

## ***PA Criteria***

<b><i>Prior Authorization Group</i></b>	ABIRATERONE
<b><i>Drug Names</i></b>	ABIRATERONE ACETATE
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Node-positive (N1), non-metastatic (M0) prostate cancer
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	The requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

<b><i>Prior Authorization Group</i></b>	ACITRETIN
<b><i>Drug Names</i></b>	ACITRETIN
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Prevention of non-melanoma skin cancers in high risk individuals, Lichen planus, Keratosis follicularis (Darier Disease)
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	Psoriasis: The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to methotrexate or cyclosporine.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

<b><i>Prior Authorization Group</i></b>	ACTIMMUNE
<b><i>Drug Names</i></b>	ACTIMMUNE
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Mycosis fungoides, Sezary syndrome.
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	ADEMPAS
<b><i>Drug Names</i></b>	ADEMPAS
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></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><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	AIMOVIG
<b><i>Drug Names</i></b>	AIMOVIG
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	1) The patient received at least 3 months of treatment with the requested drug, and the patient had a reduction in migraine days per month from baseline, OR 2) The patient experienced an inadequate treatment response with a 4-week trial of any of the following: Antiepileptic drugs (AEDs), Beta-adrenergic blocking agents, Antidepressants, OR 3) The patient experienced an intolerance or has a contraindication that would prohibit a 4-week trial of any of the following: Antiepileptic drugs (AEDs), Beta-adrenergic blocking agents, Antidepressants.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Initial 3 months, Reauthorization Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	ALDURAZYME
<b><i>Drug Names</i></b>	ALDURAZYME
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For mucopolysaccharidosis I: Diagnosis of mucopolysaccharidosis I was confirmed by an enzyme assay demonstrating a deficiency of alpha-L-iduronidase enzyme activity or by genetic testing. Patients with Scheie syndrome must have moderate to severe symptoms.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	ALECENSA
<b><i>Drug Names</i></b>	ALECENSA
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Recurrent ALK-positive non-small cell lung cancer (NSCLC), brain metastases from ALK-positive NSCLC.
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	ALOSETRON
<b><i>Drug Names</i></b>	ALOSETRON HYDROCHLORIDE
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	1) The requested drug is being prescribed for a biological female or a person that self-identifies as a female with a diagnosis of severe diarrhea-predominant irritable bowel syndrome (IBS) AND 2) Chronic IBS symptoms lasting at least 6 months AND 3) Gastrointestinal tract abnormalities have been ruled out AND 4) Inadequate response to one conventional therapy (e.g., antispasmodics, antidepressants, antidiarrheals).
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	ALPHA1-PROTEINASE INHIBITOR
<b><i>Drug Names</i></b>	ARALAST NP, PROLASTIN-C, ZEMAIRA
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></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 mg/dL by radial immunodiffusion or 50 mg/dL by nephelometry).
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	ALUNBRIG
<b><i>Drug Names</i></b>	ALUNBRIG
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Recurrent ALK-positive non-small cell lung cancer (NSCLC), brain metastases from ALK-positive NSCLC.
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	AMBRISANTAN
<b><i>Drug Names</i></b>	AMBRISANTAN
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	Pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): Diagnosis was confirmed by right heart catheterization. For PAH 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 3 Wood units.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	AMPHETAMINES
<b><i>Drug Names</i></b>	AMPHETAMINE/DEXTROAMPHETA
<b><i>PA Indication Indicator</i></b>	All Medically-accepted Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></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><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	ARCALYST
<b><i>Drug Names</i></b>	ARCALYST
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Prevention of gout flares in patients initiating or continuing urate-lowering therapy.
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></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.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	For prevention of gout flares: 4 months. Other: Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	ARMODAFINIL
<b><i>Drug Names</i></b>	ARMODAFINIL
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	1) The patient has a diagnosis of narcolepsy and the diagnosis is confirmed by sleep lab evaluation OR 2) The patient has a diagnosis of Shift Work Disorder (SWD) OR 3) The patient has a diagnosis of obstructive sleep apnea (OSA) and the diagnosis is confirmed by polysomnography.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	AUSTEDO
<b><i>Drug Names</i></b>	AUSTEDO
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Tourette's syndrome
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH CHOICE

