic anticonvulsant AND 2) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to any of the following: Aptiom (if 4 years of age or older), Xcopri (if 18 years of age or older), Spritam (if 4 years of age or older). For monotherapy treatment of primary generalized tonic-clonic seizures: 1) The patient has experienced an inadequate treatment response or intolerance to a generic topiramate immediate release product, OR 2) The patient has difficulty swallowing solid oral dosage forms (e.g., tablets, capsules). For adjunctive treatment of primary generalized tonic-clonic seizures: 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a generic anticonvulsant AND 2) If the patient is 6 years of age or older, the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to Spritam. For the preventative treatment of migraines: 1) The patient has experienced an inadequate treatment response or intolerance to a generic topiramate immediate release product, OR 2) The patient has difficulty swallowing solid oral dosage forms (e.g., tablets, capsules). |
| <b>Age Restrictions</b>              | Epilepsy: 2 years of age or older, Migraine: 12 years of age or older                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Prior Authorization Group</b>     | ERGOTAMINE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Drug Names</b>                    | ERGOTAMINE TARTRATE/CAFFE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Exclusion Criteria</b>            | Coverage will be denied when used in conjunction with potent CYP3A4 inhibitors (e.g., ritonavir, nelfinavir, indinavir, erythromycin, clarithromycin).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Required Medical Information</b>  | The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least ONE triptan 5-HT <sub>1</sub> agonist.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |

|                                      |                                                                                                                                                                                                                                                                                                                                             |
|--------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | ERIVEDGE - PENDING CMS REVIEW                                                                                                                                                                                                                                                                                                               |
| <b>Drug Names</b>                    | ERIVEDGE                                                                                                                                                                                                                                                                                                                                    |
| <b>PA Indication Indicator</b>       | -                                                                                                                                                                                                                                                                                                                                           |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                           |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                           |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                           |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                           |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                           |
| <b>Coverage Duration</b>             | -                                                                                                                                                                                                                                                                                                                                           |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                           |
| <b>Prior Authorization Group</b>     | ERLEADA                                                                                                                                                                                                                                                                                                                                     |
| <b>Drug Names</b>                    | ERLEADA                                                                                                                                                                                                                                                                                                                                     |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                           |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                           |
| <b>Required Medical Information</b>  | The requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy.                                                                                                                                                                                                          |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                           |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                           |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                   |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                           |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                          |
| <b>Prior Authorization Group</b>     | ERLOTINIB                                                                                                                                                                                                                                                                                                                                   |
| <b>Drug Names</b>                    | ERLOTINIB HYDROCHLORIDE                                                                                                                                                                                                                                                                                                                     |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                           |
| <b>Off-label Uses</b>                | Recurrent non-small cell lung cancer (NSCLC), recurrent chordoma, relapsed or stage IV renal cell carcinoma (RCC), brain metastases from non-small cell lung cancer (NSCLC), recurrent pancreatic cancer                                                                                                                                    |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                           |
| <b>Required Medical Information</b>  | For non-small cell lung cancer (NSCLC) (including brain metastases from NSCLC): 1) the disease is recurrent, advanced, or metastatic, AND 2) the patient has sensitizing epidermal growth factor receptor (EGFR) mutation-positive disease. For pancreatic cancer: the disease is locally advanced, unresectable, recurrent, or metastatic. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                           |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                           |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                   |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                           |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                          |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|--------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | ESBRIET                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Drug Names</b>                    | PIRFENIDONE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Required Medical Information</b>  | For idiopathic pulmonary fibrosis (new starts only): 1) other causes of pulmonary fibrosis have been excluded, AND 2) the patient meets one of the following: a) a high-resolution computed tomography (HRCT) study of the chest or a lung biopsy reveals the usual interstitial pneumonia (UIP) pattern, OR b) HRCT study of the chest reveals a result other than the UIP pattern (e.g., probable UIP, indeterminate for UIP) and the diagnosis is supported either by a lung biopsy or by a multidisciplinary discussion between at least a radiologist and pulmonologist who are experienced in idiopathic pulmonary fibrosis if a lung biopsy has not been conducted. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|--------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | ETANERCEPT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Drug Names</b>                    | ENBREL, ENBREL MINI, ENBREL SURECLICK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Off-label Uses</b>                | Hidradenitis suppurativa, non-radiographic axial spondyloarthritis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Required Medical Information</b>  | For moderately to severely active rheumatoid arthritis (new starts only): 1) Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to methotrexate (MTX) OR 2) Patient has experienced an inadequate treatment response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. For active ankylosing spondylitis and non-radiographic axial spondyloarthritis (new starts only): 1) Patient has experienced an inadequate treatment response or intolerance to a non-steroidal anti-inflammatory drug (NSAID) OR 2) The patient has a contraindication that would prohibit a trial of NSAIDs. For moderate to severe plaque psoriasis (new starts only): 1) Crucial body areas (e.g., hands, feet, face, scalp, neck, genitals/groin, intertriginous areas) are affected at the time of diagnosis, OR 2) Patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of the body surface area is affected), OR 3) At least 3% of body surface area (BSA) is affected and patient meets either of the following: a) Patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) Pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated. For hidradenitis suppurativa (new starts only): patient has severe, refractory disease. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|--------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | EUCRISA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Drug Names</b>                    | EUCRISA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Required Medical Information</b>  | For mild to moderate atopic dermatitis, the patient meets either of the following criteria:<br>1) If the patient is 2 years of age or older and the requested drug will be used on sensitive skin areas (e.g., face, genitals, or skin folds), the patient has experienced an inadequate treatment response, intolerance, or contraindication to a topical calcineurin inhibitor OR 2) If the patient is 2 years of age or older and the requested drug is being prescribed for use on non-sensitive (or remaining) skin areas, the patient has experienced an inadequate treatment response, intolerance, or contraindication to a medium or higher potency topical corticosteroid or a topical calcineurin inhibitor. |
| <b>Age Restrictions</b>              | 3 months of age or older                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |

**Prior Authorization Group****Drug Names****PA Indication Indicator****Off-label Uses**

EVEROLIMUS

EVEROLIMUS, TORPENZ

All FDA-approved Indications, Some Medically-accepted Indications

Classic Hodgkin lymphoma, thymomas and thymic carcinomas, previously treated Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, soft tissue sarcoma (perivascular epithelioid cell tumors (PEComa) and lymphangioleiomyomatosis subtypes), gastrointestinal stromal tumors, neuroendocrine tumors of the thymus, well differentiated grade 3 neuroendocrine tumors, thyroid carcinoma (papillary, oncocytic, and follicular), endometrial carcinoma, uterine sarcoma, breast cancer (in combination with fulvestrant or tamoxifen), histiocytic neoplasms (Rosai-Dorfman Disease, Erdheim-Chester Disease, Langerhans Cell Histiocytosis), meningiomas.

**Exclusion Criteria**

-

**Required Medical Information**

For breast cancer: 1) The disease is recurrent unresectable, advanced, or metastatic hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, AND 2) The requested drug is prescribed in combination with exemestane, fulvestrant, or tamoxifen, AND 3) The requested drug is used for subsequent treatment. For renal cell carcinoma: The disease is relapsed, advanced, or stage IV. For subependymal giant cell astrocytoma (SEGA): The requested drug is given as adjuvant treatment. For gastrointestinal stromal tumor: 1) The disease is residual, recurrent, unresectable, or metastatic/tumor rupture, AND 2) The disease has progressed after use of at least two FDA-approved therapies (e.g., imatinib, sunitinib, regorafenib, ripretinib). For Erdheim-Chester Disease (ECD), Rosai-Dorfman Disease, and Langerhans Cell Histiocytosis (LCH): the patient must have a phosphatidylinositol-4,5-bisphosphate 3-kinase catalytic subunit alpha (PIK3CA) mutation.

**Age Restrictions**

-

**Prescriber Restrictions**

-

**Coverage Duration**

Plan Year

**Other Criteria**

-

**Prerequisite Therapy Required**

Yes

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|--------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | FABRAZYME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Drug Names</b>                    | FABRAZYME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Required Medical Information</b>  | For Fabry disease, the patient meets ANY of the following: 1) Diagnosis of Fabry disease was confirmed by an enzyme assay demonstrating a deficiency of alpha-galactosidase enzyme activity or by genetic testing, OR 2) The patient is a symptomatic obligate carrier.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Prior Authorization Group</b>     | FANAPT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Drug Names</b>                    | FANAPT, FANAPT TITRATION PACK A, FANAPT TITRATION PACK B, FANAPT TITRATION PACK C                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Required Medical Information</b>  | For treatment of schizophrenia: 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following generic products: aripiprazole, asenapine, lurasidone, olanzapine, quetiapine, risperidone, ziprasidone, AND 2) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following brand products: Lybalvi, Caplyta, Rexulti, Secuado, Vraylar. For acute treatment of manic or mixed episodes associated with bipolar I disorder: 1) The patient experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following generic products: aripiprazole, asenapine, olanzapine, quetiapine, risperidone, ziprasidone, AND 2) The patient experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following brand products: Lybalvi, Vraylar. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|--------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | FASENRA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Drug Names</b>                    | FASENRA, FASENRA PEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Required Medical Information</b>  | For severe asthma, initial therapy: 1) Either a) Patient has baseline blood eosinophil count of at least 150 cells per microliter OR b) Patient is dependent on systemic corticosteroids, AND 2) Patient has a history of severe asthma despite current treatment with both of the following medications: a) medium-to-high-dose inhaled corticosteroid AND b) additional controller (i.e., long-acting beta2-agonist, long-acting muscarinic antagonist, leukotriene modifier, or sustained-release theophylline), unless patient has an intolerance or contraindication to such therapies. For severe asthma, continuation of therapy: Asthma control has improved on treatment with the requested drug, as demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations or a reduction in the daily maintenance oral corticosteroid dose. For eosinophilic granulomatosis with polyangiitis (EGPA), initial therapy: patient has a history or the presence of an eosinophil count of more than 1000 cells per microliter or a blood eosinophil level of greater than 10 percent. For EGPA, continuation of therapy: patient has a beneficial response to treatment with the requested drug, as demonstrated by any of the following: 1) a reduction in the frequency of relapses, 2) a reduction in the daily oral corticosteroid dose, OR 3) no active vasculitis. |
| <b>Age Restrictions</b>              | Asthma: 6 years of age or older, EGPA: 18 years of age or older                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|--------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | FENTANYL PATCH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Drug Names</b>                    | FENTANYL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Required Medical Information</b>  | The requested drug is being prescribed for pain associated with cancer, sickle cell disease, a terminal condition, or pain being managed through palliative care OR the patient meets all of the following: 1) The requested drug is being prescribed for pain severe and persistent enough to require an extended treatment period with a daily opioid analgesic in a patient who has been taking an opioid AND 2) The patient can safely take the requested dose based on their history of opioid use [Note: This drug should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.] AND 3) The patient has been evaluated and the patient will be monitored for the development of opioid use disorder AND 4) This request is for continuation of therapy for a patient who has been receiving an extended-release opioid agent for at least 30 days OR the patient has taken an immediate-release opioid for at least one week. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prior Authorization Group</b>     | FETZIMA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Drug Names</b>                    | FETZIMA, FETZIMA TITRATION PACK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Required Medical Information</b>  | For major depressive disorder (MDD): The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to TWO of the following: serotonin and norepinephrine reuptake inhibitors (SNRIs), selective serotonin reuptake inhibitors (SSRIs), mirtazapine, bupropion.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |

|                                      |                                  |
|--------------------------------------|----------------------------------|
| <b>Prior Authorization Group</b>     | FINTEPLA                         |
| <b>Drug Names</b>                    | FINTEPLA                         |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications     |
| <b>Off-label Uses</b>                | -                                |
| <b>Exclusion Criteria</b>            | -                                |
| <b>Required Medical Information</b>  | -                                |
| <b>Age Restrictions</b>              | 2 years of age or older          |
| <b>Prescriber Restrictions</b>       | -                                |
| <b>Coverage Duration</b>             | Plan Year                        |
| <b>Other Criteria</b>                | -                                |
| <b>Prerequisite Therapy Required</b> | No                               |
| <b>Prior Authorization Group</b>     | FIRMAGON                         |
| <b>Drug Names</b>                    | FIRMAGON                         |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications     |
| <b>Off-label Uses</b>                | -                                |
| <b>Exclusion Criteria</b>            | -                                |
| <b>Required Medical Information</b>  | -                                |
| <b>Age Restrictions</b>              | -                                |
| <b>Prescriber Restrictions</b>       | -                                |
| <b>Coverage Duration</b>             | Plan Year                        |
| <b>Other Criteria</b>                | -                                |
| <b>Prerequisite Therapy Required</b> | No                               |
| <b>Prior Authorization Group</b>     | FLUCYTOSINE - PENDING CMS REVIEW |
| <b>Drug Names</b>                    | FLUCYTOSINE                      |
| <b>PA Indication Indicator</b>       | -                                |
| <b>Off-label Uses</b>                | -                                |
| <b>Exclusion Criteria</b>            | -                                |
| <b>Required Medical Information</b>  | -                                |
| <b>Age Restrictions</b>              | -                                |
| <b>Prescriber Restrictions</b>       | -                                |
| <b>Coverage Duration</b>             | -                                |
| <b>Other Criteria</b>                | -                                |

|                                      |                                                                                                                                                                                                                                          |
|--------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | FORM ALT PA CLINDAMYCIN - PENDING CMS REVIEW                                                                                                                                                                                             |
| <b>Drug Names</b>                    | CLINDAMYCIN PHOSPHATE                                                                                                                                                                                                                    |
| <b>PA Indication Indicator</b>       | -                                                                                                                                                                                                                                        |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                        |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                        |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                        |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                        |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                        |
| <b>Coverage Duration</b>             | -                                                                                                                                                                                                                                        |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                        |
| <b>Prior Authorization Group</b>     | FOTIVDA - PENDING CMS REVIEW                                                                                                                                                                                                             |
| <b>Drug Names</b>                    | FOTIVDA                                                                                                                                                                                                                                  |
| <b>PA Indication Indicator</b>       | -                                                                                                                                                                                                                                        |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                        |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                        |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                        |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                        |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                        |
| <b>Coverage Duration</b>             | -                                                                                                                                                                                                                                        |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                        |
| <b>Prior Authorization Group</b>     | FRUZAQLA                                                                                                                                                                                                                                 |
| <b>Drug Names</b>                    | FRUZAQLA                                                                                                                                                                                                                                 |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                        |
| <b>Off-label Uses</b>                | Appendiceal adenocarcinoma                                                                                                                                                                                                               |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                        |
| <b>Required Medical Information</b>  | For colorectal cancer and appendiceal adenocarcinoma: 1) the disease is advanced or metastatic, AND 2) the requested drug will be used as a single agent, AND 3) the requested drug will be used as a second line or subsequent therapy. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                        |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                        |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                        |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                       |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|--------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | FULPHILA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Drug Names</b>                    | FULPHILA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Off-label Uses</b>                | Stem cell transplantation-related indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Required Medical Information</b>  | If receiving chemotherapy, the requested drug will be administered at least 24 hours after chemotherapy. For prophylaxis of myelosuppressive chemotherapy-induced febrile neutropenia: the patient must meet both of the following: 1) Patient has a solid tumor or non-myeloid cancer, AND 2) Patient is currently receiving or will be receiving treatment with myelosuppressive anti-cancer therapy.                                                                                                                                                                                                                                                                                                    |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Coverage Duration</b>             | 6 months                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Prior Authorization Group</b>     | FYCOMPA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Drug Names</b>                    | FYCOMPA, PERAMPANEL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Required Medical Information</b>  | For treatment of partial-onset seizures (i.e., focal-onset seizures): 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a generic anticonvulsant AND 2) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to any of the following: Aptiom, Xcopri, Spritam. For adjunctive treatment of primary generalized tonic-clonic seizures: 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a generic anticonvulsant AND 2) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to Spritam. |
| <b>Age Restrictions</b>              | Partial-onset seizures (i.e., focal-onset seizures): 4 years of age or older. Primary generalized tonic-clonic seizures: 12 years of age or older                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |

|                                      |                                                                                                                                                                                                                                       |
|--------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | GATTEX - PENDING CMS REVIEW                                                                                                                                                                                                           |
| <b>Drug Names</b>                    | GATTEX                                                                                                                                                                                                                                |
| <b>PA Indication Indicator</b>       | -                                                                                                                                                                                                                                     |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                     |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                     |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                     |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                     |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                     |
| <b>Coverage Duration</b>             | -                                                                                                                                                                                                                                     |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                     |
| <b>Prior Authorization Group</b>     | GAVRETO                                                                                                                                                                                                                               |
| <b>Drug Names</b>                    | GAVRETO                                                                                                                                                                                                                               |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                     |
| <b>Off-label Uses</b>                | Recurrent rearranged during transfection (RET) rearrangement-positive non-small cell lung cancer, RET gene fusion positive gallbladder cancer                                                                                         |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                     |
| <b>Required Medical Information</b>  | For non-small cell lung cancer, patient must meet all of the following: 1) The disease is recurrent, advanced, or metastatic, AND 2) The tumor is rearranged during transfection (RET) fusion-positive or RET rearrangement-positive. |
| <b>Age Restrictions</b>              | Non-small cell lung cancer: 18 years of age or older, Thyroid cancer: 12 years of age or older                                                                                                                                        |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                     |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                             |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                     |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                    |
| <b>Prior Authorization Group</b>     | GILENYA                                                                                                                                                                                                                               |
| <b>Drug Names</b>                    | FINGOLIMOD HYDROCHLORIDE                                                                                                                                                                                                              |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                          |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                     |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                     |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                     |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                     |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                     |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                             |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                     |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                    |

|                                      |                                                                                                                                                                                                                                                                                                                                                                          |
|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | GILOTRIF                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Drug Names</b>                    | GILOTRIF                                                                                                                                                                                                                                                                                                                                                                 |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                             |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Required Medical Information</b>  | For epidermal growth factor receptor (EGFR)-positive non-small cell lung cancer (NSCLC): 1) The disease is recurrent, advanced, or metastatic, AND 2) The patient has experienced an intolerable adverse event or contraindication to erlotinib, gefitinib, or osimertinib. For metastatic squamous NSCLC: The disease has progressed after platinum-based chemotherapy. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Prior Authorization Group</b>     | GLATIRAMER                                                                                                                                                                                                                                                                                                                                                               |
| <b>Drug Names</b>                    | COPAXONE, GLATIRAMER ACETATE, GLATOPA                                                                                                                                                                                                                                                                                                                                    |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                             |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Prior Authorization Group</b>     | GOMEKLI                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Drug Names</b>                    | GOMEKLI                                                                                                                                                                                                                                                                                                                                                                  |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                             |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Age Restrictions</b>              | 2 years of age or older                                                                                                                                                                                                                                                                                                                                                  |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                       |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|--------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | GROWTH HORMONE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Drug Names</b>                    | GENOTROPIN, GENOTROPIN MINIQICK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>PA Indication Indicator</b>       | All Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Exclusion Criteria</b>            | Pediatric patients with closed epiphyses                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Required Medical Information</b>  | Pediatric growth hormone deficiency (GHD): Patient (pt) is a neonate or was diagnosed with GHD as a neonate OR meets any of the following: 1) younger than 2.5 years old (yo) with pre-treatment (pre-tx) height (ht) more than 2 standard deviations (SD) below mean and slow growth velocity OR 2) 2.5 yo or older AND one of the following: a) pre-tx 1-year ht velocity more than 2 SD below mean OR b) pre-tx ht more than 2 SD below mean and 1-year ht velocity more than 1 SD below mean, AND patient meets any of the following: 1) failed 2 pre-tx growth hormone (GH) stimulation tests (peak below 10 ng/mL), OR 2) pituitary/central nervous system (CNS) disorder (e.g., genetic defects, acquired structural abnormalities, congenital structural abnormalities) and pre-tx insulin-like growth factor-1 (IGF-1) more than 2 SD below mean. Turner syndrome (TS): 1) Confirmed by karyotyping AND 2) pre-tx ht is less than the 5th percentile for age. Small for gestational age (SGA): 1) Birth weight (wt) less than 2500g at gestational age (GA) greater than 37 weeks, OR birth wt or length below 3rd percentile for GA or at least 2 SD below mean for GA, AND 2) did not manifest catch-up growth by age 2. |
| <b>Age Restrictions</b>              | SGA: 2 years of age or older                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Prescriber Restrictions</b>       | Prescribed by or in consultation with an endocrinologist, nephrologist, infectious disease specialist, gastroenterologist/nutritional support specialist, or geneticist                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Other Criteria</b>                | Adult GHD: Pt meets any of the following: 1) failed 2 pre-tx GH stimulation tests, OR 2) pre-tx IGF-1 more than 2 SD below mean AND failed 1 pre-tx GH stimulation test, OR 3) organic hypothalamic-pituitary disease (e.g., suprasellar mass with previous surgery and cranial irradiation) with 3 or more pituitary hormone deficiencies AND pre-tx IGF-1 more than 2 SD below mean, OR 4) genetic or structural hypothalamic-pituitary defects, OR 5) childhood-onset GHD with congenital (genetic or structural) abnormality of the hypothalamus/pituitary/CNS. For pediatric GHD, TS, SGA, and adult GHD, continuation of therapy: Patient is experiencing improvement.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|--------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | HADLIMA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Drug Names</b>                    | HADLIMA, HADLIMA PUSHTOUCH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Off-label Uses</b>                | Non-radiographic axial spondyloarthritis, Behcet's disease                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Required Medical Information</b>  | For moderately to severely active rheumatoid arthritis (new starts only): 1) patient (pt) has experienced an inadequate treatment response, intolerance, or has a contraindication to methotrexate (MTX) OR 2) pt has experienced an inadequate treatment response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. For active ankylosing spondylitis and non-radiographic axial spondyloarthritis (new starts only): 1) pt has experienced an inadequate treatment response or intolerance to a non-steroidal anti-inflammatory drug (NSAID) OR 2) pt has a contraindication that would prohibit a trial of NSAIDs. For moderate to severe plaque psoriasis (new starts): 1) Crucial body areas (e.g., hands, feet, face, scalp, neck, genitals/groin, intertriginous areas) are affected at the time of diagnosis OR 2) patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of the body surface area is affected) OR 3) at least 3% of body surface area (BSA) is affected and patient meets either of the following: a) patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Other Criteria</b>                | For non-infectious intermediate, posterior and panuveitis (new starts only): 1) pt has experienced an inadequate treatment response or intolerance to a corticosteroid OR 2) pt has a contraindication that would prohibit a trial of corticosteroids.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|--------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | HAEGARDA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Drug Names</b>                    | HAEGARDA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Required Medical Information</b>  | For the prophylaxis of angioedema attacks due to hereditary angioedema (HAE): 1) the patient has HAE with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing, OR 2) the patient has HAE with normal C1 inhibitor confirmed by laboratory testing and one of the following: a) the patient tested positive for an F12, angiopoietin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation, b) the patient has a family history of angioedema and the angioedema was refractory to a trial of high-dose antihistamine therapy for at least one month. |
| <b>Age Restrictions</b>              | 6 years of age or older                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Prescriber Restrictions</b>       | Prescribed by or in consultation with an immunologist, allergist, or rheumatologist                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |

**Prior Authorization Group****Drug Names****PA Indication Indicator****Off-label Uses**

HERCEPTIN

HERCEPTIN

All FDA-approved Indications, Some Medically-accepted Indications

Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent or advanced unresectable HER2-positive breast cancer, leptomeningeal metastases from HER2-positive breast cancer, brain metastases from HER2-positive breast cancer, HER2-positive esophageal and esophagogastric junction adenocarcinoma, HER2-positive advanced, recurrent, or metastatic uterine serous carcinoma, HER2-amplified and RAS and BRAF wild-type colorectal cancer (including appendiceal adenocarcinoma), HER2-positive recurrent salivary gland tumor, HER2-positive unresectable or metastatic hepatobiliary carcinoma (gallbladder cancer, intrahepatic cholangiocarcinoma, extrahepatic cholangiocarcinoma), HER2 overexpression positive locally advanced, unresectable, or recurrent gastric adenocarcinoma, HER2-positive endometrial cancer

**Exclusion Criteria**

-

**Required Medical Information**

All indications: the patient had an intolerable adverse event to Trazimera and that adverse event was NOT attributed to the active ingredient as described in the prescribing information. For colorectal cancer (including appendiceal adenocarcinoma): 1) the disease is HER2-amplified and RAS and BRAF wild-type and 2) the requested drug is used in combination with pertuzumab, tucatinib or lapatinib and 3) the patient has not had previous treatment with a HER2 inhibitor OR 4) the patient has metachronous metastases. For hepatobiliary carcinoma: 1) the disease is HER2-positive AND 2) the requested drug is used in combination with pertuzumab or tucatinib. For endometrial cancer: 1) the disease is HER2-positive AND 2) the requested drug is used in combination with paclitaxel and continued as a single agent for maintenance therapy.