GENERATIONS

<b>Prior Authorization Group</b>	AVASTIN
<b>Drug Names</b>	AVASTIN
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Breast cancer, central nervous system (CNS) tumor types: adult low-grade (WHO Grade II) infiltrative supratentorial astrocytoma/oligodendroglioma, adult intracranial and spinal ependymoma, anaplastic gliomas, adult medulloblastoma, primary central nervous system lymphoma, meningiomas, limited and extensive brain metastases, metastatic spine tumors, malignant pleural mesothelioma, ovarian cancer/fallopian tube cancer/primary peritoneal cancer types: carcinosarcoma (malignant mixed Mullerian tumors), clear cell carcinoma, mucinous carcinoma, grade 1 endometrioid carcinoma, low-grade serous carcinoma, ovarian borderline epithelial tumors (low malignant potential) with invasive implants, and malignant sex cord-stromal tumors, soft tissue sarcoma types: angiosarcoma and solitary fibrous tumor/hemangiopericytoma, uterine neoplasms, endometrial carcinoma, vulvar squamous cell carcinoma, 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, small bowel adenocarcinoma.
<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. For all indications except ophthalmic-related disorders: The patient had an intolerable adverse event to both Mvasi AND Zirabev and that adverse event was NOT attributed to the active ingredient as described in the prescribing information.



# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	AYVAKIT
<b><i>Drug Names</i></b>	AYVAKIT
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Myeloid and lymphoid neoplasms with eosinophilia, gastrointestinal stromal tumor (GIST) for unresectable, recurrent, or metastatic disease without platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></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 D842A 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 PDGFRA D842V mutations, OR 2) The requested drug will be used after failure on at least two Food and Drug Administration (FDA)-approved therapies in unresectable, recurrent, or metastatic disease without PDGFRA exon 18 mutation. For advanced systemic mastocytosis (AdvSM): 1) the patient has a diagnosis of 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/mcL.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

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

B VS. D  
 ABELCET, ABRAXANE, ACETYLCYSTEINE, ACYCLOVIR SODIUM, ADRIAMYCIN, ALBUTEROL SULFATE, ALIMTA, AMBISOME, AMPHOTERICIN B, AMPHOTERICIN B LIPOSOME, APREPITANT, AZACITIDINE, AZATHIOPRINE, 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%, DIPHTHERIA/TETANUS TOXOID, DOCETAXEL, DOXORUBICIN HCL, DOXORUBICIN HYDROCHLORIDE, DRONABINOL, ENGERIX-B, EPIRUBICIN HCL, ETOPOSIDE, EVEROLIMUS, FLUOROURACIL, FREAMINE III, FULVESTRANT, GAMASTAN, GANCICLOVIR, GEMCITABINE HCL, GEMCITABINE HYDROCHLORIDE, GENGRAF, GRANISETRON HYDROCHLORIDE, HEPARIN SODIUM, HEPATAMINE, HUMULIN R U-500 (CONCENTR, IBANDRONATE SODIUM, IMOVAX RABIES (H.D.C.V.), INTRALIPID, INTRON A, IPRATROPIUM BROMIDE, IPRATROPIUM BROMIDE/ALBUT, IRINOTECAN, IRINOTECAN HYDROCHLORIDE, KADCYLA, LEUCOVORIN CALCIUM, LEVALBUTEROL, LEVALBUTEROL HCL, LEVOCARNITINE, LIDOCAINE HCL, LIDOCAINE HYDROCHLORIDE, METHOTREXATE, METHOTREXATE SODIUM, METHYLPREDNISOLONE, METHYLPREDNISOLONE ACETAT, METHYLPREDNISOLONE SODIUM, MORPHINE SULFATE, MYCOPHENOLATE MOFETIL, MYCOPHENOLIC ACID DR, NULOJIX, NUTRILIPID, ONDANSETRON HCL, ONDANSETRON HYDROCHLORIDE, ONDANSETRON ODT, OXALIPLATIN, PACLITAXEL, PACLITAXEL PROTEIN-BOUND, PAMIDRONATE DISODIUM, PARAPLATIN, PARICALCITOL, PEMETREXED, PENTAMIDINE ISETHIONATE, PLENAMINE, PREDNISOLONE, PREDNISOLONE SODIUM PHOSP, PREDNISONE, PREDNISONE INTENSOL, PREHEVBRIO, PREMASOL, PROCALAMINE, PROGRAF, PROSOL, RABAVERT, RECOMBIVAX HB, SANDIMMUNE, SIROLIMUS, TACROLIMUS, TDVAX, TENIVAC, TOPOSAR, TPN ELECTROLYTES, TRAVASOL, TROPHAMINE, VINCRISTINE SULFATE, VINOURELBINE TARTRATE, XATMEP, ZOLEDRONIC ACID, ZORTRESS

**PA Indication Indicator**

**Off-label Uses**

**Exclusion Criteria**

**Required Medical Information**

**Age Restrictions**

**Prescriber Restrictions**

All Medically-accepted Indications

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# HEALTH | CHOICE

GENERATIONS

<i>Coverage Duration</i>	N/A
<i>Other Criteria</i>	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.
<i>Prior Authorization Group</i>	BALVERSA
<i>Drug Names</i>	BALVERSA
<i>PA Indication Indicator</i>	All FDA-approved Indications
<i>Off-label Uses</i>	-
<i>Exclusion Criteria</i>	-
<i>Required Medical Information</i>	-
<i>Age Restrictions</i>	-
<i>Prescriber Restrictions</i>	-
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	-
<i>Prior Authorization Group</i>	BANZEL
<i>Drug Names</i>	RUFINAMIDE
<i>PA Indication Indicator</i>	All FDA-approved Indications
<i>Off-label Uses</i>	-
<i>Exclusion Criteria</i>	-
<i>Required Medical Information</i>	-
<i>Age Restrictions</i>	1 year of age or older
<i>Prescriber Restrictions</i>	-
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	BENLYSTA
<b><i>Drug Names</i></b>	BENLYSTA
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	For patients new to therapy: severe active central nervous system lupus.
<b><i>Required Medical Information</i></b>	For systemic lupus erythematosus (SLE): 1) Patient is currently receiving a stable standard therapy regimen (e.g., corticosteroid or antimalarial) for SLE OR 2) patient is not currently receiving stable standard therapy regimen for SLE because patient tried and had an inadequate response or intolerance to stable standard therapy regimen. For lupus nephritis: 1) Patient is currently receiving a stable standard therapy regimen (e.g., corticosteroid) for lupus nephritis OR 2) patient is not currently receiving a stable standard therapy regimen for lupus nephritis because patient tried and had an inadequate response or intolerance to a stable standard therapy regimen.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	BERINERT
<b><i>Drug Names</i></b>	BERINERT
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For hereditary angioedema (HAE): The requested drug is being used for the treatment of acute angioedema attacks. Patient has HAE with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing OR patient has HAE with normal C1 inhibitor confirmed by laboratory testing. For patients with HAE with normal C1 inhibitor, EITHER 1) Patient tested positive for an F12, angiotensin-1, plasminogen, or kininogen-1 (KNG1) gene mutation OR 2) Patient has a family history of angioedema and the angioedema was refractory to a trial of an antihistamine for at least one month.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	Immunologist, allergist, rheumatologist
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	BESREMI
<b><i>Drug Names</i></b>	BESREMI
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	BETASERON
<b><i>Drug Names</i></b>	BETASERON
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	BEXAROTENE
<b><i>Drug Names</i></b>	BEXAROTENE
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Mycosis fungoides, Sezary syndrome, CD30-positive primary cutaneous anaplastic large cell lymphoma, CD30-positive lymphomatoid papulosis.
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	BOSENTAN
<b><i>Drug Names</i></b>	BOSENTAN
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): Diagnosis was confirmed by right heart catheterization. For PAH 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 3 Wood units.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