**Age Restrictions**

-

**Prescriber Restrictions**

-

**Coverage Duration**

Plan Year

**Other Criteria**

Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

**Prerequisite Therapy Required**

Yes

|                                      |                                                                                                                                                                        |
|--------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | HERCEPTIN HYLECTA                                                                                                                                                      |
| <b>Drug Names</b>                    | HERCEPTIN HYLECTA                                                                                                                                                      |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                      |
| <b>Off-label Uses</b>                | Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent or advanced unresectable HER2-positive breast cancer       |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                      |
| <b>Required Medical Information</b>  | -                                                                                                                                                                      |
| <b>Age Restrictions</b>              | -                                                                                                                                                                      |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                      |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                              |
| <b>Other Criteria</b>                | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual. |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                     |
| <b>Prior Authorization Group</b>     | HERNEXEOS - PENDING CMS REVIEW                                                                                                                                         |
| <b>Drug Names</b>                    | HERNEXEOS                                                                                                                                                              |
| <b>PA Indication Indicator</b>       | -                                                                                                                                                                      |
| <b>Off-label Uses</b>                | -                                                                                                                                                                      |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                      |
| <b>Required Medical Information</b>  | -                                                                                                                                                                      |
| <b>Age Restrictions</b>              | -                                                                                                                                                                      |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                      |
| <b>Coverage Duration</b>             | -                                                                                                                                                                      |
| <b>Other Criteria</b>                | -                                                                                                                                                                      |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|--------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | HERZUMA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Drug Names</b>                    | HERZUMA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Off-label Uses</b>                | Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent or advanced unresectable HER2-positive breast cancer, leptomeningeal metastases from HER2-positive breast cancer, brain metastases from HER2-positive breast cancer, HER2-positive esophageal and esophagogastric junction adenocarcinoma, HER2-positive advanced, recurrent, or metastatic uterine serous carcinoma, HER2-amplified and RAS and BRAF wild-type colorectal cancer (including appendiceal adenocarcinoma), HER2-positive recurrent salivary gland tumor, HER2-positive unresectable or metastatic hepatobiliary carcinoma (gallbladder cancer, intrahepatic cholangiocarcinoma, extrahepatic cholangiocarcinoma), HER2 overexpression positive locally advanced, unresectable, or recurrent gastric adenocarcinoma, HER2-positive endometrial cancer |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Required Medical Information</b>  | All indications: the patient had an intolerable adverse event to Trazimera and that adverse event was NOT attributed to the active ingredient as described in the prescribing information. For colorectal cancer (including appendiceal adenocarcinoma): 1) the disease is HER2-amplified and RAS and BRAF wild-type and 2) the requested drug is used in combination with pertuzumab, tucatinib or lapatinib and 3) the patient has not had previous treatment with a HER2 inhibitor OR 4) the patient has metachronous metastases. For hepatobiliary carcinoma: 1) the disease is HER2-positive AND 2) the requested drug is used in combination with pertuzumab or tucatinib. For endometrial cancer: 1) the disease is HER2-positive AND 2) the requested drug is used in combination with paclitaxel and continued as a single agent for maintenance therapy.              |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Other Criteria</b>                | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|--------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | HETLIOZ                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Drug Names</b>                    | TASIMELTEON                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Required Medical Information</b>  | For Non-24-Hour Sleep-Wake Disorder: 1) For initial therapy and continuation of therapy, the patient must meet both of the following: a) diagnosis of total blindness in both eyes (e.g., nonfunctioning retinas) and b) unable to perceive light in either eye, AND 2) If currently on therapy with the requested drug, patient must meet at least one of the following: a) increased total nighttime sleep or b) decreased daytime nap duration. For nighttime sleep disturbances in Smith-Magenis Syndrome (SMS): 1) For initial therapy and continuation therapy, the patient has a confirmed diagnosis of SMS, AND 2) If currently on therapy with the requested drug, the patient experienced improvement in the quality of sleep since starting therapy. |
| <b>Age Restrictions</b>              | Non-24: 18 years of age or older, SMS: 16 years of age or older                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prescriber Restrictions</b>       | Prescribed by or in consultation with a sleep disorder specialist, neurologist, or psychiatrist                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Coverage Duration</b>             | Initial: 6 months, Continuation: Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Prior Authorization Group</b>     | HIGH RISK MEDICATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Drug Names</b>                    | DIPYRIDAMOLE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Required Medical Information</b>  | Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Other Criteria</b>                | This Prior Authorization only applies to patients 65 years of age or older. (The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | HRM-AMITRIPTYLINE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Drug Names</b>                    | AMITRIPTYLINE HCL, AMITRIPTYLINE HYDROCHLORI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Off-label Uses</b>                | Neuropathic pain, chronic tension-type headache prophylaxis, chronic neck pain                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Required Medical Information</b>  | For depression: 1) The patient tried two of the following alternative drugs: SSRIs (selective serotonin reuptake inhibitors), SNRIs (serotonin-norepinephrine reuptake inhibitors), bupropion, mirtazapine, or trazodone AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following alternative drugs: SSRIs (selective serotonin reuptake inhibitors), SNRIs (serotonin-norepinephrine reuptake inhibitors), bupropion, mirtazapine, or trazodone. For all indications: 1) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient, AND 2) If the patient is taking one or more additional anticholinergic medications (e.g., oxybutynin, meclizine, paroxetine, amitriptyline, dicyclomine, cyclobenzaprine) with the requested drug, the prescriber has determined that taking multiple anticholinergic medications is medically necessary for the patient [Note: Use of multiple anticholinergic medications in older adults is associated with an increased risk of cognitive decline.]. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Other Criteria</b>                | This Prior Authorization only applies to patients 65 years of age or older. (The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Prior Authorization Group</b>     | HRM-ANTICONVULSANTS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Drug Names</b>                    | PHENOBARBITAL, PHENOBARBITAL SODIUM                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Off-label Uses</b>                | Epilepsy                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Required Medical Information</b>  | Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Other Criteria</b>                | This Prior Authorization only applies to patients 65 years of age or older. (The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|--------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | HRM-ANTIPARKINSON                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Drug Names</b>                    | BENZTROPINE MESYLATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Required Medical Information</b>  | EPS (extrapyramidal symptoms): 1) The patient has not tried the non-HRM alternative drug amantadine AND 2) The patient has a contraindication to the non-HRM alternative drug amantadine OR 3) The patient has tried the non-HRM alternative drug amantadine AND 4) The patient experienced an inadequate treatment response OR intolerance to the non-HRM alternative drug amantadine. Parkinson's: 1) The patient has tried two of the following non-HRM alternative drugs: amantadine, carbidopa/levodopa, pramipexole, or ropinirole AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following non-HRM alternative drugs: amantadine, carbidopa/levodopa, pramipexole, or ropinirole. For all indications: 1) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient, AND 2) If the patient is taking one or more additional anticholinergic medications (e.g., oxybutynin, meclizine, paroxetine, amitriptyline, dicyclomine, cyclobenzaprine) with the requested drug, the prescriber has determined that taking multiple anticholinergic medications is medically necessary for the patient [Note: Use of multiple anticholinergic medications in older adults is associated with an increased risk of cognitive decline.]. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Other Criteria</b>                | This Prior Authorization only applies to patients 65 years of age or older. (The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | HRM-CYPROHEPTADINE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Drug Names</b>                    | CYPROHEPTADINE HCL, CYPROHEPTADINE HYDROCHLOR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Off-label Uses</b>                | Pruritus, spasticity due to spinal cord injury                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Required Medical Information</b>  | For rhinitis: 1) The patient has tried two of the following non-HRM alternative drugs: levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following non-HRM alternative drugs: levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal. For all indications: 1) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient, AND 2) If the patient is taking one or more additional anticholinergic medications (e.g., oxybutynin, meclizine, paroxetine, amitriptyline, dicyclomine, cyclobenzaprine) with the requested drug, the prescriber has determined that taking multiple anticholinergic medications is medically necessary for the patient [Note: Use of multiple anticholinergic medications in older adults is associated with an increased risk of cognitive decline.]. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Coverage Duration</b>             | 3 months                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Other Criteria</b>                | This Prior Authorization only applies to patients 65 years of age or older. (The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.). Prior Authorization applies to greater than cumulative 30 days of therapy per year.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|--------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | HRM-DOXEPIN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Drug Names</b>                    | DOXEPIN HCL, DOXEPIN HYDROCHLORIDE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Required Medical Information</b>  | For depression: 1) The patient tried two of the following alternative drugs: SSRIs (selective serotonin reuptake inhibitors), SNRIs (serotonin-norepinephrine reuptake inhibitors), bupropion, mirtazapine, or trazodone AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following alternative drugs: SSRIs (selective serotonin reuptake inhibitors), SNRIs (serotonin-norepinephrine reuptake inhibitors), bupropion, mirtazapine, or trazodone. For anxiety: 1) The patient has tried two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline, or venlafaxine extended-release AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline, or venlafaxine extended-release. For all indications: 1) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient, AND 2) If the patient is taking one or more additional anticholinergic medications (e.g., oxybutynin, meclizine, paroxetine, amitriptyline, dicyclomine, cyclobenzaprine) with the requested drug, the prescriber has determined that taking multiple anticholinergic medications is medically necessary for the patient [Note: Use of multiple anticholinergic medications in older adults is associated with an increased risk of cognitive decline.]. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Other Criteria</b>                | This Prior Authorization only applies to patients 65 years of age or older. (The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |

|                                      |                                                                                                                                                                                                                                                               |
|--------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | HRM-GUANFACINE ER                                                                                                                                                                                                                                             |
| <b>Drug Names</b>                    | GUANFACINE HYDROCHLORIDE                                                                                                                                                                                                                                      |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                  |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                             |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                             |
| <b>Required Medical Information</b>  | Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient.                                                                                                                       |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                             |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                             |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                     |
| <b>Other Criteria</b>                | This Prior Authorization only applies to patients 65 years of age or older. (The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                            |
| <b>Prior Authorization Group</b>     | HRM-GUANFACINE IR                                                                                                                                                                                                                                             |
| <b>Drug Names</b>                    | GUANFACINE HYDROCHLORIDE                                                                                                                                                                                                                                      |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                  |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                             |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                             |
| <b>Required Medical Information</b>  | Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient.                                                                                                                       |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                             |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                             |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                     |
| <b>Other Criteria</b>                | This Prior Authorization only applies to patients 65 years of age or older. (The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                            |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | HRM-HYDROXYZINE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Drug Names</b>                    | HYDROXYZINE HCL, HYDROXYZINE HYDROCHLORIDE, HYDROXYZINE PAMOATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Required Medical Information</b>  | For anxiety: 1) The patient has tried two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline, or venlafaxine extended-release AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline, or venlafaxine extended-release OR 3) The patient has not tried two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline or venlafaxine extended-release AND 4) The patient has acute anxiety. For all indications: 1) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient. AND 2) If the patient is taking one or more additional anticholinergic medications (e.g., oxybutynin, meclizine, paroxetine, amitriptyline, dicyclomine, cyclobenzaprine) with the requested drug, the prescriber has determined that taking multiple anticholinergic medications is medically necessary for the patient [Note: Use of multiple anticholinergic medications in older adults is associated with an increased risk of cognitive decline.]. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Coverage Duration</b>             | 3 months                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Other Criteria</b>                | This Prior Authorization only applies to patients 65 years of age or older. (The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.). Prior authorization applies to greater than cumulative 30 days of therapy per year.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|--------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | HRM-HYDROXYZINE INJ                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Drug Names</b>                    | HYDROXYZINE HCL, HYDROXYZINE HYDROCHLORIDE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Required Medical Information</b>  | Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient. For Alcohol Withdrawal Syndrome: 1) The patient has not tried one of the following alternative drugs: clorazepate or lorazepam AND 2) The patient has a contraindication to one of the following alternative drugs: clorazepate or lorazepam OR 3) The patient has tried one of the following alternative drugs: clorazepate or lorazepam AND 4) The patient experienced an inadequate treatment response OR intolerance to one of the following alternative drugs: clorazepate or lorazepam. For anxiety: 1) The patient has tried two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline or venlafaxine extended-release AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline or venlafaxine extended-release OR 3) The patient has not tried two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline or venlafaxine extended-release AND 4) The patient has acute anxiety. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Other Criteria</b>                | This Prior Authorization only applies to patients 65 years of age or older. (The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|--------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | HRM-HYPNOTICS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Drug Names</b>                    | ZOLPIDEM TARTRATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Required Medical Information</b>  | For insomnia: 1) The patient meets one of the following: a) the patient has a contraindication to the non-HRM (non-High Risk Medication) alternative drugs doxepin (3 mg or 6 mg) and ramelteon OR b) The patient has tried one of the following non-HRM (non-High Risk Medication) alternative drugs: doxepin (3 mg or 6 mg) or ramelteon AND the patient experienced an inadequate treatment response OR intolerance to one of the following non-HRM (non-High Risk Medication) alternative drugs: doxepin (3 mg or 6 mg) or ramelteon AND 2) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient AND 3) If the patient is using two or more additional central nervous system (CNS) active medications (e.g., lorazepam, quetiapine, sertraline, clonazepam, escitalopram, alprazolam) with the requested drug, the prescriber has determined that taking multiple central nervous system (CNS) active medications is medically necessary for the patient [Note: Use of multiple central nervous system (CNS) active medications in older adults is associated with an increased risk of falls.]. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Other Criteria</b>                | This Prior Authorization only applies to patients 65 years of age or older. (The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prior authorization applies to greater than cumulative 90 days of therapy per year.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | HRM-MECLIZINE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Drug Names</b>                    | MECLIZINE HCL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>PA Indication Indicator</b>       | All Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Required Medical Information</b>  | For all indications: 1) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient, AND 2) If the patient is taking one or more additional anticholinergic medications (e.g., oxybutynin, meclizine, paroxetine, amitriptyline, dicyclomine, cyclobenzaprine) with the requested drug, the prescriber has determined that taking multiple anticholinergic medications is medically necessary for the patient [Note: Use of multiple anticholinergic medications in older adults is associated with an increased risk of cognitive decline.]. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Coverage Duration</b>             | 3 months                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Other Criteria</b>                | This Prior Authorization only applies to patients 65 years of age or older. (The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prior authorization applies to greater than cumulative 30 days of therapy per year.                                                                                                                                                                                                                                                                        |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | HRM-PROMETHAZINE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Drug Names</b>                    | PROMETHAZINE HCL, PROMETHAZINE HYDROCHLORID                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Required Medical Information</b>  | For rhinitis: 1) The patient has tried two of the following non-HRM alternative drugs: levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following non-HRM alternative drugs: levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal. For all indications: 1) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient, AND 2) If the patient is taking one or more additional anticholinergic medications (e.g., oxybutynin, meclizine, paroxetine, amitriptyline, dicyclomine, cyclobenzaprine) with the requested drug, the prescriber has determined that taking multiple anticholinergic medications is medically necessary for the patient [Note: Use of multiple anticholinergic medications in older adults is associated with an increased risk of cognitive decline.]. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Coverage Duration</b>             | 3 months                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Other Criteria</b>                | This Prior Authorization only applies to patients 65 years of age or older. (The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.). Prior authorization applies to greater than cumulative 30 days of therapy per year.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|--------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | HRM-SKELETAL MUSCLE RELAXANTS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Drug Names</b>                    | CYCLOBENZAPRINE HYDROCHLO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Required Medical Information</b>  | 1) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient AND 2) If the patient is using one or more additional anticholinergic medications (e.g., oxybutynin, meclizine, paroxetine, amitriptyline, dicyclomine, hydroxyzine) with the requested drug, the prescriber has determined that taking multiple anticholinergic medications is medically necessary for the patient [Note: Use of multiple anticholinergic medications in older adults is associated with an increased risk of cognitive decline.]. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Coverage Duration</b>             | 3 months                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Other Criteria</b>                | This Prior Authorization only applies to patients 65 years of age or older. (The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prior authorization applies to greater than cumulative 90 days of therapy per year.                                                                                                                                                                                                                                             |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | HRM-TCA NEUROPATHIC PAIN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Drug Names</b>                    | DESIPRAMINE HYDROCHLORIDE, IMIPRAMINE HCL, IMIPRAMINE HYDROCHLORIDE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Off-label Uses</b>                | Neuropathic pain                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Required Medical Information</b>  | For depression: 1) The patient tried two of the following alternative drugs: SSRIs (selective serotonin reuptake inhibitors), SNRIs (serotonin-norepinephrine reuptake inhibitors), bupropion, mirtazapine, or trazodone AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following alternative drugs: SSRIs (selective serotonin reuptake inhibitors), SNRIs (serotonin-norepinephrine reuptake inhibitors), bupropion, mirtazapine, or trazodone. For all indications: 1) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient, AND 2) If the patient is taking one or more additional anticholinergic medications (e.g., oxybutynin, meclizine, paroxetine, amitriptyline, dicyclomine, cyclobenzaprine) with the requested drug, the prescriber has determined that taking multiple anticholinergic medications is medically necessary for the patient [Note: Use of multiple anticholinergic medications in older adults is associated with an increased risk of cognitive decline.]. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Other Criteria</b>                | This Prior Authorization only applies to patients 65 years of age or older. (The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|--------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | HUMIRA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Drug Names</b>                    | HUMIRA, HUMIRA PEN, HUMIRA PEN-CD/UC/HS START, HUMIRA PEN-PS/UV STARTER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Off-label Uses</b>                | Non-radiographic axial spondyloarthritis, Behcet's disease                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Required Medical Information</b>  | For moderately to severely active rheumatoid arthritis (new starts only): 1) patient (pt) has experienced an inadequate treatment response, intolerance, or has a contraindication to methotrexate (MTX) OR 2) pt has experienced an inadequate treatment response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. For active ankylosing spondylitis and non-radiographic axial spondyloarthritis (new starts only): 1) pt has experienced an inadequate treatment response or intolerance to a non-steroidal anti-inflammatory drug (NSAID) OR 2) pt has a contraindication that would prohibit a trial of NSAIDs. For moderate to severe plaque psoriasis (new starts): 1) Crucial body areas (e.g., hands, feet, face, scalp, neck, genitals/groin, intertriginous areas) are affected at the time of diagnosis OR 2) patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of the body surface area is affected) OR 3) at least 3% of body surface area (BSA) is affected and patient meets either of the following: a) patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Other Criteria</b>                | For non-infectious intermediate, posterior and panuveitis (new starts only): 1) pt has experienced an inadequate treatment response or intolerance to a corticosteroid OR 2) pt has a contraindication that would prohibit a trial of corticosteroids.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Prior Authorization Group</b>     | IBRANCE - PENDING CMS REVIEW                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Drug Names</b>                    | IBRANCE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>PA Indication Indicator</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Coverage Duration</b>             | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|--------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | IBTROZI - PENDING CMS REVIEW                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Drug Names</b>                    | IBTROZI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>PA Indication Indicator</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Coverage Duration</b>             | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Prior Authorization Group</b>     | ICATIBANT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Drug Names</b>                    | ICATIBANT ACETATE, SAJAZIR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Required Medical Information</b>  | For the treatment of acute angioedema attacks due to hereditary angioedema (HAE):<br>1) the patient has HAE with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing OR 2) the patient has HAE with normal C1 inhibitor confirmed by laboratory testing and one of the following: a) the patient tested positive for an F12, angiotensin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation, b) the patient has a family history of angioedema and the angioedema was refractory to a trial of high-dose antihistamine therapy for at least one month. |
| <b>Age Restrictions</b>              | 18 years of age or older                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Prescriber Restrictions</b>       | Prescribed by or in consultation with an immunologist, allergist, or rheumatologist                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | ICLUSIG                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Drug Names</b>                    | ICLUSIG                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Off-label Uses</b>                | Myeloid and/or lymphoid neoplasms with eosinophilia and FGFR1 or ABL1 rearrangement in the chronic phase or blast phase, Gastrointestinal Stromal Tumors                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Required Medical Information</b>  | For chronic myeloid leukemia (CML), including patients who have received a hematopoietic stem cell transplant: 1) Patient has accelerated or blast phase CML and no other kinase inhibitor is indicated, OR 2) Patient has chronic phase CML and has experienced resistance or intolerance to at least 2 prior kinase inhibitors AND at least one of those was imatinib, dasatinib, or nilotinib, OR 3) Patient is positive for the T315I mutation, OR 4) Patient has no identifiable BCR-ABL1 mutation and resistance to primary therapy with imatinib, bosutinib, dasatinib, or nilotinib. For acute lymphoblastic leukemia (ALL), including patients who have received a hematopoietic stem cell transplant: Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For gastrointestinal stromal tumors (GIST): 1) Disease meets any of the following: A) residual, B) unresectable, C) recurrent, D) metastatic/tumor rupture, AND 2) Disease has progressed after use of at least two Food and Drug Administration (FDA) approved therapies (e.g., imatinib, sunitinib, regorafenib, ripretinib). |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Prior Authorization Group</b>     | IDHIFA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Drug Names</b>                    | IDHIFA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Off-label Uses</b>                | Newly-diagnosed acute myeloid leukemia                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Required Medical Information</b>  | For acute myeloid leukemia (AML) with an isocitrate dehydrogenase-2 (IDH2) mutation: 1) patient has newly-diagnosed AML and is not a candidate for or declines intensive induction therapy, OR 2) the requested drug will be used as post-induction therapy following response to induction therapy with the requested drug, OR 3) patient has relapsed or refractory AML, OR 4) the requested drug will be used as consolidation therapy.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|--------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | IMATINIB - PENDING CMS REVIEW                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Drug Names</b>                    | IMATINIB MESYLATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>PA Indication Indicator</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Coverage Duration</b>             | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Prior Authorization Group</b>     | IMBRUVICA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Drug Names</b>                    | IMBRUVICA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Off-label Uses</b>                | Hairy cell leukemia, lymphoplasmacytic lymphoma, primary central nervous system (CNS) lymphoma, human immunodeficiency virus (HIV)-related B-cell lymphoma, diffuse large B-cell lymphoma, post-transplant lymphoproliferative disorders, high-grade B-cell lymphoma, mantle cell lymphoma, marginal zone lymphoma (including extranodal marginal zone lymphoma of the stomach, extranodal marginal zone lymphoma of nongastric sites, nodal marginal zone lymphoma, splenic marginal zone lymphoma), brain metastases in lymphoma                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Required Medical Information</b>  | For mantle cell lymphoma: 1) the requested drug will be used as subsequent therapy OR 2) the requested drug will be used in combination with rituximab as pretreatment to induction therapy with RHyperCVAD (rituximab, cyclophosphamide, vincristine, doxorubicin, and dexamethasone) regimen, OR 3) the requested drug will be used as aggressive induction therapy. For marginal zone lymphoma (including extranodal marginal zone lymphoma of the stomach, extranodal marginal zone lymphoma of nongastric sites, nodal marginal zone lymphoma, and splenic marginal zone lymphoma): the requested drug will be used as second-line or subsequent therapy. For hairy cell leukemia: the requested drug will be used as a single agent for disease progression. For primary CNS lymphoma: 1) the disease is relapsed or refractory OR 2) the requested drug is used for induction therapy as a single agent. For diffuse large B-cell lymphoma, high-grade B-cell lymphoma, human immunodeficiency virus (HIV)-related B-cell lymphoma: The requested drug will be used as a single agent and as second-line or subsequent therapy for relapsed or refractory disease. For post-transplant lymphoproliferative disorders: the requested drug will be used in patients who have received prior chemoimmunotherapy. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|--------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | IMKELDI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Drug Names</b>                    | IMKELDI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Off-label Uses</b>                | Recurrent chordoma, cutaneous melanoma, Kaposi sarcoma                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Required Medical Information</b>  | For all indications: The patient is unable to use imatinib tablets. For chronic myeloid leukemia (CML) or Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), including patients who have received a hematopoietic stem cell transplant: Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML: Patient did not fail (excluding failure due to intolerance) prior therapy with a tyrosine kinase inhibitor. For cutaneous melanoma: 1) Disease is metastatic or unresectable AND 2) Disease is positive for c-KIT activating mutations AND 3) Requested medication will be used as subsequent therapy AND 4) Patient has had disease progression, intolerance, or risk of progression with BRAF-targeted therapy. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Prior Authorization Group</b>     | IMPAVIDO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Drug Names</b>                    | IMPAVIDO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Exclusion Criteria</b>            | Pregnancy. Sjogren-Larsson-Syndrome.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Age Restrictions</b>              | 12 years of age or older                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Coverage Duration</b>             | 28 days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|--------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | INBRIJA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Drug Names</b>                    | INBRIJA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Required Medical Information</b>  | For initial treatment of off episodes in Parkinson's disease: 1) The patient is currently being treated with oral carbidopa/levodopa, AND 2) The patient does not have any of the following: asthma, chronic obstructive pulmonary disease (COPD), or other chronic underlying lung disease. For continuation treatment of off episodes in Parkinson's disease: The patient is experiencing improvement on the requested drug.                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Prior Authorization Group</b>     | INCRELEX                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Drug Names</b>                    | INCRELEX                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Exclusion Criteria</b>            | Pediatric patients with closed epiphyses                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Required Medical Information</b>  | For growth failure due to severe primary insulin-like growth factor-1 (IGF-1) deficiency or growth hormone (GH) gene deletion in patients who have developed neutralizing antibodies to GH, patient meets all of the following prior to beginning therapy with the requested drug (new starts only): 1) height 3 or more standard deviations (SD) below the mean for children of the same age and gender AND 2) basal IGF-1 level 3 or more SD below the mean for children of the same age and gender AND 3) provocative growth hormone test showing a normal or elevated growth hormone level. For growth failure due to severe primary IGF-1 deficiency or GH gene deletion in patients who have developed neutralizing antibodies to GH, continuation of therapy: patient is experiencing improvement. |
| <b>Age Restrictions</b>              | 2 years of age or older                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Prescriber Restrictions</b>       | Prescribed by or in consultation with an endocrinologist                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |

|                                      |                                                                                                                                                                  |
|--------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | INLYTA                                                                                                                                                           |
| <b>Drug Names</b>                    | INLYTA                                                                                                                                                           |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                |
| <b>Off-label Uses</b>                | Thyroid carcinoma (papillary, oncocytic, or follicular), alveolar soft part sarcoma                                                                              |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                |
| <b>Required Medical Information</b>  | For renal cell carcinoma: the disease is advanced, relapsed, or Stage IV.                                                                                        |
| <b>Age Restrictions</b>              | -                                                                                                                                                                |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                        |
| <b>Other Criteria</b>                | -                                                                                                                                                                |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                               |
| <b>Prior Authorization Group</b>     | INQOVI                                                                                                                                                           |
| <b>Drug Names</b>                    | INQOVI                                                                                                                                                           |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                     |
| <b>Off-label Uses</b>                | -                                                                                                                                                                |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                |
| <b>Required Medical Information</b>  | -                                                                                                                                                                |
| <b>Age Restrictions</b>              | -                                                                                                                                                                |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                        |
| <b>Other Criteria</b>                | -                                                                                                                                                                |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                               |
| <b>Prior Authorization Group</b>     | INREBIC                                                                                                                                                          |
| <b>Drug Names</b>                    | INREBIC                                                                                                                                                          |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                |
| <b>Off-label Uses</b>                | Myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and janus kinase 2 (JAK2) rearrangement, accelerated or blast phase myeloproliferative neoplasms |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                |
| <b>Required Medical Information</b>  | For myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and JAK2 rearrangement: the disease is in chronic or blast phase.                            |
| <b>Age Restrictions</b>              | -                                                                                                                                                                |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                        |
| <b>Other Criteria</b>                | -                                                                                                                                                                |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                               |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|--------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | INSULIN SUPPLIES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Drug Names</b>                    | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Required Medical Information</b>  | The requested product is being used with insulin.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Prior Authorization Group</b>     | IR BEFORE ER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Drug Names</b>                    | HYDROCODONE BITARTRATE ER, METHADONE HCL, METHADONE HYDROCHLORIDE I, MORPHINE SULFATE ER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Required Medical Information</b>  | The requested drug is being prescribed for pain associated with cancer, sickle cell disease, a terminal condition, or pain being managed through palliative care OR the patient meets all of the following: 1) The requested drug is being prescribed for pain severe and persistent enough to require an extended treatment period with a daily opioid analgesic in a patient who has been taking an opioid AND 2) The patient can safely take the requested dose based on their history of opioid use [Note: This drug should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.] AND 3) The patient has been evaluated and the patient will be monitored for the development of opioid use disorder AND 4) This request is for continuation of therapy for a patient who has been receiving an extended-release opioid agent for at least 30 days OR the patient has taken an immediate-release opioid for at least one week. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |

|                                      |                                                                                                                                                                                                                                                                                                                                                         |
|--------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | IRESSA                                                                                                                                                                                                                                                                                                                                                  |
| <b>Drug Names</b>                    | GEFITINIB                                                                                                                                                                                                                                                                                                                                               |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                       |
| <b>Off-label Uses</b>                | Sensitizing epidermal growth factor receptor (EGFR) mutation-positive recurrent non-small cell lung cancer (NSCLC)                                                                                                                                                                                                                                      |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                       |
| <b>Required Medical Information</b>  | For non-small cell lung cancer (NSCLC): 1) the disease is recurrent, advanced, or metastatic, AND 2) the patient has sensitizing epidermal growth factor receptor (EGFR) mutation-positive disease.                                                                                                                                                     |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                       |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                       |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                               |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                       |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                      |
| <b>Prior Authorization Group</b>     | ISOTRETINOIN                                                                                                                                                                                                                                                                                                                                            |
| <b>Drug Names</b>                    | ACCUTANE, AMNESTEEM, CLARAVIS, ISOTRETINOIN, ZENATANE                                                                                                                                                                                                                                                                                                   |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                       |
| <b>Off-label Uses</b>                | Severe acne vulgaris, severe refractory rosacea, neuroblastoma, cutaneous T-cell lymphoma (CTCL) (e.g., mycosis fungoides, Sezary syndrome), high risk for developing skin cancer (squamous cell cancers), transient acantholytic dermatosis (Grover's Disease), keratosis follicularis (Darier Disease), lamellar ichthyosis, pityriasis rubra pilaris |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                       |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                       |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                       |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                       |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                               |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                       |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                      |
| <b>Prior Authorization Group</b>     | ITOVEBI - PENDING CMS REVIEW                                                                                                                                                                                                                                                                                                                            |
| <b>Drug Names</b>                    | ITOVEBI                                                                                                                                                                                                                                                                                                                                                 |
| <b>PA Indication Indicator</b>       | -                                                                                                                                                                                                                                                                                                                                                       |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                       |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                       |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                       |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                       |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                       |
| <b>Coverage Duration</b>             | -                                                                                                                                                                                                                                                                                                                                                       |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                       |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | IVERMECTIN TAB                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Drug Names</b>                    | IVERMECTIN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Off-label Uses</b>                | Ascariasis, Cutaneous larva migrans, Mansonelliasis, Scabies, Gnathostomiasis, Pediculosis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Required Medical Information</b>  | The requested drug is not being prescribed for the prevention or treatment of coronavirus disease 2019 (COVID-19).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Coverage Duration</b>             | 1 month                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Prior Authorization Group</b>     | IVIG                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Drug Names</b>                    | ALYGLO, BIVIGAM, FLEBOGAMMA DIF, GAMMAGARD LIQUID, GAMMAGARD S/D IGA LESS TH, GAMMAKED, GAMMAPLEX, GAMUNEX-C, OCTAGAM, PANZYGA, PRIVIGEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>PA Indication Indicator</b>       | All Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Required Medical Information</b>  | For B-cell chronic lymphocytic leukemia (CLL): 1) serum IgG less than 500 mg/dL OR 2) a history of recurrent bacterial infections. For bone marrow transplant/hematopoietic stem cell transplant (BMT/HSCT): 1) IVIG is requested within the first 100 days post-transplant OR 2) serum IgG less than 400 mg/dL. For pediatric human immunodeficiency virus (HIV) infection: 1) serum IgG less than 400 mg/dL OR 2) history of recurrent bacterial infections. For dermatomyositis and polymyositis: 1) at least one standard first-line treatment (corticosteroid or immunosuppressant) has been tried but was unsuccessful or not tolerated OR 2) patient is unable to receive standard therapy because of a contraindication or other clinical reason. For pure red cell aplasia (PRCA): PRCA is secondary to parvovirus B19 infection. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Other Criteria</b>                | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|--------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | IWILFIN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Drug Names</b>                    | IWILFIN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prior Authorization Group</b>     | JAKAFI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Drug Names</b>                    | JAKAFI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Off-label Uses</b>                | Lower-risk myelofibrosis, accelerated or blast phase myeloproliferative neoplasms, acute lymphoblastic leukemia (ALL), chronic myelomonocytic leukemia (CMML)-2, myelodysplastic syndrome/myeloproliferative neoplasm (MDS/MPN) with neutrophilia, essential thrombocythemia, myeloid, lymphoid or mixed lineage neoplasms with eosinophilia and JAK2 rearrangement, T-cell prolymphocytic leukemia, T-cell large granular lymphocytic leukemia                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Required Medical Information</b>  | For polycythemia vera: 1) patient has an inadequate response, intolerance, or resistance to hydroxyurea AND 2) patient meets ONE of the following: a) patient has an inadequate response or intolerance to Besremi (ropeginterferon alfa-2b-njft), OR b) patient has high risk disease. For acute lymphoblastic leukemia: patient has a cytokine receptor-like factor 2 (CRLF2) mutation or a mutation associated with activation of the Janus kinase/signal transducers and activators of transcription (JAK/STAT) pathway. For CMML-2: the requested drug is used in combination with a hypomethylating agent. For myelodysplastic syndrome/myeloproliferative neoplasm (MDS/MPN) with neutrophilia: the requested drug is used as a single agent or in combination with a hypomethylating agent. For essential thrombocythemia: patient had an inadequate response or loss of response to hydroxyurea, interferon therapy, or anagrelide. For myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and JAK2 rearrangement: the disease is in chronic or blast phase. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|--------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | JAYPIRCA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Drug Names</b>                    | JAYPIRCA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Off-label Uses</b>                | Marginal zone lymphoma (including extranodal marginal zone lymphoma of the stomach, extranodal marginal zone lymphoma of nongastric sites, nodal marginal zone lymphoma, splenic marginal zone lymphoma)                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Required Medical Information</b>  | For chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL): The patient meets both of the following: 1) The patient has received prior treatment with a Bruton Tyrosine Kinase (BTK) inhibitor, for example Calquence (acalabrutinib), AND 2) The patient has received prior treatment with a B-cell lymphoma 2 (BCL-2) inhibitor. For mantle cell lymphoma: the patient has received prior treatment for a BTK inhibitor, for example Calquence (acalabrutinib). For marginal zone lymphoma (MZL): the patient has received a covalent Bruton Tyrosine Kinase (BTK) inhibitor, for example, Calquence (acalabrutinib). |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prior Authorization Group</b>     | JYNARQUE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Drug Names</b>                    | TOLVAPTAN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |

|                                      |                                                                                                                                                                                                     |
|--------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | KALYDECO                                                                                                                                                                                            |
| <b>Drug Names</b>                    | KALYDECO                                                                                                                                                                                            |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                        |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                   |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                   |
| <b>Required Medical Information</b>  | For cystic fibrosis: the requested drug will not be used in combination with other CFTR (cystic fibrosis transmembrane conductance regulator) potentiating agents (e.g., ivacaftor, deutivacaftor). |
| <b>Age Restrictions</b>              | 1 month of age or older                                                                                                                                                                             |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                   |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                           |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                   |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                  |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|--------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | KANJINTI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Drug Names</b>                    | KANJINTI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Off-label Uses</b>                | Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent or advanced unresectable HER2-positive breast cancer, leptomeningeal metastases from HER2-positive breast cancer, brain metastases from HER2-positive breast cancer, HER2-positive esophageal and esophagogastric junction adenocarcinoma, HER2-positive advanced, recurrent, or metastatic uterine serous carcinoma, HER2-amplified and RAS and BRAF wild-type colorectal cancer (including appendiceal adenocarcinoma), HER2-positive recurrent salivary gland tumor, HER2-positive unresectable or metastatic hepatobiliary carcinoma (gallbladder cancer, intrahepatic cholangiocarcinoma, extrahepatic cholangiocarcinoma), HER2 overexpression positive locally advanced, unresectable, or recurrent gastric adenocarcinoma, HER2-positive endometrial cancer |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Required Medical Information</b>  | All indications: the patient had an intolerable adverse event to Trazimera and that adverse event was NOT attributed to the active ingredient as described in the prescribing information. For colorectal cancer (including appendiceal adenocarcinoma): 1) the disease is HER2-amplified and RAS and BRAF wild-type and 2) the requested drug is used in combination with pertuzumab, tucatinib or lapatinib and 3) the patient has not had previous treatment with a HER2 inhibitor OR 4) the patient has metachronous metastases. For hepatobiliary carcinoma: 1) the disease is HER2-positive AND 2) the requested drug is used in combination with pertuzumab or tucatinib. For endometrial cancer: 1) the disease is HER2-positive AND 2) the requested drug is used in combination with paclitaxel and continued as a single agent for maintenance therapy.              |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Other Criteria</b>                | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                              |
|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | KESIMPTA                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Drug Names</b>                    | KESIMPTA                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Prior Authorization Group</b>     | KETOCONAZOLE                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Drug Names</b>                    | KETOCONAZOLE                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                            |
| <b>Off-label Uses</b>                | Cushing's syndrome                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Exclusion Criteria</b>            | Acute or chronic liver disease. Concurrent use with drugs that are contraindicated with ketoconazole tablets: dofetilide, quinidine, pimozide, cisapride, methadone, disopyramide, dronedarone, ranolazine, ergot alkaloids, irinotecan, lurasidone, oral midazolam, alprazolam, triazolam, felodipine, nisoldipine, tolvaptan, eplerenone, lovastatin, simvastatin, or colchicine.                          |
| <b>Required Medical Information</b>  | The potential benefits outweigh the risks of treatment with oral ketoconazole. For systemic fungal infections, the patient has any of the following diagnoses: blastomycosis, coccidioidomycosis, histoplasmosis, chromomycosis, or paracoccidioidomycosis. For Cushing's syndrome: the requested drug is being prescribed for a patient who cannot tolerate surgery or where surgery has not been curative. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Coverage Duration</b>             | 6 months                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                           |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|--------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | KEYTRUDA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Drug Names</b>                    | KEYTRUDA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>PA Indication Indicator</b>       | All Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Prior Authorization Group</b>     | KINERET                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Drug Names</b>                    | KINERET                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Off-label Uses</b>                | Systemic juvenile idiopathic arthritis, adult-onset Still's disease, multicentric Castleman's disease, Schnitzler syndrome, Erdheim-Chester disease.                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Required Medical Information</b>  | For moderately to severely active rheumatoid arthritis (new starts only): The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to two of the following products: Enbrel (etanercept), Hadlima (adalimumab-bwwd), Humira (adalimumab), Rinvoq (upadacitinib), Tyenne (tocilizumab-aazg), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib-extended release). For active systemic juvenile idiopathic arthritis (new starts only): The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to Tyenne (tocilizumab-aazg). |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |

|                                      |                                                                                                                                                                                                                                                                   |
|--------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | KISQALI                                                                                                                                                                                                                                                           |
| <b>Drug Names</b>                    | KISQALI, KISQALI FEMARA 400 DOSE, KISQALI FEMARA 600 DOSE                                                                                                                                                                                                         |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                 |
| <b>Off-label Uses</b>                | Recurrent hormone receptor-positive, human epidermal growth factor receptor 2 (HER2)-negative breast cancer, in combination with an aromatase inhibitor, or fulvestrant. Endometrial cancer, in combination with letrozole, for estrogen receptor positive tumors |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                 |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                 |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                 |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                 |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                         |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                 |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                |
| <b>Prior Authorization Group</b>     | KORLYM                                                                                                                                                                                                                                                            |
| <b>Drug Names</b>                    | MIFEPRISTONE                                                                                                                                                                                                                                                      |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                      |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                 |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                 |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                 |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                 |
| <b>Prescriber Restrictions</b>       | Prescribed by or in consultation with an endocrinologist                                                                                                                                                                                                          |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                         |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                 |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                |
| <b>Prior Authorization Group</b>     | KOSELUGO                                                                                                                                                                                                                                                          |
| <b>Drug Names</b>                    | KOSELUGO                                                                                                                                                                                                                                                          |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                 |
| <b>Off-label Uses</b>                | BRAF fusion or BRAF V600E activating mutation-positive recurrent or progressive circumscribed glioma, Langerhans cell histiocytosis                                                                                                                               |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                 |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                 |
| <b>Age Restrictions</b>              | For neurofibromatosis type 1: 2 years of age or older                                                                                                                                                                                                             |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                 |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                         |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                 |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|--------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | KRAZATI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Drug Names</b>                    | KRAZATI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Off-label Uses</b>                | Recurrent KRAS G12C-positive non-small cell lung cancer (NSCLC), Central nervous system (CNS) brain metastases from KRAS G12C-positive NSCLC, KRAS G12C-positive pancreatic adenocarcinoma, KRAS G12C-positive ampullary adenocarcinoma, KRAS G12C-positive appendiceal adenocarcinoma, KRAS G12C-positive Biliary Tract Cancer (intrahepatic cholangiocarcinoma, extrahepatic cholangiocarcinoma, gall bladder cancer)                                                                                                    |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Prior Authorization Group</b>     | LAPATINIB                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Drug Names</b>                    | LAPATINIB DITOSYLATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Off-label Uses</b>                | Brain metastases from human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent HER2-positive breast cancer, recurrent epidermal growth factor receptor (EGFR)-positive chordoma, HER2-amplified and RAS and BRAF wild-type colorectal cancer (including appendiceal adenocarcinoma)                                                                                                                                                                                                               |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Required Medical Information</b>  | For breast cancer, the patient meets all the following: a) the disease is recurrent, advanced, or metastatic (including brain metastases), b) the disease is human epidermal growth factor receptor 2 (HER2)-positive, c) the requested drug will be used in combination with any of the following: 1) aromatase inhibitor, 2) capecitabine, OR 3) trastuzumab. For colorectal cancer: 1) requested drug will be used in combination with trastuzumab and 2) patient has not had previous treatment with a HER2 inhibitor. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|--------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | LAZCLUZE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Drug Names</b>                    | LAZCLUZE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Prior Authorization Group</b>     | LENVIMA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Drug Names</b>                    | LENVIMA 10 MG DAILY DOSE, LENVIMA 12MG 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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Off-label Uses</b>                | Medullary thyroid carcinoma, recurrent endometrial carcinoma, thymic carcinoma, unresectable or metastatic cutaneous melanoma.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Required Medical Information</b>  | For differentiated thyroid cancer (follicular, papillary, or oncocytic): disease is not amenable to radioactive iodine therapy and unresectable, locally recurrent, persistent, or metastatic. For hepatocellular carcinoma (HCC): disease is unresectable, extrahepatic/metastatic, or liver-confined. For renal cell carcinoma (RCC): the disease is advanced, relapsed, or stage IV. For endometrial carcinoma (EC), the patient meets ALL of the following: 1) The disease is advanced, recurrent, or metastatic, 2) The requested drug will be used in combination with pembrolizumab, 3) The patient experienced disease progression following prior systemic therapy. For anaplastic thyroid carcinoma, the patient meets ALL of the following: 1) The disease is metastatic, 2) The requested drug will be used in combination with pembrolizumab. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|--------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | LEUKERAN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Drug Names</b>                    | LEUKERAN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Prior Authorization Group</b>     | LEUPROLIDE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Drug Names</b>                    | LEUPROLIDE ACETATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Off-label Uses</b>                | Use in combination with growth hormone for children with growth failure and advancing puberty, recurrent androgen receptor positive salivary gland tumors, central precocious puberty                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Required Medical Information</b>  | For central precocious puberty (CPP): Patients not currently receiving therapy must meet all of the following criteria: 1) Diagnosis of CPP was confirmed by a pubertal response to a gonadotropin releasing hormone (GnRH) agonist test OR a pubertal level of a third generation luteinizing hormone (LH) assay, 2) Assessment of bone age versus chronological age supports the diagnosis of CPP, 3) The onset of secondary sexual characteristics occurred prior to 8 years of age for female patients OR prior to 9 years of age for male patients. |
| <b>Age Restrictions</b>              | CPP: Patient must be less than 12 years old if female and less than 13 years old if male                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |

|                                      |                                                                                                                                                                                                           |
|--------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | LIDOCAINE PATCHES                                                                                                                                                                                         |
| <b>Drug Names</b>                    | LIDOCAINE, LIDOCAN, TRIDACAINE II                                                                                                                                                                         |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                         |
| <b>Off-label Uses</b>                | Pain associated with diabetic neuropathy, pain associated with cancer-related neuropathy (including treatment-related neuropathy [e.g., neuropathy associated with radiation treatment or chemotherapy]). |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                         |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                         |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                         |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                         |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                 |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                         |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                        |
| <b>Prior Authorization Group</b>     | LIVTENCITY                                                                                                                                                                                                |
| <b>Drug Names</b>                    | LIVTENCITY                                                                                                                                                                                                |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                              |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                         |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                         |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                         |
| <b>Age Restrictions</b>              | 12 years of age or older                                                                                                                                                                                  |
| <b>Prescriber Restrictions</b>       | Prescribed by or in consultation with an infectious disease specialist, transplant specialist, hematologist, or oncologist                                                                                |
| <b>Coverage Duration</b>             | 3 months                                                                                                                                                                                                  |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                         |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                        |
| <b>Prior Authorization Group</b>     | LONSURF - PENDING CMS REVIEW                                                                                                                                                                              |
| <b>Drug Names</b>                    | LONSURF                                                                                                                                                                                                   |
| <b>PA Indication Indicator</b>       | -                                                                                                                                                                                                         |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                         |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                         |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                         |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                         |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                         |
| <b>Coverage Duration</b>             | -                                                                                                                                                                                                         |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                         |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|--------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | LORBRENA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Drug Names</b>                    | LORBRENA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Off-label Uses</b>                | Anaplastic lymphoma kinase (ALK)-positive recurrent non-small cell lung cancer (NSCLC), proto-oncogene tyrosine-protein kinase ROS1 (ROS1) rearrangement-positive recurrent, advanced, or metastatic NSCLC, symptomatic or relapsed/refractory ALK-positive Erdheim-Chester Disease, inflammatory myofibroblastic tumor (IMT) with ALK translocation (including advanced, recurrent/metastatic, or inoperable uterine sarcoma for IMT with ALK translocation), central nervous system (CNS) brain metastases from ALK rearrangement-positive NSCLC, relapsed or refractory ALK-positive Diffuse Large B-Cell Lymphoma, relapsed or refractory ALK-positive Peripheral T-Cell Lymphoma |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Required Medical Information</b>  | For recurrent, advanced, or metastatic non-small cell lung cancer: 1) Disease is ALK-positive AND 2) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following products: Alecensa (alectinib) or Alunbrig (brigatinib) OR 3) Disease is positive for ROS1 rearrangement and the requested drug is being used following disease progression on one of the following: crizotinib, entrectinib, or ceritinib, or repotrectinib.                                                                                                                                                                                       |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Prior Authorization Group</b>     | LUMAKRAS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Drug Names</b>                    | LUMAKRAS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Off-label Uses</b>                | Recurrent KRAS G12C-positive non-small cell lung cancer (NSCLC), recurrent, locally advanced, or metastatic KRAS G12C-positive pancreatic adenocarcinoma, advanced or unresectable KRAS G12C-positive colorectal cancer (including appendiceal adenocarcinoma), progressive KRAS G12C-positive ampullary adenocarcinoma                                                                                                                                                                                                                                                                                                                                                               |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Required Medical Information</b>  | For non-small cell lung cancer (NSCLC): 1) the disease is recurrent, advanced, or metastatic, AND 2) the patient has KRAS G12C mutation-positive disease.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|--------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | LUMIZYME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Drug Names</b>                    | LUMIZYME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Required Medical Information</b>  | For Pompe disease: Diagnosis was confirmed by an enzyme assay demonstrating a deficiency of acid alpha-glucosidase (GAA) enzyme activity or by genetic testing.                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Prior Authorization Group</b>     | LUPRON PED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Drug Names</b>                    | LUPRON DEPOT-PED (1-MONTH, LUPRON DEPOT-PED (3-MONTH, LUPRON DEPOT-PED (6-MONTH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Required Medical Information</b>  | For central precocious puberty (CPP): Patients not currently receiving therapy must meet all of the following criteria: 1) Diagnosis of CPP was confirmed by a pubertal response to a gonadotropin releasing hormone (GnRH) agonist test OR a pubertal level of a third generation luteinizing hormone (LH) assay, AND 2) Assessment of bone age versus chronological age supports the diagnosis of CPP, AND 3) The onset of secondary sexual characteristics occurred prior to 8 years of age for female patients OR prior to 9 years of age for male patients. |
| <b>Age Restrictions</b>              | CPP: Patient must be less than 12 years old if female and less than 13 years old if male                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | LUPRON-ENDOMETRIOSIS                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Drug Names</b>                    | LUPRON DEPOT (1-MONTH), LUPRON DEPOT (3-MONTH)                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Off-label Uses</b>                | Breast cancer, ovarian cancer/fallopian tube cancer/primary peritoneal cancer, androgen receptor positive recurrent salivary gland tumor                                                                                                                                                                                                                                                                                                                                             |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Required Medical Information</b>  | For retreatment of endometriosis, the requested drug is used in combination with norethindrone acetate. For uterine fibroids, patient must meet one of the following: 1) diagnosis of anemia (for example, hematocrit less than or equal to 30 percent and/or hemoglobin less than or equal to 10g/dL), OR 2) the requested medication will be used prior to surgery for uterine fibroids. For breast cancer, the requested drug is used for hormone receptor (HR)-positive disease. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Coverage Duration</b>             | Fibroids: 3 months (mo), max 6 mo total. Endometriosis: 6 mo, max 12 mo total. Others: Plan Year                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Prior Authorization Group</b>     | LYNPARZA - PENDING CMS REVIEW                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Drug Names</b>                    | LYNPARZA                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>PA Indication Indicator</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Coverage Duration</b>             | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Prior Authorization Group</b>     | LYTGOBI - PENDING CMS REVIEW                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Drug Names</b>                    | LYTGOBI                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>PA Indication Indicator</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Coverage Duration</b>             | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|--------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | MAVYRET                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Drug Names</b>                    | MAVYRET                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Exclusion Criteria</b>            | Decompensated cirrhosis/moderate or severe hepatic impairment (Child Turcotte Pugh [CTP] class B or C).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Required Medical Information</b>  | For hepatitis C virus (HCV): Infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [CTP class B or C]), presence or absence of human immunodeficiency virus (HIV) coinfection, presence or absence of resistance-associated substitutions where applicable, transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current American Association for the Study of Liver Diseases and Infectious Diseases Society of America (AASLD-IDSA) treatment guidelines. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Coverage Duration</b>             | Criteria will be applied consistent with current AASLD-IDSA guidance                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Prior Authorization Group</b>     | MEGESTROL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Drug Names</b>                    | MEGESTROL ACETATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Off-label Uses</b>                | Cancer-related cachexia in adults                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Required Medical Information</b>  | Patient has experienced an inadequate treatment response or intolerance to megestrol 40 milligrams per milliliter (40mg/mL) oral suspension.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | MEKINIST                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Drug Names</b>                    | MEKINIST                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Off-label Uses</b>                | Langerhans cell histiocytosis, Erdheim-Chester disease, Rosai-Dorfman disease, hairy cell leukemia.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Required Medical Information</b>  | For melanoma: 1) The tumor is positive for a BRAF mutation, AND 2) The requested drug will be used as a single agent or in combination with dabrafenib, AND 3) The requested drug will be used for either of the following: a) unresectable, limited resectable, or metastatic disease, b) adjuvant or neoadjuvant systemic therapy. For uveal melanoma: The requested drug will be used as a single agent. For ovarian cancer, fallopian tube cancer, and primary peritoneal cancer: The requested drug will be used to treat persistent or recurrent disease. For papillary, follicular, and oncocytic thyroid carcinoma: 1) The disease is positive for BRAF V600E mutation, AND 2) The disease is not amenable to radioactive iodine (RAI) therapy, AND 3) The requested drug will be used in combination with dabrafenib. For hairy cell leukemia: 1) the requested drug will be used in combination with dabrafenib, AND 2) the patient has not had previous treatment with BRAF inhibitor therapy. For solid tumors: 1) The tumor is positive for a BRAF V600E mutation, AND 2) The requested drug will be used in combination with dabrafenib. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|--------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | MEKTOVI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Drug Names</b>                    | MEKTOVI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Off-label Uses</b>                | Adjuvant or neoadjuvant systemic therapy for cutaneous melanoma, Langerhans Cell Histiocytosis, recurrent non-small cell lung cancer (NSCLC)                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Required Medical Information</b>  | For melanoma: 1) The tumor is positive for BRAF V600 activating mutation (e.g., V600E or V600K), AND 2) The requested drug will be used in combination with encorafenib, AND 3) The requested drug will be used for either of the following: a) unresectable, limited resectable, or metastatic disease, b) adjuvant or neoadjuvant systemic therapy. For non-small cell lung cancer: 1) The tumor is positive for BRAF V600E mutation, AND 2) The requested drug will be used in combination with encorafenib, AND 3) The disease is advanced, recurrent, or metastatic. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Prior Authorization Group</b>     | MEMANTINE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Drug Names</b>                    | MEMANTINE HYDROCHLORIDE, MEMANTINE HYDROCHLORIDE E                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Other Criteria</b>                | This prior authorization only applies to patients less than 30 years of age.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | MEPRON                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Drug Names</b>                    | ATOVAQUONE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Off-label Uses</b>                | Babesiosis, Toxoplasmosis, Pneumocystis jirovecii pneumonia prophylaxis in pediatric patients, mild-to-moderate Pneumocystis jirovecii pneumonia treatment in pediatric patients                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Required Medical Information</b>  | For the treatment of mild-to-moderate Pneumocystis jirovecii pneumonia (PCP): the patient had an intolerance or has a contraindication to sulfamethoxazole/trimethoprim (SMX-TMP). For the prevention of PCP and primary toxoplasmosis prophylaxis indications: 1) the patient had an intolerance or has a contraindication to SMX-TMP, AND 2) the patient is immunocompromised. For secondary toxoplasmosis prophylaxis: the patient is immunocompromised. For babesiosis treatment: the requested drug is used concurrently with azithromycin. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Coverage Duration</b>             | Secondary toxoplasmosis prophylaxis: 6 months, All other indications: 3 months                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Prior Authorization Group</b>     | METHYLPHENIDATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Drug Names</b>                    | METHYLPHENIDATE HYDROCHLO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>PA Indication Indicator</b>       | All Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Required Medical Information</b>  | 1) The patient has a diagnosis of Attention-Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) OR 2) The patient has a diagnosis of narcolepsy confirmed by a sleep study OR 3) The requested drug is being prescribed for the treatment of cancer-related fatigue after other causes of fatigue have been ruled out.                                                                                                                                                                                                     |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|--------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | MODAFINIL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Drug Names</b>                    | MODAFINIL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Off-label Uses</b>                | Idiopathic hypersomnia                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Required Medical Information</b>  | For excessive sleepiness associated with narcolepsy: The diagnosis has been confirmed by sleep lab evaluation. For excessive sleepiness associated with obstructive sleep apnea (OSA): The diagnosis has been confirmed by polysomnography or home sleep apnea testing (HSAT) with a technically adequate device. For idiopathic hypersomnia, initial request, the diagnosis has been confirmed by ALL of the following: 1) Patient has experienced lapses into sleep or an irrepressible need to sleep during daytime, on a daily basis, for at least 3 months, AND 2) Insufficient sleep syndrome is confirmed absent, AND 3) Cataplexy is absent, AND 4) Fewer than 2 sleep onset rapid eye movement periods (SOREMPs) or no SOREMPs, if the rapid eye movement latency on an overnight sleep study was less than or equal to 15 minutes, AND 5) Average sleep latency of less than or equal to 8 minutes on Multiple Sleep Latency Test or total 24-hour sleep time is greater than or equal to 11 hours, AND 6) Another condition (sleep disorder, medical or psychiatric disorder, or drug/medication use) does not better explain the hypersomnolence and test results. For idiopathic hypersomnia, continuation of therapy: The patient has experienced a decrease in daytime sleepiness from baseline. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Prior Authorization Group</b>     | MODEYSO - PENDING CMS REVIEW                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Drug Names</b>                    | MODEYSO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>PA Indication Indicator</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Coverage Duration</b>             | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|--------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | MONJUVI                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Drug Names</b>                    | MONJUVI                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Off-label Uses</b>                | HIV-related B-cell lymphoma, monomorphic post-transplant lymphoproliferative disorder (B-cell type), high-grade B-cell lymphoma                                                                                                                                                                                                                                                                                                                      |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Required Medical Information</b>  | For diffuse large B-cell lymphoma (DLBCL) not otherwise specified, HIV-related B-cell lymphoma, monomorphic post-transplant lymphoproliferative disorder (B-cell type), high-grade B-cell lymphoma, diffuse large B-cell lymphoma (DLBCL) not otherwise specified including DLBCL arising from low grade lymphoma: 1) the patient has relapsed or refractory disease, AND 2) the patient is not eligible for autologous stem cell transplant (ASCT). |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Prior Authorization Group</b>     | MOUNJARO                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Drug Names</b>                    | MOUNJARO                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Prior Authorization Group</b>     | MRESVIA                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Drug Names</b>                    | MRESVIA                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Required Medical Information</b>  | For the prevention of lower respiratory tract disease (LRTD) and severe LRTD caused by respiratory syncytial virus (RSV): The patient has not previously received an RSV vaccine (i.e., Abrysvo, Arexvy, Mresvia).                                                                                                                                                                                                                                   |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Coverage Duration</b>             | 3 months                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                   |

|                                      |                                                                                                                                                                                                                           |
|--------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | NAGLAZYME                                                                                                                                                                                                                 |
| <b>Drug Names</b>                    | NAGLAZYME                                                                                                                                                                                                                 |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                              |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                         |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                         |
| <b>Required Medical Information</b>  | Diagnosis of Mucopolysaccharidosis VI (Maroteaux-Lamy syndrome) was confirmed by an enzyme assay demonstrating a deficiency of N-acetylgalactosamine 4-sulfatase (arylsulfatase B) enzyme activity or by genetic testing. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                         |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                         |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                 |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                         |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                        |
| <b>Prior Authorization Group</b>     | NERLYNX                                                                                                                                                                                                                   |
| <b>Drug Names</b>                    | NERLYNX                                                                                                                                                                                                                   |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                         |
| <b>Off-label Uses</b>                | Recurrent human epidermal growth factor receptor 2 (HER2)-positive breast cancer, brain metastases from HER2-positive breast cancer                                                                                       |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                         |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                         |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                         |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                         |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                 |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                         |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                        |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|--------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | NEXAVAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Drug Names</b>                    | SORAFENIB TOSYLATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Off-label Uses</b>                | Acute myeloid leukemia, soft tissue sarcoma (angiosarcoma, desmoid tumors/aggressive fibromatosis, and solitary fibrous tumor subtypes), gastrointestinal stromal tumor, medullary thyroid carcinoma, osteosarcoma, recurrent chordoma, epithelial ovarian cancer, fallopian tube cancer, primary peritoneal cancer, lymphoid and/or myeloid neoplasms with eosinophilia and FLT3 rearrangement in chronic or blast phase                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Required Medical Information</b>  | For acute myeloid leukemia: the disease is FMS-like tyrosine kinase 3-internal tandem duplication (FLT3-ITD) mutation-positive and any of the following is met :1) the requested drug will be used as maintenance therapy after hematopoietic stem cell transplant, OR 2) the requested drug is being used for low-intensity treatment induction, post-induction therapy, or consolidation therapy, OR 3) the disease is relapsed/refractory. For thyroid carcinoma: histology is follicular, papillary, oncocytic, or medullary. For gastrointestinal stromal tumor (GIST): 1) the disease is residual, unresectable, recurrent, or metastatic/tumor rupture, AND 2) the disease has progressed after use of at least two FDA-approved therapies (e.g., imatinib, sunitinib, regorafenib, ripretinib). |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Prior Authorization Group</b>     | NINLARO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Drug Names</b>                    | NINLARO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Off-label Uses</b>                | Relapsed/refractory systemic light chain amyloidosis, Waldenstrom macroglobulinemia, lymphoplasmacytic lymphoma                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|--------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | NITISINONE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Drug Names</b>                    | NITISINONE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Required Medical Information</b>  | For hereditary tyrosinemia type 1 (HT-1): Diagnosis of HT-1 is confirmed by one of the following: 1) biochemical testing (e.g., detection of succinylacetone in urine), 2) genetic testing (mutation analysis), 3) enzyme assay.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Prior Authorization Group</b>     | NORTHERA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Drug Names</b>                    | DROXIDOPA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Required Medical Information</b>  | For neurogenic orthostatic hypotension (nOH): For initial therapy, patient has a persistent, consistent decrease in systolic blood pressure of at least 20 mmHg OR decrease in diastolic blood pressure of at least 10 mmHg within 3 minutes of standing or head-up tilt test. For continuation of therapy, patient has experienced a sustained reduction in symptoms of nOH (i.e., decrease in dizziness, lightheadedness, or feeling faint). For both initial and continuation of therapy, the requested drug will be used for patients with neurogenic orthostatic hypotension associated with one of the following diagnoses: 1) primary autonomic failure due to Parkinson's disease, multiple system atrophy, or pure autonomic failure, OR 2) dopamine beta-hydroxylase deficiency, OR 3) non-diabetic autonomic neuropathy. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Coverage Duration</b>             | 3 months                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|--------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | NUBEQA                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Drug Names</b>                    | NUBEQA                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Required Medical Information</b>  | The requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy.                                                                                                                                                                                                                                                                                                        |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Prior Authorization Group</b>     | NUEDEXTA                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Drug Names</b>                    | NUEDEXTA                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Required Medical Information</b>  | For pseudobulbar affect (PBA), initial: 1) The patient has a diagnosis of pseudobulbar affect due to underlying neurological disease or injury AND 2) the patient is experiencing PBA episodes characterized by involuntary, sudden, and frequent episodes of laughing and/or crying. For PBA, continuation: The patient has experienced a decrease in pseudobulbar affect (PBA) episodes since starting therapy with the requested drug. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Coverage Duration</b>             | Initial: 4 months, Continuation: Plan Year                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Prior Authorization Group</b>     | NUPLAZID                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Drug Names</b>                    | NUPLAZID                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Required Medical Information</b>  | For hallucinations and delusions associated with Parkinson's disease psychosis, the diagnosis of Parkinson's disease must be made prior to the onset of psychotic symptoms.                                                                                                                                                                                                                                                               |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                        |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|--------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | NURTEC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Drug Names</b>                    | NURTEC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Required Medical Information</b>  | For acute migraine treatment: The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to at least one triptan 5-HT <sub>1</sub> receptor agonist. For preventative treatment of migraine: The requested drug will not be used concurrently with another calcitonin gene-related peptide (CGRP) receptor antagonist. For preventive treatment of migraine, continuation: The patient received at least 3 months of treatment with the requested drug and had a reduction in migraine days per month from baseline. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Coverage Duration</b>             | Preventive treatment of migraine, initial: 3 months, All other indications: Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Prior Authorization Group</b>     | OCTREOTIDE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Drug Names</b>                    | OCTREOTIDE ACETATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Off-label Uses</b>                | Tumor control of thymomas and thymic carcinomas                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Required Medical Information</b>  | For acromegaly, initial: 1) Patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range AND 2) Patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy. For acromegaly, continuation of therapy: Patient's IGF-1 level has decreased or normalized since initiation of therapy.                                                                                                        |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|--------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | ODOMZO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Drug Names</b>                    | ODOMZO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Prior Authorization Group</b>     | OFEV                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Drug Names</b>                    | OFEV                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Required Medical Information</b>  | For idiopathic pulmonary fibrosis (new starts only): 1) other causes of pulmonary fibrosis have been excluded, AND 2) the patient meets one of the following: a) a high-resolution computed tomography (HRCT) study of the chest or a lung biopsy reveals the usual interstitial pneumonia (UIP) pattern, OR b) HRCT study of the chest reveals a result other than the UIP pattern (e.g., probable UIP, indeterminate for UIP) and the diagnosis is supported either by a lung biopsy or by a multidisciplinary discussion between at least a radiologist and pulmonologist who are experienced in idiopathic pulmonary fibrosis if a lung biopsy has not been conducted. For chronic fibrosing interstitial lung diseases with progressive phenotype (progressive pulmonary fibrosis): the patient has confirmed progressive disease (e.g., forced vital capacity [FVC] decline, worsening respiratory symptoms, increased extent of fibrosis on high resolution computed tomography [HRCT]). For treatment of sclerosis-associated interstitial lung disease: the diagnosis was confirmed by a high-resolution computed tomography (HRCT) study of the chest. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|--------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | OGIVRI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Drug Names</b>                    | OGIVRI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Off-label Uses</b>                | Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent or advanced unresectable HER2-positive breast cancer, leptomeningeal metastases from HER2-positive breast cancer, brain metastases from HER2-positive breast cancer, HER2-positive esophageal and esophagogastric junction adenocarcinoma, HER2-positive advanced, recurrent, or metastatic uterine serous carcinoma, HER2-amplified and RAS and BRAF wild-type colorectal cancer (including appendiceal adenocarcinoma), HER2-positive recurrent salivary gland tumor, HER2-positive unresectable or metastatic hepatobiliary carcinoma (gallbladder cancer, intrahepatic cholangiocarcinoma, extrahepatic cholangiocarcinoma), HER2 overexpression positive locally advanced, unresectable, or recurrent gastric adenocarcinoma, HER2-positive endometrial cancer |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Required Medical Information</b>  | All indications: the patient had an intolerable adverse event to Trazimera and that adverse event was NOT attributed to the active ingredient as described in the prescribing information. For colorectal cancer (including appendiceal adenocarcinoma): 1) the disease is HER2-amplified and RAS and BRAF wild-type and 2) the requested drug is used in combination with pertuzumab, tucatinib or lapatinib and 3) the patient has not had previous treatment with a HER2 inhibitor OR 4) the patient has metachronous metastases. For hepatobiliary carcinoma: 1) the disease is HER2-positive AND 2) the requested drug is used in combination with pertuzumab or tucatinib. For endometrial cancer: 1) the disease is HER2-positive AND 2) the requested drug is used in combination with paclitaxel and continued as a single agent for maintenance therapy.              |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Other Criteria</b>                | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|--------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | OGSIVEO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Drug Names</b>                    | OGSIVEO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prior Authorization Group</b>     | OJEMDA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Drug Names</b>                    | OJEMDA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Required Medical Information</b>  | For relapsed or refractory pediatric low-grade glioma (LGG): the patient's tumor is positive for either a) BRAF fusion or rearrangement OR b) BRAF V600 mutation.                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prior Authorization Group</b>     | OJJAARA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Drug Names</b>                    | OJJAARA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Off-label Uses</b>                | Accelerated or blast phase myeloproliferative neoplasms                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Required Medical Information</b>  | For myelofibrosis, patient meets ALL of the following: 1) the patient has a diagnosis of intermediate or high-risk primary myelofibrosis or secondary myelofibrosis (i.e., post-polycythemia vera or post-essential thrombocythemia), AND 2) the patient has anemia defined as hemoglobin less than 10 grams per deciliter (g/dL) or having transfusion-dependent anemia, AND 3) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to Jakafi (ruxolitinib) OR has hemoglobin less than 8 g/dL. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|--------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | OMEGA-3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Drug Names</b>                    | OMEGA-3-ACID ETHYL ESTERS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Required Medical Information</b>  | For hypertriglyceridemia: Prior to the start of treatment with a triglyceride lowering drug, the patient has/had a pretreatment triglyceride level greater than or equal to 500 milligram per deciliter (mg/dL).                                                                                                                                                                                                                                                                                                      |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Prior Authorization Group</b>     | OMNIPOD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Drug Names</b>                    | OMNIPOD 5 DEXCOM G7G6 INT, OMNIPOD 5 DEXCOM G7G6 POD, OMNIPOD 5 LIBRE2 PLUS G6, OMNIPOD DASH INTRO KIT (G, OMNIPOD DASH PODS (GEN 4)                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Required Medical Information</b>  | Initial: 1) The patient has diabetes requiring insulin management with multiple daily injections, AND 2) The patient is self-testing glucose levels 4 or more times per day OR the patient is using a continuous glucose monitor, AND 3) The patient has experienced any of the following with the current diabetes regimen: inadequate glycemic control, recurrent hypoglycemia, wide fluctuations in blood glucose, dawn phenomenon with persistent severe early morning hyperglycemia, severe glycemic excursions. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|--------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | ONTRUZANT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Drug Names</b>                    | ONTRUZANT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Off-label Uses</b>                | Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent or advanced unresectable HER2-positive breast cancer, leptomeningeal metastases from HER2-positive breast cancer, brain metastases from HER2-positive breast cancer, HER2-positive esophageal and esophagogastric junction adenocarcinoma, HER2-positive advanced, recurrent, or metastatic uterine serous carcinoma, HER2-amplified and RAS and BRAF wild-type colorectal cancer (including appendiceal adenocarcinoma), HER2-positive recurrent salivary gland tumor, HER2-positive unresectable or metastatic hepatobiliary carcinoma (gallbladder cancer, intrahepatic cholangiocarcinoma, extrahepatic cholangiocarcinoma), HER2 overexpression positive locally advanced, unresectable, or recurrent gastric adenocarcinoma, HER2-positive endometrial cancer |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Required Medical Information</b>  | All indications: the patient had an intolerable adverse event to Trazimera and that adverse event was NOT attributed to the active ingredient as described in the prescribing information. For colorectal cancer (including appendiceal adenocarcinoma): 1) the disease is HER2-amplified and RAS and BRAF wild-type and 2) the requested drug is used in combination with pertuzumab, tucatinib or lapatinib and 3) the patient has not had previous treatment with a HER2 inhibitor OR 4) the patient has metachronous metastases. For hepatobiliary carcinoma: 1) the disease is HER2-positive AND 2) the requested drug is used in combination with pertuzumab or tucatinib. For endometrial cancer: 1) the disease is HER2-positive AND 2) the requested drug is used in combination with paclitaxel and continued as a single agent for maintenance therapy.              |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Other Criteria</b>                | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | ONUREG                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Drug Names</b>                    | ONUREG                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Off-label Uses</b>                | Peripheral T-cell lymphoma                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Prior Authorization Group</b>     | OPIPZA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Drug Names</b>                    | OPIPZA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Required Medical Information</b>  | For treatment of schizophrenia, 1) the patient meets both of the following: a) The patient experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following generic products: aripiprazole, asenapine, lurasidone, olanzapine, quetiapine, risperidone, ziprasidone, AND b) The patient experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following brand products: Caplyta, Lybalvi, Rexulti, Secuado, Vraylar, OR 2) The patient is unable to swallow oral formulations. For adjunctive treatment of major depressive disorder (MDD), 1) the patient meets both of the following: a) The patient experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following generic products: aripiprazole, olanzapine, quetiapine, AND b) The patient experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following brand products: Rexulti, Vraylar, OR 2) The patient is unable to swallow oral formulations. For treatment of irritability associated with autistic disorder: 1) The patient experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following generic products: aripiprazole, risperidone, OR 2) The patient is unable to swallow oral formulations. For the treatment of Tourette's disorder: 1) The patient experienced an inadequate treatment response or intolerance to generic aripiprazole, OR 2) The patient is unable to swallow oral formulations. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                |
|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | OPSUMIT                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Drug Names</b>                    | OPSUMIT                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Required Medical Information</b>  | For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For PAH new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) Pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Prior Authorization Group</b>     | ORGOVYX                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Drug Names</b>                    | ORGOVYX                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Prior Authorization Group</b>     | ORKAMBI                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Drug Names</b>                    | ORKAMBI                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Required Medical Information</b>  | For cystic fibrosis (CF): the requested drug will not be used in combination with other CFTR (cystic fibrosis transmembrane conductance regulator) potentiating agents (e.g., ivacaftor, deutevacaftor).                                                                                                                                                                                                                       |
| <b>Age Restrictions</b>              | 1 year of age or older                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                             |

|                                      |                                                                                         |
|--------------------------------------|-----------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | ORSERDU - PENDING CMS REVIEW                                                            |
| <b>Drug Names</b>                    | ORSERDU                                                                                 |
| <b>PA Indication Indicator</b>       | -                                                                                       |
| <b>Off-label Uses</b>                | -                                                                                       |
| <b>Exclusion Criteria</b>            | -                                                                                       |
| <b>Required Medical Information</b>  | -                                                                                       |
| <b>Age Restrictions</b>              | -                                                                                       |
| <b>Prescriber Restrictions</b>       | -                                                                                       |
| <b>Coverage Duration</b>             | -                                                                                       |
| <b>Other Criteria</b>                | -                                                                                       |
| <b>Prior Authorization Group</b>     | OZEMPIC                                                                                 |
| <b>Drug Names</b>                    | OZEMPIC                                                                                 |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                            |
| <b>Off-label Uses</b>                | -                                                                                       |
| <b>Exclusion Criteria</b>            | -                                                                                       |
| <b>Required Medical Information</b>  | -                                                                                       |
| <b>Age Restrictions</b>              | -                                                                                       |
| <b>Prescriber Restrictions</b>       | -                                                                                       |
| <b>Coverage Duration</b>             | Plan Year                                                                               |
| <b>Other Criteria</b>                | -                                                                                       |
| <b>Prerequisite Therapy Required</b> | No                                                                                      |
| <b>Prior Authorization Group</b>     | PANRETIN                                                                                |
| <b>Drug Names</b>                    | PANRETIN                                                                                |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                       |
| <b>Off-label Uses</b>                | Topical treatment of cutaneous lesions in patients with non-AIDS-related Kaposi sarcoma |
| <b>Exclusion Criteria</b>            | -                                                                                       |
| <b>Required Medical Information</b>  | -                                                                                       |
| <b>Age Restrictions</b>              | -                                                                                       |
| <b>Prescriber Restrictions</b>       | -                                                                                       |
| <b>Coverage Duration</b>             | Plan Year                                                                               |
| <b>Other Criteria</b>                | -                                                                                       |
| <b>Prerequisite Therapy Required</b> | No                                                                                      |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                          |
|--------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | PEGASYS                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Drug Names</b>                    | PEGASYS                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                        |
| <b>Off-label Uses</b>                | Myeloproliferative neoplasm (essential thrombocythemia, polycythemia vera, symptomatic lower-risk myelofibrosis), systemic mastocytosis, adult T-cell leukemia/lymphoma, mycosis fungoides/sezary syndrome, primary cutaneous CD30+ T-cell lymphoproliferative disorders, hairy cell leukemia, Erdheim-Chester disease, initial treatment during pregnancy for chronic myeloid leukemia. |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Required Medical Information</b>  | For chronic hepatitis C: Hepatitis C virus (HCV) confirmed by presence of hepatitis C virus HCV RNA in serum prior to starting treatment and the planned treatment regimen.                                                                                                                                                                                                              |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Coverage Duration</b>             | HCV: 12-48wks. HBV: 48wks. Other: Plan Yr                                                                                                                                                                                                                                                                                                                                                |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Prior Authorization Group</b>     | PEMAZYRE                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Drug Names</b>                    | PEMAZYRE                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                             |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Prior Authorization Group</b>     | PHENYLBUTYRATE                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Drug Names</b>                    | SODIUM PHENYLBUTYRATE                                                                                                                                                                                                                                                                                                                                                                    |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                             |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Required Medical Information</b>  | For chronic management of urea cycle disorders (UCD): Diagnosis of UCD was confirmed by enzymatic, biochemical, or genetic testing.                                                                                                                                                                                                                                                      |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                       |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|--------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | PHESGO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Drug Names</b>                    | PHESGO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Off-label Uses</b>                | Recurrent human epidermal growth factor receptor 2 (HER2)-positive breast cancer                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prior Authorization Group</b>     | PIMECROLIMUS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Drug Names</b>                    | PIMECROLIMUS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Off-label Uses</b>                | Psoriasis on the face, genitals, or skin folds.                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Required Medical Information</b>  | For mild to moderate atopic dermatitis (eczema): the patient meets either of the following criteria: 1) the disease affects sensitive skin areas (e.g., face, genitals, or skin folds), OR 2) the patient has experienced an inadequate treatment response, intolerance, or contraindication to at least one first line therapy agent (e.g., medium or higher potency topical corticosteroid). For all indications: the requested drug is prescribed for short-term or non-continuous chronic use. |
| <b>Age Restrictions</b>              | 2 years of age or older                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prior Authorization Group</b>     | PIQRAY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Drug Names</b>                    | PIQRAY 200MG DAILY DOSE, PIQRAY 250MG DAILY DOSE, PIQRAY 300MG DAILY DOSE                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Off-label Uses</b>                | Recurrent hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, phosphatidylinositol-3-kinase catalytic alpha subunit (PIK3CA)-mutated breast cancer in combination with fulvestrant                                                                                                                                                                                                                                                                           |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|--------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | POLYPHARMACY-ACH                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Drug Names</b>                    | AMOXAPINE, DICYCLOMINE HCL, DICYCLOMINE HYDROCHLORIDE, PAROXETINE HCL, PAROXETINE HYDROCHLORIDE                                                                                                                                                                                                                                                                                                                                                   |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Required Medical Information</b>  | If the patient is taking one or more additional anticholinergic medications (e.g., oxybutynin, meclizine, paroxetine, amitriptyline, dicyclomine, cyclobenzaprine) with the requested drug, the prescriber has determined that taking multiple anticholinergic medications is medically necessary for the patient [Note: Use of multiple anticholinergic medications in older adults is associated with an increased risk of cognitive decline.]. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Other Criteria</b>                | This Prior Authorization only applies to patients 65 years of age or older.                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prior Authorization Group</b>     | POMALYST                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Drug Names</b>                    | POMALYST                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Off-label Uses</b>                | Relapsed/refractory systemic light chain amyloidosis, primary central nervous system (CNS) lymphoma                                                                                                                                                                                                                                                                                                                                               |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Required Medical Information</b>  | For multiple myeloma: patient has previously received at least two prior therapies, including an immunomodulatory agent AND a proteasome inhibitor.                                                                                                                                                                                                                                                                                               |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                               |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|--------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | POSACONAZOLE                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Drug Names</b>                    | POSACONAZOLE DR                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Required Medical Information</b>  | The requested drug will be used orally. For prophylaxis of invasive Aspergillus and Candida infections: patient weighs greater than 40 kilograms.                                                                                                                                                                                                                                                                                  |
| <b>Age Restrictions</b>              | Treatment of Invasive Aspergillosis: 13 years of age or older, Prophylaxis of Invasive Aspergillus and Candida Infections: 2 years of age or older                                                                                                                                                                                                                                                                                 |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Coverage Duration</b>             | 6 months                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prior Authorization Group</b>     | PREGABALIN                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Drug Names</b>                    | PREGABALIN                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Off-label Uses</b>                | Cancer-related neuropathic pain, cancer treatment-related neuropathic pain                                                                                                                                                                                                                                                                                                                                                         |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Required Medical Information</b>  | For all indications: If the request is for Lyrica (pregabalin) oral solution, the patient has difficulty swallowing solid oral dosage forms (e.g., tablets, capsules). For the management of postherpetic neuralgia and management of neuropathic pain associated with diabetic peripheral neuropathy: The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to generic gabapentin. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Other Criteria</b>                | This Prior Authorization only applies to patients 65 years of age or older.                                                                                                                                                                                                                                                                                                                                                        |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                |

|                                      |                                                                                                                                                                                                                                                                                                                                                                     |
|--------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | PREVYMIS                                                                                                                                                                                                                                                                                                                                                            |
| <b>Drug Names</b>                    | PREVYMIS                                                                                                                                                                                                                                                                                                                                                            |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                        |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Required Medical Information</b>  | For prophylaxis of cytomegalovirus (CMV) infection or disease in hematopoietic stem cell transplant (HSCT): 1) the patient is CMV-seropositive, AND 2) the patient is a recipient of an allogeneic HSCT. For prophylaxis of CMV disease in kidney transplant: 1) the patient is CMV-seronegative, AND 2) the patient is a high risk recipient of kidney transplant. |
| <b>Age Restrictions</b>              | HSCT: 6 months of age or older, kidney transplant: 12 years of age or older                                                                                                                                                                                                                                                                                         |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Coverage Duration</b>             | 7 months                                                                                                                                                                                                                                                                                                                                                            |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Prior Authorization Group</b>     | PROCRIT - PENDING CMS REVIEW                                                                                                                                                                                                                                                                                                                                        |
| <b>Drug Names</b>                    | PROCRIT                                                                                                                                                                                                                                                                                                                                                             |
| <b>PA Indication Indicator</b>       | -                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Coverage Duration</b>             | -                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Prior Authorization Group</b>     | PULMOZYME                                                                                                                                                                                                                                                                                                                                                           |
| <b>Drug Names</b>                    | PULMOZYME                                                                                                                                                                                                                                                                                                                                                           |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                        |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                           |
| <b>Other Criteria</b>                | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.                                                                                                                                                                                              |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                  |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | PYZCHIVA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Drug Names</b>                    | PYZCHIVA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Required Medical Information</b>  | For moderate to severe plaque psoriasis (new starts only): 1) Crucial body areas (e.g., hands, feet, face, scalp, neck, genitals/groin, intertriginous areas) are affected at the time of diagnosis, OR 2) Patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of the body surface area is affected), OR 3) At least 3% of body surface area (BSA) is affected and patient meets either of the following: a) Patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) Pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Prior Authorization Group</b>     | QINLOCK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Drug Names</b>                    | QINLOCK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Off-label Uses</b>                | Gastrointestinal stromal tumor (GIST) for residual, unresectable, tumor rupture, recurrent, or progressive disease. Metastatic or unresectable cutaneous melanoma.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Required Medical Information</b>  | For residual, unresectable, tumor rupture, advanced, recurrent/metastatic, or progressive gastrointestinal stromal tumor (GIST): 1) Patient has received prior treatment with 3 or more kinase inhibitors, including imatinib OR 2) Patient has experienced disease progression following treatment with avapritinib and dasatinib OR 3) Patient has received prior treatment with imatinib and is intolerant of second-line sunitinib. For cutaneous melanoma: 1) Disease is metastatic or unresectable AND 2) Disease is positive for KIT activating mutations AND 3) Requested drug will be used as subsequent therapy AND 4) Patient has had disease progression, intolerance, or risk of progression with BRAF-targeted therapy.            |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | QUETIAPINE XR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Drug Names</b>                    | QUETIAPINE FUMARATE ER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Off-label Uses</b>                | Maintenance monotherapy treatment in bipolar I disorder, monotherapy treatment of generalized anxiety disorder, monotherapy treatment of major depressive disorder                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Required Medical Information</b>  | For all indications: If the patient is 65 years of age or older AND is using two or more additional central nervous system (CNS) active medications (e.g., lorazepam, sertraline, clonazepam, escitalopram, alprazolam, zolpidem) with the requested drug, the prescriber determined that taking multiple central nervous system (CNS) active medications is medically necessary. [Note: Use of multiple central nervous system (CNS) active medications in older adults is associated with an increased risk of falls].<br>For treatment of schizophrenia: The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following generic products: aripiprazole, asenapine, lurasidone, olanzapine, quetiapine immediate-release, risperidone, ziprasidone. For acute treatment of manic or mixed episodes associated with bipolar I disorder or maintenance treatment of bipolar I disorder: The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following generic products: aripiprazole, asenapine, olanzapine, quetiapine immediate-release, risperidone, ziprasidone. For acute treatment of depressive episodes associated with bipolar I disorder: The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following generic products: lurasidone, olanzapine, quetiapine immediate-release. For acute treatment of depressive episodes associated with bipolar II disorder: The patient experienced an inadequate treatment response or intolerance to generic quetiapine immediate-release. For adjunctive treatment of major depressive disorder (MDD): The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following generic products: aripiprazole, olanzapine, quetiapine immediate-release. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

|                                      |                                                                                                                                                                                                                                                                                                                                                                 |
|--------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | QUININE SULFATE                                                                                                                                                                                                                                                                                                                                                 |
| <b>Drug Names</b>                    | QUININE SULFATE                                                                                                                                                                                                                                                                                                                                                 |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                               |
| <b>Off-label Uses</b>                | Babesiosis, uncomplicated Plasmodium vivax malaria.                                                                                                                                                                                                                                                                                                             |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                               |
| <b>Required Medical Information</b>  | For babesiosis: the requested drug is used in combination with clindamycin.                                                                                                                                                                                                                                                                                     |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                               |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                               |
| <b>Coverage Duration</b>             | 1 month                                                                                                                                                                                                                                                                                                                                                         |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                               |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                              |
| <b>Prior Authorization Group</b>     | QULIPTA                                                                                                                                                                                                                                                                                                                                                         |
| <b>Drug Names</b>                    | QULIPTA                                                                                                                                                                                                                                                                                                                                                         |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                    |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                               |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                               |
| <b>Required Medical Information</b>  | For preventative treatment of migraine: The requested drug will not be used concurrently with another calcitonin gene-related peptide (CGRP) receptor antagonist. For preventive treatment of migraine, continuation: The patient received at least 3 months of treatment with the requested drug and had a reduction in migraine days per month from baseline. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                               |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                               |
| <b>Coverage Duration</b>             | Initial: 3 months, Continuation: Plan Year                                                                                                                                                                                                                                                                                                                      |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                               |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                              |
| <b>Prior Authorization Group</b>     | RALDESY                                                                                                                                                                                                                                                                                                                                                         |
| <b>Drug Names</b>                    | RALDESY                                                                                                                                                                                                                                                                                                                                                         |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                    |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                               |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                               |
| <b>Required Medical Information</b>  | The patient is unable to swallow trazodone tablets.                                                                                                                                                                                                                                                                                                             |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                               |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                               |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                       |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                               |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                             |

|                                     |                                   |
|-------------------------------------|-----------------------------------|
| <b>Prior Authorization Group</b>    | RELISTOR INJ - PENDING CMS REVIEW |
| <b>Drug Names</b>                   | RELISTOR                          |
| <b>PA Indication Indicator</b>      | -                                 |
| <b>Off-label Uses</b>               | -                                 |
| <b>Exclusion Criteria</b>           | -                                 |
| <b>Required Medical Information</b> | -                                 |
| <b>Age Restrictions</b>             | -                                 |
| <b>Prescriber Restrictions</b>      | -                                 |
| <b>Coverage Duration</b>            | -                                 |
| <b>Other Criteria</b>               | -                                 |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|--------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | REMICADE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Drug Names</b>                    | INFLIXIMAB, REMICADE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Off-label Uses</b>                | Behcet's disease, hidradenitis suppurativa, sarcoidosis, Takayasu's arteritis, uveitis.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Required Medical Information</b>  | For moderately to severely active rheumatoid arthritis (new starts only): 1) patient (pt) meets any of the following: a) requested drug will be used in combination with methotrexate (MTX), b) pt has experienced an intolerance or contraindication to MTX, AND 2) pt meets any of the following: a) pt has experienced an inadequate treatment response, intolerance or contraindication to MTX, b) pt has experienced an inadequate treatment response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. For active ankylosing spondylitis (new starts only): pt has experienced an inadequate treatment response or intolerance to a non-steroidal anti-inflammatory drug (NSAID) OR the pt has a contraindication that would prohibit a trial of NSAIDs. For moderate to severe plaque psoriasis (new starts): 1) Crucial body areas (e.g., hands, feet, face, scalp, neck, genitals/groin, intertriginous areas) are affected at the time of diagnosis OR 2) patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of the body surface area is affected) OR 3) at least 3% of body surface area (BSA) is affected and patient meets either of the following: a) patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Other Criteria</b>                | For hidradenitis suppurativa (new starts only): Pt has severe, refractory disease. For uveitis (new starts only): 1) pt has experienced an inadequate treatment response or intolerance to immunosuppressive therapy for uveitis OR 2) pt has a contraindication that would prohibit a trial of immunosuppressive therapy for uveitis. For all indications: The patient experienced an intolerable adverse event to Renflexis and that adverse event was NOT attributed to the active ingredient as described in the prescribing information.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|--------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | RENFLEXIS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Drug Names</b>                    | RENFLEXIS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Off-label Uses</b>                | Behcet's disease, hidradenitis suppurativa, sarcoidosis, Takayasu's arteritis, uveitis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Required Medical Information</b>  | For moderately to severely active rheumatoid arthritis (new starts only): 1) patient (pt) meets any of the following: a) requested drug will be used in combination with methotrexate (MTX), b) pt has experienced an intolerance or has a contraindication to MTX, AND 2) pt meets any of the following: a) pt has experienced an inadequate treatment response, intolerance or has a contraindication to MTX, b) pt has experienced an inadequate treatment response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. For active ankylosing spondylitis (new starts only): 1) pt has experienced an inadequate treatment response or intolerance to a non-steroidal anti-inflammatory drug (NSAID) OR 2) pt has a contraindication that would prohibit a trial of NSAIDs. For moderate to severe plaque psoriasis (new starts): 1) Crucial body areas (e.g., hands, feet, face, scalp, neck, genitals/groin, intertriginous areas) are affected at the time of diagnosis OR 2) patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of the body surface area is affected) OR 3) at least 3% of body surface area (BSA) is affected and patient meets either of the following: a) patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Other Criteria</b>                | For hidradenitis suppurativa (new starts only): pt has severe, refractory disease. For uveitis (new starts only): 1) pt has experienced an inadequate treatment response or intolerance to immunosuppressive therapy for uveitis OR 2) pt has a contraindication that would prohibit a trial of immunosuppressive therapy for uveitis.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|--------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | REPATHA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Drug Names</b>                    | REPATHA, REPATHA SURECLICK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prior Authorization Group</b>     | RETEVMO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Drug Names</b>                    | RETEVMO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Off-label Uses</b>                | Recurrent rearranged during transfection (RET)-rearrangement positive non-small cell lung cancer (NSCLC), brain metastases from RET fusion-positive NSCLC, Langerhans cell histiocytosis with a RET gene fusion, symptomatic or relapsed/refractory Erdheim-Chester Disease with a RET gene fusion, symptomatic or relapsed/refractory Rosai-Dorfman Disease with a RET gene fusion, occult primary cancer with RET gene fusion, solid tumors with RET-gene fusion for recurrent disease                                                                                          |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Required Medical Information</b>  | For non-small cell lung cancer (NSCLC), patient must meet all of the following: 1) The disease is recurrent, advanced or metastatic, AND 2) The tumor is rearranged during transfection (RET) fusion-positive or RET rearrangement positive. For solid tumors, patient must meet all of the following: 1) The disease is recurrent, persistent, progressive, unresectable, locally advanced, or metastatic, 2) The patient has progressed on or following prior systemic treatment or has no satisfactory alternative treatment options, AND 3) The tumor is RET fusion-positive. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|--------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | REVCOVI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Drug Names</b>                    | REVCOVI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Prior Authorization Group</b>     | REVLIMID                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Drug Names</b>                    | LENALIDOMIDE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Off-label Uses</b>                | Systemic light chain amyloidosis, classical Hodgkin lymphoma, myelodysplastic syndrome without the 5q deletion cytogenetic abnormality, POEMS (polyneuropathy, organomegaly, endocrinopathy, monoclonal protein, skin changes) syndrome, myeloproliferative neoplasms, Kaposi Sarcoma, Langerhans cell histiocytosis, Rosai-Dorfman disease, peripheral T-Cell lymphomas not otherwise specified, angioimmunoblastic T-cell lymphoma (AITL), enteropathy-associated T-cell lymphoma, monomorphic epitheliotropic intestinal T-cell lymphoma, nodal peripheral T-cell lymphoma, adult T-cell leukemia/lymphoma, hepatosplenic T-cell lymphoma, primary central nervous system (CNS) lymphoma, chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL), human immunodeficiency virus (HIV)-related B-cell lymphomas, monomorphic post-transplant lymphoproliferative disorder, diffuse large B-cell lymphoma, multicentric Castlemans disease, high-grade B-cell lymphomas, histologic transformation of indolent lymphoma to diffuse large B-cell lymphoma |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Required Medical Information</b>  | For myelodysplastic syndrome (MDS): patient has lower risk MDS with symptomatic anemia per the Revised International Prognostic Scoring System (IPSS-R), International Prognostic Scoring System (IPSS), or World Health organization (WHO) classification-based Prognostic Scoring System (WPSS).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|--------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | REVUFORJ                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Drug Names</b>                    | REVUFORJ                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Prior Authorization Group</b>     | REZDIFFRA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Drug Names</b>                    | REZDIFFRA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Required Medical Information</b>  | For noncirrhotic nonalcoholic steatohepatitis (NASH), initial: patient has moderate to advanced liver fibrosis (consistent with Stages F2 to F3 ) at baseline, which was confirmed by liver biopsy or magnetic resonance elastography (MRE). For NASH (continuation): The patient demonstrates a beneficial response to therapy (for example, improvement in liver function such as reduction in alanine aminotransferase (ALT), reduction of liver fat content by imaging such as magnetic resonance imaging-protein density fat fraction (MRI-PDFF) or FibroScan controlled attenuation parameter (CAP)). |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Prescriber Restrictions</b>       | The requested drug is being prescribed by, or in consultation with, a gastroenterologist or hepatologist.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Coverage Duration</b>             | Initial: Plan Year, Continuation: Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Prior Authorization Group</b>     | REZLIDHIA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Drug Names</b>                    | REZLIDHIA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |

|                                      |                              |
|--------------------------------------|------------------------------|
| <b>Prior Authorization Group</b>     | REZUROCK                     |
| <b>Drug Names</b>                    | REZUROCK                     |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications |
| <b>Off-label Uses</b>                | -                            |
| <b>Exclusion Criteria</b>            | -                            |
| <b>Required Medical Information</b>  | -                            |
| <b>Age Restrictions</b>              | 12 years of age or older     |
| <b>Prescriber Restrictions</b>       | -                            |
| <b>Coverage Duration</b>             | Plan Year                    |
| <b>Other Criteria</b>                | -                            |
| <b>Prerequisite Therapy Required</b> | No                           |

|                                     |                             |
|-------------------------------------|-----------------------------|
| <b>Prior Authorization Group</b>    | RINVOQ - PENDING CMS REVIEW |
| <b>Drug Names</b>                   | RINVOQ, RINVOQ LQ           |
| <b>PA Indication Indicator</b>      | -                           |
| <b>Off-label Uses</b>               | -                           |
| <b>Exclusion Criteria</b>           | -                           |
| <b>Required Medical Information</b> | -                           |
| <b>Age Restrictions</b>             | -                           |
| <b>Prescriber Restrictions</b>      | -                           |
| <b>Coverage Duration</b>            | -                           |
| <b>Other Criteria</b>               | -                           |

|                                      |                              |
|--------------------------------------|------------------------------|
| <b>Prior Authorization Group</b>     | ROMVIMZA                     |
| <b>Drug Names</b>                    | ROMVIMZA                     |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications |
| <b>Off-label Uses</b>                | -                            |
| <b>Exclusion Criteria</b>            | -                            |
| <b>Required Medical Information</b>  | -                            |
| <b>Age Restrictions</b>              | -                            |
| <b>Prescriber Restrictions</b>       | -                            |
| <b>Coverage Duration</b>             | Plan Year                    |
| <b>Other Criteria</b>                | -                            |
| <b>Prerequisite Therapy Required</b> | No                           |

|                                      |                                                                                                                                                                                                                                                                |
|--------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | ROZLYTREK                                                                                                                                                                                                                                                      |
| <b>Drug Names</b>                    | ROZLYTREK                                                                                                                                                                                                                                                      |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                              |
| <b>Off-label Uses</b>                | Recurrent ROS1-positive non-small cell lung cancer (NSCLC), Non-metastatic neurotrophic tyrosine receptor kinase (NTRK) gene fusion-positive solid tumors, ROS1-gene fusion-positive cutaneous melanoma                                                        |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                              |
| <b>Required Medical Information</b>  | For all neurotrophic tyrosine receptor kinase (NTRK) gene fusion-positive solid tumors: the disease is without a known acquired resistance mutation. For ROS1-positive non-small cell lung cancer: the patient has recurrent, advanced, or metastatic disease. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                              |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                              |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                      |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                              |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                             |
| <b>Prior Authorization Group</b>     | RUBRACA - PENDING CMS REVIEW                                                                                                                                                                                                                                   |
| <b>Drug Names</b>                    | RUBRACA                                                                                                                                                                                                                                                        |
| <b>PA Indication Indicator</b>       | -                                                                                                                                                                                                                                                              |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                              |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                              |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                              |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                              |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                              |
| <b>Coverage Duration</b>             | -                                                                                                                                                                                                                                                              |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                              |
| <b>Prior Authorization Group</b>     | RYBELSUS                                                                                                                                                                                                                                                       |
| <b>Drug Names</b>                    | RYBELSUS                                                                                                                                                                                                                                                       |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                   |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                              |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                              |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                              |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                              |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                              |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                      |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                              |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                             |

|                                      |                                                                                                                                                                                                                                                                                          |
|--------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | RYDAPT                                                                                                                                                                                                                                                                                   |
| <b>Drug Names</b>                    | RYDAPT                                                                                                                                                                                                                                                                                   |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                        |
| <b>Off-label Uses</b>                | Re-induction in residual disease for AML, maintenance therapy for AML, myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and FGFR1 or FLT3 rearrangements                                                                                                                  |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                        |
| <b>Required Medical Information</b>  | For acute myeloid leukemia (AML): AML is FMS-like tyrosine kinase 3 (FLT3) mutation-positive. For myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and Fibroblast growth factor receptor type 1 (FGFR1) or FLT3 rearrangements: the disease is in chronic or blast phase. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                        |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                        |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                        |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                       |
| <b>Prior Authorization Group</b>     | SANTYL                                                                                                                                                                                                                                                                                   |
| <b>Drug Names</b>                    | SANTYL                                                                                                                                                                                                                                                                                   |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                             |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                        |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                        |
| <b>Required Medical Information</b>  | For debriding chronic dermal ulcers and severely burned areas, continuation: 1) wound has been evaluated since beginning treatment with the requested drug AND 2) granulation tissue is not well established.                                                                            |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                        |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                        |
| <b>Coverage Duration</b>             | 3 months                                                                                                                                                                                                                                                                                 |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                        |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                       |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|--------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | SAPROPTERIN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Drug Names</b>                    | JAVYGTOR, SAPROPTERIN DIHYDROCHLORI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Required Medical Information</b>  | For phenylketonuria (PKU): For patients who have not yet received a therapeutic trial of the requested drug, the patient's pretreatment (including before dietary management) phenylalanine level is greater than 6 mg/dL (360 micromol/L). For patients who completed a therapeutic trial of the requested drug, the patient must have experienced improvement (e.g., reduction in blood phenylalanine levels, improvement in neuropsychiatric symptoms).                                                                                                       |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Coverage Duration</b>             | Initial: 2 months, All others: Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Prior Authorization Group</b>     | SCEMBLIX                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Drug Names</b>                    | SCEMBLIX                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Off-label Uses</b>                | Myeloid and/or lymphoid neoplasms with eosinophilia and ABL1 rearrangement in chronic phase or blast phase                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Required Medical Information</b>  | For chronic myeloid leukemia (CML) in chronic phase: 1) Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene, AND 2) Patient meets one of the following: A) Patient has newly diagnosed CML and has resistance or intolerance to imatinib, dasatinib, or nilotinib OR B) Patient has previously treated CML AND at least one of the prior treatments was imatinib, dasatinib, or nilotinib OR C) Patient is positive for the T315I mutation, AND 3) Patient is negative for the following mutations: A337T, P465S, and F359V/I/C. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|--------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | SIGNIFOR                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Drug Names</b>                    | SIGNIFOR                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Prescriber Restrictions</b>       | Prescribed by or in consultation with an endocrinologist                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Prior Authorization Group</b>     | SILDENAFIL                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Drug Names</b>                    | SILDENAFIL CITRATE                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Required Medical Information</b>  | For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For PAH new starts only: 1) Pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) Pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) If the request is for an adult, pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Prior Authorization Group</b>     | SIRTURO - PENDING CMS REVIEW                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Drug Names</b>                    | SIRTURO                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>PA Indication Indicator</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Coverage Duration</b>             | -                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                              |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | SKYRIZI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Drug Names</b>                    | SKYRIZI, SKYRIZI PEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Required Medical Information</b>  | For moderate to severe plaque psoriasis (new starts only): 1) Crucial body areas (e.g., hands, feet, face, scalp, neck, genitals/groin, intertriginous areas) are affected at the time of diagnosis, OR 2) Patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of the body surface area is affected), OR 3) At least 3% of body surface area (BSA) is affected and patient meets either of the following: a) Patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) Pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Prior Authorization Group</b>     | SOMATULINE DEPOT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Drug Names</b>                    | LANREOTIDE ACETATE, SOMATULINE DEPOT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Off-label Uses</b>                | Tumor control of neuroendocrine tumors (NETs) (including tumors of the lung, thymus, unresected primary gastrinoma, well-differentiated grade 3 NETs not of gastroenteropancreatic origin with favorable biology, and pheochromocytoma/paraganglioma)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Required Medical Information</b>  | For acromegaly, initial: 1) Patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range, AND 2) Patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy. For acromegaly, continuation of therapy: Patient's IGF-1 level has decreased or normalized since initiation of therapy.                                                                                                                                                                                                                                                                             |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | SOMAVERT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Drug Names</b>                    | SOMAVERT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Required Medical Information</b>  | For acromegaly, initial: 1) Patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range, AND 2) Patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy. For acromegaly, continuation of therapy: Patient's IGF-1 level has decreased or normalized since initiation of therapy.                                                                                                                                                                                                                                                                             |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Prior Authorization Group</b>     | SOTYKTU                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Drug Names</b>                    | SOTYKTU                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Required Medical Information</b>  | For moderate to severe plaque psoriasis (new starts only): 1) Crucial body areas (e.g., hands, feet, face, scalp, neck, genitals/groin, intertriginous areas) are affected at the time of diagnosis, OR 2) Patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of the body surface area is affected), OR 3) At least 3% of body surface area (BSA) is affected and patient meets either of the following: a) Patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) Pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | SPRYCEL - PENDING CMS REVIEW                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Drug Names</b>                    | DASATINIB                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>PA Indication Indicator</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Coverage Duration</b>             | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prior Authorization Group</b>     | STELARA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Drug Names</b>                    | STELARA, USTEKINUMAB                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Required Medical Information</b>  | For moderate to severe plaque psoriasis (new starts only): 1) Crucial body areas (e.g., hands, feet, face, scalp, neck, genitals/groin, intertriginous areas) are affected at the time of diagnosis, OR 2) Patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of the body surface area is affected), OR 3) At least 3% of body surface area (BSA) is affected and patient meets either of the following: a) Patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) Pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Prior Authorization Group</b>     | STIVARGA - PENDING CMS REVIEW                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Drug Names</b>                    | STIVARGA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>PA Indication Indicator</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Coverage Duration</b>             | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|--------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | SUTENT                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Drug Names</b>                    | SUNITINIB MALATE                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Off-label Uses</b>                | Thyroid carcinoma (follicular, medullary, papillary, and oncocytic), soft tissue sarcoma (angiosarcoma, solitary fibrous tumor, alveolar soft part sarcoma, and extraskeletal myxoid chondrosarcoma subtypes), recurrent chordoma, thymic carcinoma, lymphoid and/or myeloid neoplasms with eosinophilia and FLT3 rearrangement in chronic or blast phase, pheochromocytoma, paraganglioma, well differentiated grade 3 neuroendocrine tumors |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Required Medical Information</b>  | For renal cell carcinoma (RCC): 1) The disease is relapsed, advanced, or stage IV OR 2) the requested drug is being used as adjuvant treatment for patients that are at high risk of recurrent RCC following nephrectomy.                                                                                                                                                                                                                     |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Prior Authorization Group</b>     | SYMDEKO                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Drug Names</b>                    | SYMDEKO                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Required Medical Information</b>  | For cystic fibrosis: the requested drug will not be used in combination with other CFTR (cystic fibrosis transmembrane conductance regulator) potentiating agents (e.g., ivacaftor, deutevacaftor).                                                                                                                                                                                                                                           |
| <b>Age Restrictions</b>              | 6 years of age or older                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                            |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|--------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | SYMPAZAN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Drug Names</b>                    | SYMPAZAN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Off-label Uses</b>                | Seizures associated with Dravet syndrome                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Age Restrictions</b>              | Seizures associated with Lennox-Gastaut syndrome (LGS): 2 years of age or older                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Prior Authorization Group</b>     | SYNAREL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Drug Names</b>                    | SYNAREL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Required Medical Information</b>  | For central precocious puberty (CPP): Patients not currently receiving therapy must meet all of the following criteria: 1) Diagnosis of CPP was confirmed by a pubertal response to a gonadotropin releasing hormone (GnRH) agonist test OR a pubertal level of a third generation luteinizing hormone (LH) assay, AND 2) Assessment of bone age versus chronological age supports the diagnosis of CPP, AND 3) The onset of secondary sexual characteristics occurred prior to 8 years of age for female patients OR prior to 9 years of age for male patients. |
| <b>Age Restrictions</b>              | CPP: Patient must be less than 12 years of age if female and less than 13 years of age if male, Endometriosis: 18 years of age or older                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Coverage Duration</b>             | CPP: Plan Year, Endometriosis: max 6 months total                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Prior Authorization Group</b>     | TABLOID                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Drug Names</b>                    | TABLOID                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Off-label Uses</b>                | Acute lymphocytic leukemia (ALL), circumscribed glioma                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |

|                                      |                                                                                                                                                                                                                                  |
|--------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | TABRECTA                                                                                                                                                                                                                         |
| <b>Drug Names</b>                    | TABRECTA                                                                                                                                                                                                                         |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                |
| <b>Off-label Uses</b>                | Recurrent non-small cell lung cancer (NSCLC), NSCLC with high-level mesenchymal-epithelial transition (MET) amplification, central nervous system (CNS) brain metastases from MET exon-14 mutated NSCLC                          |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                |
| <b>Required Medical Information</b>  | For recurrent, advanced, or metastatic non-small cell lung cancer (NSCLC): Tumor is positive for mesenchymal-epithelial transition (MET) exon 14 skipping mutation.                                                              |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                        |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                               |
| <b>Prior Authorization Group</b>     | TADALAFIL (BPH)                                                                                                                                                                                                                  |
| <b>Drug Names</b>                    | TADALAFIL                                                                                                                                                                                                                        |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                     |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                |
| <b>Exclusion Criteria</b>            | Erectile Dysfunction.                                                                                                                                                                                                            |
| <b>Required Medical Information</b>  | For benign prostatic hyperplasia (BPH): the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to both of the following: 1) alpha blocker, 2) 5-alpha reductase inhibitor (5-ARI). |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                |
| <b>Coverage Duration</b>             | 26 weeks                                                                                                                                                                                                                         |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                              |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|--------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | TADALAFIL (PAH)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Drug Names</b>                    | ALYQ, TADALAFIL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Required Medical Information</b>  | For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For PAH new starts only: 1) Pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) Pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) Pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Prior Authorization Group</b>     | TAFINLAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Drug Names</b>                    | TAFINLAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Off-label Uses</b>                | Langerhans cell histiocytosis, Erdheim-Chester disease, hairy cell leukemia.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Required Medical Information</b>  | For melanoma: 1) The tumor is positive for a BRAF V600 activating mutation (e.g., V600E or V600K), AND 2) The requested drug will be used as a single agent or in combination with trametinib, AND 3) The requested drug will be used for either of the following: a) unresectable, limited resectable, or metastatic disease, b) adjuvant or neoadjuvant systemic therapy. For non-small cell lung cancer: 1) The tumor is positive for a BRAF V600E mutation, AND 2) The requested drug will be used as a single agent or in combination with trametinib. For papillary, follicular, and oncocytic thyroid carcinoma: 1) The tumor is BRAF V600E-positive, AND 2) The disease is not amenable to radioactive iodine (RAI) therapy, AND 3) the requested drug will be used in combination with trametinib. For Langerhans Cell Histiocytosis and Erdheim-Chester Disease: The disease is positive for a BRAF V600E mutation. For hairy cell leukemia: 1) the requested drug will be used in combination with trametinib, AND 2) the patient has not had previous treatment with BRAF inhibitor therapy. For solid tumors: 1) The tumor is positive for a BRAF V600E mutation, AND 2) The requested drug will be used in combination with trametinib. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | TAGRISSO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Drug Names</b>                    | TAGRISSO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Off-label Uses</b>                | Sensitizing epidermal growth factor receptor (EGFR) mutation-positive recurrent non-small cell lung cancer (NSCLC), brain metastases from sensitizing EGFR mutation-positive NSCLC, leptomeningeal metastases from EGFR mutation-positive NSCLC                                                                                                                                                                                                                                                                                                                    |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Required Medical Information</b>  | For non-small cell lung cancer (NSCLC), the requested drug is used in any of the following settings: 1) The patient meets both of the following: a) patient has unresectable, metastatic, advanced, or recurrent NSCLC (including brain and/or leptomeningeal metastases from NSCLC) and b) patient has a sensitizing epidermal growth factor receptor (EGFR) mutation-positive disease, OR 2) The patient meets both of the following: a) request is for adjuvant treatment of NSCLC following tumor resection and b) patient has EGFR mutation-positive disease. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prior Authorization Group</b>     | TALZENNA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Drug Names</b>                    | TALZENNA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Off-label Uses</b>                | Recurrent germline breast cancer susceptibility gene (BRCA)-mutated breast cancer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |

|                                      |                                                                                                                                                                                     |
|--------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | TARGRETIN TOPICAL                                                                                                                                                                   |
| <b>Drug Names</b>                    | BEXAROTENE                                                                                                                                                                          |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                   |
| <b>Off-label Uses</b>                | Mycosis fungoides (MF)/Sezary syndrome (SS), smoldering adult T-cell leukemia/lymphoma (ATLL), primary cutaneous marginal zone lymphoma, primary cutaneous follicle center lymphoma |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                   |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                   |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                   |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                   |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                           |
| <b>Other Criteria</b>                | -                                                                                                                                                                                   |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                  |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|--------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | TASIGNA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Drug Names</b>                    | NILOTINIB HYDROCHLORIDE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Off-label Uses</b>                | Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), gastrointestinal stromal tumor (GIST), myeloid and/or lymphoid neoplasms with eosinophilia and ABL1 rearrangement in the chronic phase or blast phase, pigmented villonodular synovitis/tenosynovial giant cell tumor, cutaneous melanoma                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Required Medical Information</b>  | For chronic myeloid leukemia (CML), including patients newly diagnosed with CML and patients who have received a hematopoietic stem cell transplant: 1) Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene, AND 2) If patient experienced resistance to an alternative tyrosine kinase inhibitor for CML, patient is negative for T315I, Y253H, E255K/V, and F359V/C/I mutations. For acute lymphoblastic leukemia (ALL), including patients who have received a hematopoietic stem cell transplant: 1) Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene, AND 2) If the patient has experienced resistance to an alternative tyrosine kinase inhibitor for ALL, patient is negative for T315I, Y253H, E255K/V, F359V/C/I and G250E mutations. For gastrointestinal stromal tumor (GIST): 1) Disease is residual, unresectable, recurrent/progressive, or metastatic/tumor rupture, AND 2) Disease has progressed on at least 2 Food and Drug Administration (FDA)-approved therapies (e.g. imatinib, sunitinib, regorafenib, ripretinib). For cutaneous melanoma: 1) Disease is metastatic or unresectable, AND 2) Disease is positive for c-KIT activating mutations, AND 3) Requested drug will be used as subsequent therapy, AND 4) Patient has had disease progression, intolerance, or risk of progression with BRAF-targeted therapy. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Prior Authorization Group</b>     | TAVNEOS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Drug Names</b>                    | TAVNEOS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Required Medical Information</b>  | For continuation of treatment for severe anti-neutrophil cytoplasmic autoantibody (ANCA)-associated vasculitis: the patient has experienced benefit from therapy.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |

|                                      |                                                                                                                                                                                                                                                                                                                                                                  |
|--------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | TAZAROTENE                                                                                                                                                                                                                                                                                                                                                       |
| <b>Drug Names</b>                    | TAZAROTENE                                                                                                                                                                                                                                                                                                                                                       |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                     |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                |
| <b>Required Medical Information</b>  | For plaque psoriasis, the patient meets the following criteria: 1) the patient has less than or equal to 20 percent of affected body surface area (BSA), AND 2) the patient experienced an inadequate treatment response or intolerance to at least one topical corticosteroid OR has a contraindication that would prohibit a trial of topical corticosteroids. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                        |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                              |
| <b>Prior Authorization Group</b>     | TAZVERIK                                                                                                                                                                                                                                                                                                                                                         |
| <b>Drug Names</b>                    | TAZVERIK                                                                                                                                                                                                                                                                                                                                                         |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                     |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                |
| <b>Age Restrictions</b>              | Epithelioid sarcoma: 16 years of age or older, Follicular lymphoma: 18 years of age or older                                                                                                                                                                                                                                                                     |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                        |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                               |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|--------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | TECENTRIQ                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Drug Names</b>                    | TECENTRIQ                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Off-label Uses</b>                | Single agent maintenance for extensive small cell lung cancer following combination treatment with etoposide and carboplatin, subsequent therapy for peritoneal mesothelioma, pericardial mesothelioma, and tunica vaginalis testis mesothelioma, urothelial carcinoma, stage IIIB non-small cell lung cancer (NSCLC), cervical cancer (persistent, recurrent, or metastatic small cell neuroendocrine carcinoma of the cervix (NECC), squamous cell carcinoma, adenocarcinoma, adenosquamous cell carcinoma of the cervix).                 |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Required Medical Information</b>  | For non-small cell lung cancer (NSCLC): 1) the patient has recurrent, advanced, or metastatic disease OR 2) the patient has stage II to IIIB disease AND the requested drug will be used as adjuvant treatment following resection and adjuvant chemotherapy. For hepatocellular carcinoma, the requested drug will be used as initial treatment in combination with bevacizumab.                                                                                                                                                            |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Prior Authorization Group</b>     | TECENTRIQ HYBREZA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Drug Names</b>                    | TECENTRIQ HYBREZA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Off-label Uses</b>                | Cervical cancer (persistent, recurrent, or metastatic small cell neuroendocrine carcinoma of the cervix (NECC), squamous cell carcinoma, adenocarcinoma, adenosquamous cell carcinoma of the cervix), stage IIIB non-small cell lung cancer (NSCLC), subsequent therapy for peritoneal mesothelioma, pericardial mesothelioma, and tunica vaginalis testis mesothelioma, single agent maintenance for extensive small cell lung cancer following combination treatment with etoposide and carboplatin, bladder cancer, urothelial carcinoma. |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Required Medical Information</b>  | For non-small cell lung cancer (NSCLC): 1) the patient has recurrent, advanced or metastatic disease OR 2) the patient has stage II to IIIB disease AND the requested drug will be used as adjuvant treatment following resection and adjuvant chemotherapy. For hepatocellular carcinoma, the requested drug will be used as initial treatment in combination with bevacizumab.                                                                                                                                                             |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|--------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | TEMAZEPAM                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Drug Names</b>                    | TEMAZEPAM                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Required Medical Information</b>  | For short-term treatment of insomnia: 1) The prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for the patient. (Note: The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) AND 2) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to doxepin (3 mg or 6 mg) or ramelteon, AND 3) If the patient is using two or more additional central nervous system (CNS) active medications (e.g., lorazepam, quetiapine, sertraline, clonazepam, escitalopram, alprazolam) with the requested drug, the prescriber has determined that taking multiple central nervous system (CNS) active medications is medically necessary for the patient [Note: Use of multiple central nervous system (CNS) active medications in older adults is associated with an increased risk of falls.].. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Other Criteria</b>                | This Prior Authorization only applies to patients 65 years of age or older.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Prior Authorization Group</b>     | TEPMETKO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Drug Names</b>                    | TEPMETKO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Off-label Uses</b>                | Recurrent non-small cell lung cancer (NSCLC), NSCLC with high level mesenchymal-epithelial transition (MET) amplification, central nervous system (CNS) cancer including brain metastases and leptomeningeal metastases from MET exon-14 mutated NSCLC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Required Medical Information</b>  | For recurrent, advanced, or metastatic non-small cell lung cancer (NSCLC): Tumor is positive for mesenchymal-epithelial transition (MET) exon 14 skipping mutation.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

|                                      |                                                                                                                                                                                                                                        |
|--------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | TERBINAFINE TABS                                                                                                                                                                                                                       |
| <b>Drug Names</b>                    | TERBINAFINE HCL                                                                                                                                                                                                                        |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                           |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                      |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                      |
| <b>Required Medical Information</b>  | For the treatment of onychomycosis due to dermatophytes (tinea unguium), patient meets ALL of the following: 1) the patient will use the requested drug orally., AND 2) the requested drug is being prescribed for non-continuous use. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                      |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                      |
| <b>Coverage Duration</b>             | 12 weeks                                                                                                                                                                                                                               |
| <b>Other Criteria</b>                | Prior authorization applies to greater than cumulative 90 days of therapy per year.                                                                                                                                                    |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                     |
| <b>Prior Authorization Group</b>     | TERIPARATIDE - PENDING CMS REVIEW                                                                                                                                                                                                      |
| <b>Drug Names</b>                    | BONSITY, TERIPARATIDE                                                                                                                                                                                                                  |
| <b>PA Indication Indicator</b>       | -                                                                                                                                                                                                                                      |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                      |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                      |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                      |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                      |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                      |
| <b>Coverage Duration</b>             | -                                                                                                                                                                                                                                      |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                      |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|--------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | TESTOSTERONE CYPIONATE INJ                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Drug Names</b>                    | DEPO-TESTOSTERONE, TESTOSTERONE CYPIONATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Off-label Uses</b>                | Gender Dysphoria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Required Medical Information</b>  | For primary hypogonadism or hypogonadotropic hypogonadism, initial therapy: The patient has at least two confirmed low morning serum total testosterone concentrations based on the reference laboratory range or current practice guidelines [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. For primary hypogonadism or hypogonadotropic hypogonadism, continuation of therapy: The patient had a confirmed low morning serum total testosterone concentration based on the reference laboratory range or current practice guidelines before starting testosterone therapy [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. For gender dysphoria: The patient is able to make an informed decision to engage in hormone therapy. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|--------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | TESTOSTERONE ENANTHATE INJ                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Drug Names</b>                    | TESTOSTERONE ENANTHATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Off-label Uses</b>                | Gender Dysphoria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Required Medical Information</b>  | For primary hypogonadism or hypogonadotropic hypogonadism, initial therapy: The patient has at least two confirmed low morning serum total testosterone concentrations based on the reference laboratory range or current practice guidelines [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. For primary hypogonadism or hypogonadotropic hypogonadism, continuation of therapy: The patient had a confirmed low morning serum total testosterone concentration based on the reference laboratory range or current practice guidelines before starting testosterone therapy [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. For gender dysphoria: The patient is able to make an informed decision to engage in hormone therapy. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|--------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | TETRABENAZINE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Drug Names</b>                    | TETRABENAZINE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Off-label Uses</b>                | Tic disorders, tardive dyskinesia                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Required Medical Information</b>  | For treatment of chorea associated with Huntington's disease, initial: patient must meet both of the following: 1) patient demonstrates characteristic motor examination features, AND 2) patient has experienced an inadequate treatment response or intolerable adverse event to deutetrabenazine. For tardive dyskinesia, initial: patient must meet all of the following: 1) patient exhibits clinical manifestation of the disease, AND 2) patient's disease has been assessed through clinical examination or with a structured evaluative tool (e.g., Abnormal Involuntary Movement Scale [AIMS], Dyskinesia Identification System: Condensed User Scale [DISCUS]), AND 3) patient has experienced an inadequate treatment response or intolerable adverse event to deutetrabenazine. For treatment of tardive dyskinesia and treatment of chorea associated with Huntington's disease, continuation: patient demonstrates a beneficial response to therapy. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Coverage Duration</b>             | Initial: 6 months, Continuation: Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prior Authorization Group</b>     | THALOMID                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Drug Names</b>                    | THALOMID                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Off-label Uses</b>                | Acquired immunodeficiency syndrome (AIDS)-related aphthous stomatitis, Kaposi sarcoma, multicentric Castleman's disease, Rosai-Dorfman disease, Langerhans cell histiocytosis, pediatric medulloblastoma                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|--------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | TIBSOVO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Drug Names</b>                    | TIBSOVO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Off-label Uses</b>                | Conventional (grades 1-3) or dedifferentiated chondrosarcoma, central nervous system (CNS) cancers (astrocytoma, oligodendroglioma)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Required Medical Information</b>  | Patient has disease with a susceptible isocitrate dehydrogenase-1 (IDH1) mutation. For acute myeloid leukemia (AML): 1) patient has newly-diagnosed AML and meets one of the following: a) 75 years of age or older, b) patient declines or has comorbidities that preclude use of intensive induction chemotherapy, OR 2) the requested drug will be used as post-induction therapy following response to induction therapy with the requested drug, OR 3) patient has relapsed or refractory AML, OR 4) therapy will be used for consolidation therapy. For locally advanced, unresectable, resected gross residual, or metastatic cholangiocarcinoma: the requested drug will be used as subsequent treatment for progression on or after systemic treatment. For CNS cancers: 1) disease is recurrent, residual, or progressive, AND 2) patient has oligodendroglioma or astrocytoma. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Prior Authorization Group</b>     | TOBI INHALER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Drug Names</b>                    | TOBI PODHALER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Off-label Uses</b>                | Non-cystic fibrosis bronchiectasis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Required Medical Information</b>  | For cystic fibrosis and non-cystic fibrosis bronchiectasis: 1) Pseudomonas aeruginosa is present in the patient's airway cultures, OR 2) The patient has a history of Pseudomonas aeruginosa infection or colonization in the airways.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |

|                                      |                                                                                                                                                                                                                                                                   |
|--------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | TOBRAMYCIN                                                                                                                                                                                                                                                        |
| <b>Drug Names</b>                    | TOBRAMYCIN                                                                                                                                                                                                                                                        |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                 |
| <b>Off-label Uses</b>                | Non-cystic fibrosis bronchiectasis                                                                                                                                                                                                                                |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                 |
| <b>Required Medical Information</b>  | For cystic fibrosis and non-cystic fibrosis bronchiectasis: 1) Pseudomonas aeruginosa is present in the patient's airway cultures, OR 2) The patient has a history of Pseudomonas aeruginosa infection or colonization in the airways.                            |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                 |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                 |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                         |
| <b>Other Criteria</b>                | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.                                                                                            |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                |
| <b>Prior Authorization Group</b>     | TOPICAL LIDOCAINE                                                                                                                                                                                                                                                 |
| <b>Drug Names</b>                    | GLYDO, LIDOCAINE, LIDOCAINE HYDROCHLORIDE                                                                                                                                                                                                                         |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                      |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                 |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                 |
| <b>Required Medical Information</b>  | 1) The requested drug is being used for topical anesthesia, AND 2) If the requested drug will be used as part of a compounded product, then all the active ingredients in the compounded product are Food and Drug Administration (FDA) approved for topical use. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                 |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                 |
| <b>Coverage Duration</b>             | 3 months                                                                                                                                                                                                                                                          |
| <b>Other Criteria</b>                | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.                                                                                            |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|--------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | TOPICAL TACROLIMUS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Drug Names</b>                    | TACROLIMUS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Off-label Uses</b>                | Psoriasis on the face, genitals, or skin folds.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Required Medical Information</b>  | For moderate to severe atopic dermatitis (eczema): the patient meets either of the following criteria: 1) the disease affects sensitive skin areas (e.g., face, genitals, or skin folds), OR 2) the patient has experienced an inadequate treatment response, intolerance, or contraindication to at least one first line therapy agent (e.g., medium or higher potency topical corticosteroid). For all indications: the requested drug is being prescribed for short-term or non-continuous chronic use.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Age Restrictions</b>              | Tacrolimus 0.03% 2 years of age or older, Tacrolimus 0.1% 16 years of age or older.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Prior Authorization Group</b>     | TOPICAL TESTOSTERONES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Drug Names</b>                    | TESTOSTERONE, TESTOSTERONE PUMP                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Off-label Uses</b>                | Gender Dysphoria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Required Medical Information</b>  | For primary hypogonadism or hypogonadotropic hypogonadism, initial therapy: The patient has at least two confirmed low morning serum total testosterone concentrations based on the reference laboratory range or current practice guidelines [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. For primary hypogonadism or hypogonadotropic hypogonadism, continuation of therapy: The patient had a confirmed low morning serum total testosterone concentration based on the reference laboratory range or current practice guidelines before starting testosterone therapy [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. For gender dysphoria: The patient is able to make an informed decision to engage in hormone therapy. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |

|                                      |                              |
|--------------------------------------|------------------------------|
| <b>Prior Authorization Group</b>     | TOPICAL TRETINOIN            |
| <b>Drug Names</b>                    | TRETINOIN                    |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications |
| <b>Off-label Uses</b>                | -                            |
| <b>Exclusion Criteria</b>            | -                            |
| <b>Required Medical Information</b>  | -                            |
| <b>Age Restrictions</b>              | -                            |
| <b>Prescriber Restrictions</b>       | -                            |
| <b>Coverage Duration</b>             | Plan Year                    |
| <b>Other Criteria</b>                | -                            |
| <b>Prerequisite Therapy Required</b> | No                           |

|                                      |                                                                                                                 |
|--------------------------------------|-----------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | TOREMIFENE                                                                                                      |
| <b>Drug Names</b>                    | TOREMIFENE CITRATE                                                                                              |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                    |
| <b>Off-label Uses</b>                | -                                                                                                               |
| <b>Exclusion Criteria</b>            | Congenital/acquired QT prolongation (long QT syndrome), uncorrected hypokalemia, or uncorrected hypomagnesemia. |
| <b>Required Medical Information</b>  | -                                                                                                               |
| <b>Age Restrictions</b>              | -                                                                                                               |
| <b>Prescriber Restrictions</b>       | -                                                                                                               |
| <b>Coverage Duration</b>             | Plan Year                                                                                                       |
| <b>Other Criteria</b>                | -                                                                                                               |
| <b>Prerequisite Therapy Required</b> | No                                                                                                              |

**Prior Authorization Group**

**Drug Names**

**PA Indication Indicator**

**Off-label Uses**

TRAZIMERA

TRAZIMERA

All FDA-approved Indications, Some Medically-accepted Indications

Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent or advanced unresectable HER2-positive breast cancer, leptomeningeal metastases from HER2-positive breast cancer, brain metastases from HER2-positive breast cancer, HER2-positive esophageal and esophagogastric junction adenocarcinoma, HER2-positive advanced, recurrent, or metastatic uterine serous carcinoma, HER2-amplified and RAS and BRAF wild-type colorectal cancer (including appendiceal adenocarcinoma), HER2-positive recurrent salivary gland tumor, HER2-positive unresectable or metastatic hepatobiliary carcinoma (gallbladder cancer, intrahepatic cholangiocarcinoma, extrahepatic cholangiocarcinoma), HER2 overexpression positive locally advanced, unresectable, or recurrent gastric adenocarcinoma, HER2-positive endometrial cancer.

**Exclusion Criteria**

-

**Required Medical Information**

For colorectal cancer (including appendiceal adenocarcinoma): 1) the disease is HER2-amplified and RAS and BRAF wild-type and 2) the requested drug is used in combination with pertuzumab, tucatinib or lapatinib AND 3) the patient has not had previous treatment with a HER2 inhibitor OR 4) the patient has metachronous metastases. For hepatobiliary carcinoma: 1) the disease is HER2-positive AND 2) the requested drug is used in combination with pertuzumab or tucatinib. For endometrial cancer: 1) the disease is HER2-positive AND 2) the requested drug is used in combination with paclitaxel and continued as a single agent for maintenance therapy.

**Age Restrictions**

-

**Prescriber Restrictions**

-

**Coverage Duration**

Plan Year

**Other Criteria**

Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

**Prerequisite Therapy Required**

No

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|--------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | TREMFYA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Drug Names</b>                    | TREMFYA, TREMFYA INDUCTION PACK FO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Required Medical Information</b>  | For moderate to severe plaque psoriasis (new starts): 1) Crucial body areas (e.g., hands, feet, face, scalp, neck, genitals/groin, intertriginous areas) are affected at the time of diagnosis OR 2) patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of the body surface area is affected) OR 3) at least 3% of body surface area (BSA) is affected and patient meets either of the following: a) patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Prior Authorization Group</b>     | TREPROSTINIL INJ                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Drug Names</b>                    | TREPROSTINIL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Required Medical Information</b>  | For pulmonary arterial hypertension (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units.                                                                                                                                                                                                                                                                                                                      |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Other Criteria</b>                | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |

|                                      |                                                                                                                                                                                                                                                                                                                                    |
|--------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | TRIENTINE                                                                                                                                                                                                                                                                                                                          |
| <b>Drug Names</b>                    | TRIENTINE HYDROCHLORIDE                                                                                                                                                                                                                                                                                                            |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                       |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                  |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                  |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                  |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                  |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                  |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                          |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                  |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                 |
| <b>Prior Authorization Group</b>     | TRIKAFTA                                                                                                                                                                                                                                                                                                                           |
| <b>Drug Names</b>                    | TRIKAFTA                                                                                                                                                                                                                                                                                                                           |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                       |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                  |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                  |
| <b>Required Medical Information</b>  | For cystic fibrosis: the requested drug will not be used in combination with other CFTR (cystic fibrosis transmembrane conductance regulator) potentiating agents (e.g., ivacaftor, deutivacaftor).                                                                                                                                |
| <b>Age Restrictions</b>              | 2 years of age or older                                                                                                                                                                                                                                                                                                            |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                  |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                          |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                  |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                 |
| <b>Prior Authorization Group</b>     | TRINTELLIX                                                                                                                                                                                                                                                                                                                         |
| <b>Drug Names</b>                    | TRINTELLIX                                                                                                                                                                                                                                                                                                                         |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                       |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                  |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                  |
| <b>Required Medical Information</b>  | For major depressive disorder (MDD): The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to ONE of the following generic products: serotonin and norepinephrine reuptake inhibitors (SNRIs), selective serotonin reuptake inhibitors (SSRIs), mirtazapine, bupropion. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                  |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                  |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                          |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                  |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                |

|                                      |                                                                            |
|--------------------------------------|----------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | TRULICITY                                                                  |
| <b>Drug Names</b>                    | TRULICITY                                                                  |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                               |
| <b>Off-label Uses</b>                | -                                                                          |
| <b>Exclusion Criteria</b>            | -                                                                          |
| <b>Required Medical Information</b>  | -                                                                          |
| <b>Age Restrictions</b>              | For glycemic control in type 2 diabetes mellitus: 10 years of age or older |
| <b>Prescriber Restrictions</b>       | -                                                                          |
| <b>Coverage Duration</b>             | Plan Year                                                                  |
| <b>Other Criteria</b>                | -                                                                          |
| <b>Prerequisite Therapy Required</b> | No                                                                         |

|                                     |                             |
|-------------------------------------|-----------------------------|
| <b>Prior Authorization Group</b>    | TRUQAP - PENDING CMS REVIEW |
| <b>Drug Names</b>                   | TRUQAP                      |
| <b>PA Indication Indicator</b>      | -                           |
| <b>Off-label Uses</b>               | -                           |
| <b>Exclusion Criteria</b>           | -                           |
| <b>Required Medical Information</b> | -                           |
| <b>Age Restrictions</b>             | -                           |
| <b>Prescriber Restrictions</b>      | -                           |
| <b>Coverage Duration</b>            | -                           |
| <b>Other Criteria</b>               | -                           |

**Prior Authorization Group****Drug Names****PA Indication Indicator****Off-label Uses**

TRUXIMA

TRUXIMA

All FDA-approved Indications, Some Medically-accepted Indications

Non-Hodgkin's lymphoma subtypes [small lymphocytic lymphoma (SLL), mantle cell lymphoma, marginal zone lymphomas (nodal, splenic, extranodal marginal zone lymphoma (EMZL) of the stomach, EMZL of nongastric sites (noncutaneous)), Burkitt lymphoma, high-grade B-cell lymphoma, histological transformation of indolent lymphomas to diffuse large B-cell lymphoma, histological transformation of chronic lymphocytic leukemia (CLL)/SLL to diffuse large B-cell lymphoma, primary cutaneous B-cell lymphoma, Castleman disease, human immunodeficiency virus (HIV)-related B-cell lymphoma, hairy cell leukemia, post-transplant lymphoproliferative disorder (PTLD), B-cell lymphoblastic lymphoma], refractory immune or idiopathic thrombocytopenic purpura (ITP), autoimmune hemolytic anemia, Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma, chronic graft-versus-host disease (GVHD), Sjogren syndrome, thrombotic thrombocytopenic purpura, refractory myasthenia gravis, nodular lymphocyte-predominant Hodgkin lymphoma, primary central nervous system (CNS) lymphoma, leptomeningeal metastases from lymphomas, acute lymphoblastic leukemia, prevention of Epstein-Barr virus (EBV)-related PTLD, relapsing remitting multiple sclerosis, immune checkpoint inhibitor-related toxicities, Rosai-Dorfman disease, pemphigus vulgaris, pediatric aggressive mature B-cell lymphomas (including Burkitt-like lymphoma, primary mediastinal large B-cell lymphoma), and pediatric mature B-cell acute leukemia, neuromyelitis optica spectrum disorder

**Exclusion Criteria**

-

**Required Medical Information**

For moderately to severely active rheumatoid arthritis (new starts only): 1) patient meets ANY of the following: a) requested drug will be used in combination with methotrexate (MTX) OR b) patient has intolerance or contraindication to MTX, AND 2) patient meets ANY of the following: a) inadequate treatment response, intolerance, or contraindication to MTX OR b) inadequate treatment response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. Hematologic malignancies must be CD20-positive.

**Age Restrictions**

-

**Prescriber Restrictions**

-

**Coverage Duration**

Immune checkpoint inhibitor-related toxicities: 3 months, All other: Plan Year

**Other Criteria**

-

**Prerequisite Therapy Required**

Yes

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|--------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | TUKYSA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Drug Names</b>                    | TUKYSA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Off-label Uses</b>                | Recurrent human epidermal growth factor receptor 2 (HER2)-positive breast cancer, HER2-positive biliary tract cancer (gallbladder cancer, intrahepatic cholangiocarcinoma, extrahepatic cholangiocarcinoma)                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Required Medical Information</b>  | For colorectal cancer (including appendiceal adenocarcinoma): 1) the patient has advanced, unresectable, or metastatic disease, AND 2) the patient has human epidermal growth factor receptor 2 (HER2)-positive disease, AND 3) the patient has RAS wild-type disease, AND 4) the requested drug will be used in combination with trastuzumab, AND 5) the patient has not previously been treated with a HER2 inhibitor. For biliary tract cancer: 1) the patient has unresectable or metastatic disease, AND 2) the patient has human epidermal growth factor receptor 2 (HER2)-positive disease, AND 3) the requested drug will be used in combination with trastuzumab. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Prior Authorization Group</b>     | TURALIO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Drug Names</b>                    | TURALIO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Off-label Uses</b>                | Langerhans cell histiocytosis, Erdheim-Chester disease, Rosai-Dorfman disease                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Required Medical Information</b>  | For Langerhans cell histiocytosis: 1) disease has colony stimulating factor 1 receptor (CSF1R) mutation. For Erdheim-Chester disease and Rosai-Dorfman disease: 1) disease has CSF1R mutation, AND 2) patient has any of the following: a) symptomatic disease OR b) relapsed/refractory disease.                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|--------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | TYENNE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Drug Names</b>                    | TYENNE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Off-label Uses</b>                | Castleman's disease, systemic sclerosis-associated interstitial lung disease                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Required Medical Information</b>  | For moderately to severely active rheumatoid arthritis (new starts only): 1) Patient has experienced an inadequate treatment response, intolerance or contraindication to methotrexate (MTX) OR 2) Patient has experienced an inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. For treatment of sclerosis-associated interstitial lung disease: the diagnosis was confirmed by a high-resolution computed tomography (HRCT) study of the chest. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Prior Authorization Group</b>     | UBRELVY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Drug Names</b>                    | UBRELVY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Required Medical Information</b>  | For acute treatment of migraine: The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to at least one triptan 5-HT1 receptor agonist.                                                                                                                                                                                                                                                                                                                                 |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                      |
|--------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | UCERIS                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Drug Names</b>                    | BUDESONIDE ER                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Required Medical Information</b>  | For the induction of remission of active, mild to moderate ulcerative colitis: patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one 5-aminosalicylic acid (5-ASA) therapy.                                                                                                                                                                               |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Coverage Duration</b>             | 2 months                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Prior Authorization Group</b>     | UPTRAVI                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Drug Names</b>                    | UPTRAVI, UPTRAVI TITRATION PACK                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Required Medical Information</b>  | For pulmonary arterial hypertension (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                   |

|                                      |                                                                                                                                                                                                                                                                                                                            |
|--------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | VALCHLOR                                                                                                                                                                                                                                                                                                                   |
| <b>Drug Names</b>                    | VALCHLOR                                                                                                                                                                                                                                                                                                                   |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                          |
| <b>Off-label Uses</b>                | Smoldering adult T-cell leukemia/lymphoma (ATLL), Stage 2 or higher mycosis fungoides (MF)/Sezary syndrome (SS), primary cutaneous marginal zone lymphoma, primary cutaneous follicle center lymphoma, CD30-positive lymphomatoid papulosis (LyP), unifocal Langerhans cell histiocytosis (LCH) with isolated skin disease |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                          |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                          |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                          |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                          |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                  |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                          |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                         |
| <b>Prior Authorization Group</b>     | VANFLYTA                                                                                                                                                                                                                                                                                                                   |
| <b>Drug Names</b>                    | VANFLYTA                                                                                                                                                                                                                                                                                                                   |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                          |
| <b>Off-label Uses</b>                | Re-induction in patients with residual disease for AML                                                                                                                                                                                                                                                                     |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                          |
| <b>Required Medical Information</b>  | For acute myeloid leukemia (AML): 1) AML is FMS-like tyrosine kinase 3 (FLT3) internal tandem duplication (ITD)-positive and 2) medication will be used for induction, re-induction, consolidation, or maintenance therapy.                                                                                                |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                          |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                          |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                  |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                          |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                         |

|                                      |                                                                                                                                                                                                                                                    |
|--------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | VELCADE                                                                                                                                                                                                                                            |
| <b>Drug Names</b>                    | BORTEZOMIB                                                                                                                                                                                                                                         |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                  |
| <b>Off-label Uses</b>                | Systemic light chain amyloidosis, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, multicentric Castleman's disease, adult T-cell leukemia/lymphoma, acute lymphoblastic leukemia, Kaposi's sarcoma, pediatric Classic Hodgkin Lymphoma |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                  |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                  |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                  |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                  |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                          |
| <b>Other Criteria</b>                | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.                                                                             |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                 |
| <b>Prior Authorization Group</b>     | VELSIPITY                                                                                                                                                                                                                                          |
| <b>Drug Names</b>                    | VELSIPITY                                                                                                                                                                                                                                          |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                       |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                  |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                  |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                  |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                  |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                  |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                          |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                  |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                 |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|--------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | VENCLEXTA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Drug Names</b>                    | VENCLEXTA, VENCLEXTA STARTING PACK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Off-label Uses</b>                | Mantle cell lymphoma, blastic plasmacytoid dendritic cell neoplasm (BPDCN), multiple myeloma, relapsed or refractory acute myeloid leukemia (AML), poor-risk AML, therapy related AML, post-induction therapy for AML following response to previous lower intensity therapy with the same regimen, Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma, relapsed or refractory systemic light chain amyloidosis with translocation t(11:14), accelerated or blast phase myeloproliferative neoplasms, B-cell acute lymphoblastic leukemia/T-cell acute lymphoblastic leukemia (B-ALL/T-ALL), hairy cell leukemia, higher risk myelodysplastic syndromes, chronic myelomonocytic leukemia (CMML)-2.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Required Medical Information</b>  | For acute myeloid leukemia (AML): 1) patient has newly-diagnosed AML and meets one of the following: a) 75 years of age or older, b) patient has comorbidities that preclude use of intensive induction chemotherapy, OR 2) will be used for induction or consolidation therapy in patients with poor-risk or therapy related AML, OR 3) patient has relapsed or refractory AML, OR 4) will be used for post-induction therapy for AML following response to previous lower intensity therapy with the same regimen. For blastic plasmacytoid dendritic cell neoplasm (BPDCN): 1) patient has systemic disease being treated with palliative intent, OR 2) patient has relapsed or refractory disease. For multiple myeloma: 1) the disease is relapsed or progressive, AND 2) the requested drug will be used in combination with one of the following: a) dexamethasone, b) dexamethasone and daratumumab c) dexamethasone with bortezomib, carfilzomib, or ixazomib AND 3) patient has t(11:14) translocation. For Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma: 1) patient has previously treated disease that did not respond to primary therapy, OR 2) patient has progressive or relapsed disease. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|--------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | VERQUVO - PENDING CMS REVIEW                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Drug Names</b>                    | VERQUVO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>PA Indication Indicator</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Coverage Duration</b>             | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Prior Authorization Group</b>     | VERSACLOZ                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Drug Names</b>                    | VERSACLOZ                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Required Medical Information</b>  | For the treatment of a severely ill patient with schizophrenia who failed to respond adequately to standard antipsychotic treatment (i.e., treatment-resistant schizophrenia):<br>1) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following generic products: aripiprazole, asenapine, lurasidone, olanzapine, quetiapine, risperidone, ziprasidone, AND 2) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following brand products: Caplyta, Lybalvi, Rexulti, Secuado, Vraylar. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|--------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | VERZENIO                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Drug Names</b>                    | VERZENIO                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Off-label Uses</b>                | Recurrent breast cancer, endometrial cancer, in combination with letrozole for estrogen receptor positive tumor                                                                                                                                                                                                                                                                                                                                                 |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Required Medical Information</b>  | For breast cancer: 1) the disease is either: a) advanced, recurrent, or metastatic, OR b) early breast cancer AND 2) the patient has hormone receptor (HR)-positive and human epidermal growth factor receptor 2 (HER2)-negative disease, AND 3) the requested drug will be used in combination with endocrine therapy or as a single agent, AND 4) the patient has experienced an intolerable adverse event or has a contraindication to Kisqali (ribociclib). |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Prior Authorization Group</b>     | VIGABATRIN                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Drug Names</b>                    | VIGABATRIN, VIGADRUNE, VIGPODER                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Required Medical Information</b>  | For complex partial seizures (i.e., focal impaired awareness seizures): patient has experienced an inadequate treatment response to at least two antiepileptic drugs for complex partial seizures (i.e., focal impaired awareness seizures).                                                                                                                                                                                                                    |
| <b>Age Restrictions</b>              | Infantile Spasms: 1 month to 2 years of age. Complex partial seizures (i.e., focal impaired awareness seizures): 2 years of age or older                                                                                                                                                                                                                                                                                                                        |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                             |

|                                      |                                                                                                                                                                                                     |
|--------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | VIGAFYDE                                                                                                                                                                                            |
| <b>Drug Names</b>                    | VIGAFYDE                                                                                                                                                                                            |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                        |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                   |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                   |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                   |
| <b>Age Restrictions</b>              | Infantile Spasms: 1 month to 2 years of age                                                                                                                                                         |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                   |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                           |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                   |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                  |
| <b>Prior Authorization Group</b>     | VITRAKVI                                                                                                                                                                                            |
| <b>Drug Names</b>                    | VITRAKVI                                                                                                                                                                                            |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                   |
| <b>Off-label Uses</b>                | Non-metastatic neurotrophic tyrosine receptor kinase (NTRK) gene fusion-positive solid tumors, first-line treatment of NTRK gene fusion-positive solid tumors.                                      |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                   |
| <b>Required Medical Information</b>  | For all neurotrophic tyrosine receptor kinase (NTRK) gene fusion-positive solid tumors, the disease is without a known acquired resistance mutation.                                                |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                   |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                   |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                           |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                   |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                  |
| <b>Prior Authorization Group</b>     | VIZIMPRO                                                                                                                                                                                            |
| <b>Drug Names</b>                    | VIZIMPRO                                                                                                                                                                                            |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                   |
| <b>Off-label Uses</b>                | Recurrent non-small cell lung cancer (NSCLC)                                                                                                                                                        |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                   |
| <b>Required Medical Information</b>  | For non-small cell lung cancer (NSCLC): 1) the disease is recurrent, advanced, or metastatic, AND 2) the patient has sensitizing epidermal growth factor receptor (EGFR) mutation-positive disease. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                   |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                   |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                           |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                   |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                  |

|                                      |                                                                                                                                                                                                                                                          |
|--------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | VONJO                                                                                                                                                                                                                                                    |
| <b>Drug Names</b>                    | VONJO                                                                                                                                                                                                                                                    |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                        |
| <b>Off-label Uses</b>                | Accelerated or blast phase myeloproliferative neoplasms                                                                                                                                                                                                  |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                        |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                        |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                        |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                        |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                        |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                       |
| <b>Prior Authorization Group</b>     | VOQUEZNA PAK                                                                                                                                                                                                                                             |
| <b>Drug Names</b>                    | VOQUEZNA DUAL PAK, VOQUEZNA TRIPLE PAK                                                                                                                                                                                                                   |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                             |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                        |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                        |
| <b>Required Medical Information</b>  | For treatment of Helicobacter pylori (H. pylori) infection: the infection is proven or strongly suspected to be caused by susceptible bacteria based on: 1) culture and susceptibility information OR 2) local epidemiology and susceptibility patterns. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                        |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                        |
| <b>Coverage Duration</b>             | 14 days                                                                                                                                                                                                                                                  |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                        |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                       |
| <b>Prior Authorization Group</b>     | VORANIGO                                                                                                                                                                                                                                                 |
| <b>Drug Names</b>                    | VORANIGO                                                                                                                                                                                                                                                 |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                             |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                        |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                        |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                        |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                        |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                        |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                        |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                       |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|--------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | VORICONAZOLE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Drug Names</b>                    | VORICONAZOLE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Required Medical Information</b>  | The patient will use the requested drug orally or intravenously.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Coverage Duration</b>             | 6 months                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Prior Authorization Group</b>     | VOSEVI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Drug Names</b>                    | VOSEVI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Exclusion Criteria</b>            | Decompensated cirrhosis/moderate or severe hepatic impairment (Child Turcotte Pugh class B or C)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Required Medical Information</b>  | For hepatitis C virus (HCV): Infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [CTP class B or C]), presence or absence of human immunodeficiency virus (HIV) coinfection, presence or absence of resistance-associated substitutions where applicable, transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current American Association for the Study of Liver Diseases and Infectious Diseases Society of America (AASLD-IDSA) treatment guidelines. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Coverage Duration</b>             | Criteria will be applied consistent with current AASLD-IDSA guidance.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Prior Authorization Group</b>     | VOTRIENT - PENDING CMS REVIEW                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Drug Names</b>                    | PAZOPANIB HYDROCHLORIDE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>PA Indication Indicator</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Coverage Duration</b>             | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                |
|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | VOWST                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Drug Names</b>                    | VOWST                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Required Medical Information</b>  | For the prevention of recurrence of Clostridioides difficile infection (CDI): 1) The diagnosis of CDI has been confirmed by a positive stool test for C. difficile toxin, AND 2) The requested drug will be administered at least 48 hours after the last dose of antibiotics used for the treatment of recurrent CDI.                                                                                                         |
| <b>Age Restrictions</b>              | 18 years of age or older                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Coverage Duration</b>             | 1 month                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Prior Authorization Group</b>     | WELIREG                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Drug Names</b>                    | WELIREG                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Prior Authorization Group</b>     | WINREVAIR                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Drug Names</b>                    | WINREVAIR                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Required Medical Information</b>  | For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For PAH new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) Pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                             |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|--------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | WYOST - PENDING CMS REVIEW                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Drug Names</b>                    | WYOST                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>PA Indication Indicator</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Coverage Duration</b>             | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Prior Authorization Group</b>     | XALKORI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Drug Names</b>                    | XALKORI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Off-label Uses</b>                | Recurrent non-small cell lung cancer (NSCLC), NSCLC with high-level MET amplification, recurrent, advanced, or metastatic NSCLC with MET exon 14 skipping mutation, symptomatic or relapsed/refractory anaplastic lymphoma kinase (ALK)-fusion positive Erdheim-Chester Disease, symptomatic or relapsed/refractory (ALK)-fusion positive Rosai-Dorfman Disease, (ALK)-fusion positive Langerhans Cell Histiocytosis, metastatic or unresectable ROS1 gene fusion positive cutaneous melanoma, metastatic or inoperable uterine sarcoma for IMT with ALK translocation                                                                                                                                                                                                  |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Required Medical Information</b>  | For non-small cell lung cancer (NSCLC), the requested drug is used in any of the following settings: 1) the patient has recurrent, advanced, or metastatic anaplastic lymphoma kinase (ALK)-positive NSCLC, AND 2) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to ONE of the following products: Alecensa (alectinib) or Alunbrig (brigatinib), OR 3) the patient has recurrent, advanced, or metastatic ROS-1 positive NSCLC, OR 4) the patient has NSCLC with high-level MET amplification, OR 5) the patient has recurrent, advanced, or metastatic MET exon 14 skipping mutation. For anaplastic large cell lymphoma (ALCL): 1) the disease is relapsed or refractory, AND 2) the disease is ALK-positive. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|--------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | XDEMVY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Drug Names</b>                    | XDEMVY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Prior Authorization Group</b>     | XELJANZ                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Drug Names</b>                    | XELJANZ, XELJANZ XR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Required Medical Information</b>  | For moderately to severely active rheumatoid arthritis, active ankylosing spondylitis, and active polyarticular course juvenile idiopathic arthritis (new starts only): Patient has experienced an inadequate treatment response, intolerance or has a contraindication to at least one tumor necrosis factor (TNF) inhibitor (for example, adalimumab, etanercept). For moderately to severely active ulcerative colitis (new starts only): Patient has experienced an inadequate treatment response, intolerance or has a contraindication to at least one tumor necrosis factor (TNF) inhibitor (for example, adalimumab). For active psoriatic arthritis (new starts only): 1) Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one TNF inhibitor (for example, adalimumab, etanercept) AND 2) the requested drug will be used in combination with a nonbiologic DMARD. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |

|                                      |                                                                                              |
|--------------------------------------|----------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | XERMELO                                                                                      |
| <b>Drug Names</b>                    | XERMELO                                                                                      |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                 |
| <b>Off-label Uses</b>                | -                                                                                            |
| <b>Exclusion Criteria</b>            | -                                                                                            |
| <b>Required Medical Information</b>  | -                                                                                            |
| <b>Age Restrictions</b>              | -                                                                                            |
| <b>Prescriber Restrictions</b>       | -                                                                                            |
| <b>Coverage Duration</b>             | Plan Year                                                                                    |
| <b>Other Criteria</b>                | -                                                                                            |
| <b>Prerequisite Therapy Required</b> | No                                                                                           |
| <b>Prior Authorization Group</b>     | XHANCE                                                                                       |
| <b>Drug Names</b>                    | XHANCE                                                                                       |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                 |
| <b>Off-label Uses</b>                | -                                                                                            |
| <b>Exclusion Criteria</b>            | -                                                                                            |
| <b>Required Medical Information</b>  | Patient has experienced an inadequate treatment response to generic fluticasone nasal spray. |
| <b>Age Restrictions</b>              | 18 years of age or older                                                                     |
| <b>Prescriber Restrictions</b>       | -                                                                                            |
| <b>Coverage Duration</b>             | Plan Year                                                                                    |
| <b>Other Criteria</b>                | -                                                                                            |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                          |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|--------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | XIFAXAN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Drug Names</b>                    | XIFAXAN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Off-label Uses</b>                | Small intestinal bacterial overgrowth syndrome (SIBO)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Required Medical Information</b>  | For irritable bowel syndrome with diarrhea (IBS-D): 1) The patient has not previously received treatment with the requested drug, OR 2) The patient has previously received treatment with the requested drug, AND a) the patient is experiencing a recurrence of symptoms, AND b) the patient has not already received an initial 14-day course of treatment and two additional 14-day courses of treatment with the requested drug. For small intestinal bacterial overgrowth (SIBO): 1) the patient is experiencing a recurrence after completion of a successful course of treatment with the requested drug OR 2) diagnosis has been confirmed via one of the following: a) quantitative culture of upper gut aspirate, b) breath testing (e.g., lactulose hydrogen or glucose hydrogen breath test). |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Coverage Duration</b>             | Reduction in risk of overt HE recurrence: 6 months, IBS-D and SIBO: 14 days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Prior Authorization Group</b>     | XOLAIR - PENDING CMS REVIEW                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Drug Names</b>                    | XOLAIR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>PA Indication Indicator</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Coverage Duration</b>             | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|--------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | XOSPATA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Drug Names</b>                    | XOSPATA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Off-label Uses</b>                | Myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and FLT3 rearrangement, acute myeloid leukemia (AML) post allogeneic hematopoietic cell transplantation (HCT), in remission.                                                                                                                                                                                                                                                                                                                                                        |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Required Medical Information</b>  | For myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and FMS-like tyrosine kinase 3 (FLT3) rearrangement: the disease is in chronic or blast phase. For AML with FLT3 mutation: The requested drug will be used for one of the following: a) relapsed or refractory disease, b) induction therapy, c) post-induction therapy following response to induction therapy with the requested drug, d) consolidation therapy, e) maintenance therapy in patients who are in remission after allogeneic hematopoietic cell transplantation. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Prior Authorization Group</b>     | XPOVIO - PENDING CMS REVIEW                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Drug Names</b>                    | XPOVIO, XPOVIO 60 MG TWICE WEEKLY, XPOVIO 80 MG TWICE WEEKLY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>PA Indication Indicator</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Coverage Duration</b>             | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |

|                                      |                                                                                                                                                                                                                                                  |
|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | XTANDI                                                                                                                                                                                                                                           |
| <b>Drug Names</b>                    | XTANDI                                                                                                                                                                                                                                           |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                     |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                |
| <b>Required Medical Information</b>  | For the treatment of castration-resistant prostate cancer or metastatic castration-sensitive prostate cancer: The requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                        |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                               |
| <b>Prior Authorization Group</b>     | XYREM - PENDING CMS REVIEW                                                                                                                                                                                                                       |
| <b>Drug Names</b>                    | SODIUM OXYBATE                                                                                                                                                                                                                                   |
| <b>PA Indication Indicator</b>       | -                                                                                                                                                                                                                                                |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                |
| <b>Coverage Duration</b>             | -                                                                                                                                                                                                                                                |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | YESINTEK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Drug Names</b>                    | YESINTEK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Required Medical Information</b>  | For moderate to severe plaque psoriasis (new starts only): 1) Crucial body areas (e.g., hands, feet, face, scalp, neck, genitals/groin, intertriginous areas) are affected at the time of diagnosis, OR 2) Patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of the body surface area is affected), OR 3) At least 3% of body surface area (BSA) is affected and patient meets either of the following: a) Patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) Pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Prior Authorization Group</b>     | YONSA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Drug Names</b>                    | YONSA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Required Medical Information</b>  | The requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|--------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | YUTREPIA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Drug Names</b>                    | YUTREPIA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Required Medical Information</b>  | For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1) or pulmonary hypertension (PH) associated with interstitial lung disease (WHO Group 3): the diagnosis was confirmed by right heart catheterization. For new starts only: 1) Pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, 2) Pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) Pretreatment pulmonary vascular resistance is greater than or equal to 2 Wood units. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Prior Authorization Group</b>     | ZARXIO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Drug Names</b>                    | ZARXIO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Off-label Uses</b>                | Neutropenia in myelodysplastic syndromes (MDS), agranulocytosis, neutropenia in aplastic anemia, human immunodeficiency virus (HIV)-related neutropenia                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Required Medical Information</b>  | If receiving chemotherapy, the requested drug will be administered at least 24 hours after chemotherapy. For prophylaxis or treatment of myelosuppressive chemotherapy-induced febrile neutropenia (FN) patient must meet both of the following: 1) Patient has a solid tumor or non-myeloid cancer, AND 2) Patient has received, is currently receiving, or will be receiving treatment with myelosuppressive anti-cancer therapy.                                                                                     |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Coverage Duration</b>             | 6 months                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|--------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | ZEJULA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Drug Names</b>                    | ZEJULA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Off-label Uses</b>                | Uterine leiomyosarcoma                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Required Medical Information</b>  | For uterine leiomyosarcoma: 1) the requested drug is used as second-line or subsequent therapy AND 2) the patient has BRCA-altered disease.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Prior Authorization Group</b>     | ZELBORAF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Drug Names</b>                    | ZELBORAF                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Off-label Uses</b>                | Non-small cell lung cancer, hairy cell leukemia, central nervous system cancer (i.e., glioma, glioblastoma, pediatric diffuse high-grade glioma), adjuvant or neoadjuvant systemic therapy for cutaneous melanoma, Langerhans cell histiocytosis.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Required Medical Information</b>  | For central nervous system (CNS) cancer (i.e., glioma, glioblastoma, pediatric diffuse high-grade glioma): 1) The tumor is positive for BRAF V600E mutation, AND 2) The requested drug will be used in combination with cobimetinib OR the requested drug is being used for the treatment of pediatric diffuse high-grade glioma. For melanoma: 1) The tumor is positive for BRAF V600 activating mutation (e.g., V600E or V600K), AND 2) the requested drug will be used as a single agent, or in combination with cobimetinib, AND 3) The requested drug will be used for either of the following: a) unresectable, limited resectable, or metastatic disease, or b) adjuvant or neoadjuvant systemic therapy. For Erdheim-Chester Disease and Langerhans Cell Histiocytosis: Tumor is positive for BRAF V600 mutation. For non-small cell lung cancer: 1) The tumor is positive for the BRAF V600E mutation, AND 2) The patient has recurrent, advanced, or metastatic disease. |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|--------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | ZIRABEV                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Drug Names</b>                    | ZIRABEV                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Off-label Uses</b>                | Ampullary adenocarcinoma, appendiceal adenocarcinoma, central nervous system (CNS) cancers (including pediatric diffuse high-grade gliomas), pleural mesothelioma, peritoneal mesothelioma, pericardial mesothelioma, tunica vaginalis testis mesothelioma, soft tissue sarcomas, uterine neoplasms, endometrial carcinoma, vulvar cancers, vaginal cancer, small bowel adenocarcinoma, and ophthalmic-related disorders: diabetic macular edema, neovascular (wet) age-related macular degeneration including polypoidal choroidopathy and retinal angiomatous proliferation subtypes, macular edema following retinal vein occlusion, proliferative diabetic retinopathy, choroidal neovascularization, neovascular glaucoma and retinopathy of prematurity. |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Other Criteria</b>                | Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Prior Authorization Group</b>     | ZOLINZA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Drug Names</b>                    | ZOLINZA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Off-label Uses</b>                | Mycosis fungoides (MF)/Sezary syndrome (SS)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|--------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | ZONISADE                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Drug Names</b>                    | ZONISADE                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Required Medical Information</b>  | For adjunctive treatment of partial-onset seizures (i.e., focal-onset seizures): 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a generic anticonvulsant AND the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to any of the following: Aptiom, Xcopri, Spritam OR 2) The patient has difficulty swallowing solid oral dosage forms (e.g., tablets, capsules). |
| <b>Age Restrictions</b>              | 16 years of age or older                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Prerequisite Therapy Required</b> | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Prior Authorization Group</b>     | ZTALMY                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Drug Names</b>                    | ZTALMY                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Age Restrictions</b>              | 2 years of age or older                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |

|                                      |                                                                                                                                                                                                                                                                                                                                                                                       |
|--------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Prior Authorization Group</b>     | ZURZUVAE                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Drug Names</b>                    | ZURZUVAE                                                                                                                                                                                                                                                                                                                                                                              |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                                                                                                                                                                                                                                                                                                                                                          |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Required Medical Information</b>  | For the treatment of postpartum depression (PPD): diagnosis was confirmed using standardized rating scales that reliably measure depressive symptoms (e.g., Hamilton Depression Rating Scale [HDRS], Edinburgh Postnatal Depression Scale [EPDS], Patient Health Questionnaire 9 [PHQ9], Montgomery-Asberg Depression Rating Scale [MADRS], Beck's Depression Inventory [BDI], etc.). |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Coverage Duration</b>             | 1 month                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Prior Authorization Group</b>     | ZYDELIG                                                                                                                                                                                                                                                                                                                                                                               |
| <b>Drug Names</b>                    | ZYDELIG                                                                                                                                                                                                                                                                                                                                                                               |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications, Some Medically-accepted Indications                                                                                                                                                                                                                                                                                                                     |
| <b>Off-label Uses</b>                | Small lymphocytic lymphoma (SLL)                                                                                                                                                                                                                                                                                                                                                      |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Required Medical Information</b>  | For chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL): the requested drug is used as second-line or subsequent therapy.                                                                                                                                                                                                                                             |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Coverage Duration</b>             | Plan Year                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Prerequisite Therapy Required</b> | No                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Prior Authorization Group</b>     | ZYKADIA - PENDING CMS REVIEW                                                                                                                                                                                                                                                                                                                                                          |
| <b>Drug Names</b>                    | ZYKADIA                                                                                                                                                                                                                                                                                                                                                                               |
| <b>PA Indication Indicator</b>       | -                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Off-label Uses</b>                | -                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Exclusion Criteria</b>            | -                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Required Medical Information</b>  | -                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Age Restrictions</b>              | -                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Prescriber Restrictions</b>       | -                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Coverage Duration</b>             | -                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Other Criteria</b>                | -                                                                                                                                                                                                                                                                                                                                                                                     |

|                                      |                                                         |
|--------------------------------------|---------------------------------------------------------|
| <b>Prior Authorization Group</b>     | ZYPREXA RELPREVV                                        |
| <b>Drug Names</b>                    | ZYPREXA RELPREVV                                        |
| <b>PA Indication Indicator</b>       | All FDA-approved Indications                            |
| <b>Off-label Uses</b>                | -                                                       |
| <b>Exclusion Criteria</b>            | -                                                       |
| <b>Required Medical Information</b>  | Tolerability with oral olanzapine has been established. |
| <b>Age Restrictions</b>              | -                                                       |
| <b>Prescriber Restrictions</b>       | -                                                       |
| <b>Coverage Duration</b>             | Plan Year                                               |
| <b>Other Criteria</b>                | -                                                       |
| <b>Prerequisite Therapy Required</b> | No                                                      |