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

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	BRAFTOVI
<b><i>Drug Names</i></b>	BRAFTOVI
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Adjuvant systemic therapy for cutaneous melanoma
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For colorectal cancer: The patient must meet both of the following criteria: 1) Tumor is positive for BRAF V600E mutation, 2) The requested drug will be used for either of the following: a) as subsequent therapy for advanced or metastatic disease, or b) as primary treatment for unresectable metachronous metastases. For cutaneous melanoma: The patient must meet all of the following criteria: 1) Tumor is positive for BRAF V600 activating mutation (e.g., V600E or V600K), 2) The requested drug will be used in combination with binimetinib, and 3) The requested drug will be used for either of the following: a) unresectable or metastatic disease, or b) adjuvant systemic therapy.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	BRIVIACT
<b><i>Drug Names</i></b>	BRIVIACT
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	1) The patient has experienced an inadequate treatment response, intolerance, or contraindication to a generic anticonvulsant AND 2) If the patient is 4 years of age or older, the patient has experienced an inadequate treatment response, intolerance, or contraindication to any of the following: Aptiom, Vimpat, Xcopri, Spritam.
<b><i>Age Restrictions</i></b>	1 month of age or older
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b>Prior Authorization Group</b>	BRIVIACT INJ
<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>	1) The patient has experienced an inadequate treatment response, intolerance, or contraindication to a generic anticonvulsant AND 2) If the patient is 4 years of age or older, the patient has experienced an inadequate treatment response, intolerance, or contraindication to any of the following: Aptiom, Vimpat, Xcopri, Spritam.
<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>Prior Authorization Group</b>	BRUKINSA
<b>Drug Names</b>	BRUKINSA
<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>Prior Authorization Group</b>	BUDESONIDE CAP
<b>Drug Names</b>	BUDESONIDE
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Treatment and maintenance of microscopic colitis in adults
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	Patient has had a clinical relapse after cessation of treatment (induction) therapy for use in maintenance of microscopic colitis.
<b>Age Restrictions</b>	Crohn's, treatment: 8 years of age or older
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Microscopic colitis, maintenance: 12 months, all other indications: 3 months
<b>Other Criteria</b>	-



# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	BUPRENORPHINE
<b><i>Drug Names</i></b>	BUPRENORPHINE HCL
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	The requested drug is being prescribed for the treatment of opioid use disorder AND patient meets one of the following: 1) The patient is pregnant or breastfeeding, and the requested drug is being prescribed for induction therapy and/or subsequent maintenance therapy for treatment of opioid use disorder OR 2) The requested drug is being prescribed for induction therapy for transition from opioid use to treatment of opioid use disorder OR 3) The requested drug is being prescribed for maintenance therapy for treatment of opioid use disorder in a patient who is intolerant to naloxone.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	12 months
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	CABOMETYX
<b><i>Drug Names</i></b>	CABOMETYX
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Non-small cell lung cancer
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For renal cell carcinoma: The disease is advanced, relapsed, or stage IV. 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 treatment.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	CALCIPOTRIENE
<b><i>Drug Names</i></b>	CALCIPOTRIENE, CALCITRENE, ENSTILAR
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	1) The requested drug is being prescribed for the treatment of psoriasis AND 2) The patient experienced an inadequate treatment response, intolerance, or the patient has a contraindication to a topical steroid.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	CALQUENCE
<b><i>Drug Names</i></b>	CALQUENCE
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For chronic lymphocytic leukemia or small lymphocytic lymphoma: the patient has experienced an intolerable adverse event with ibrutinib.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	CAPLYTA
<b><i>Drug Names</i></b>	CAPLYTA
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For treatment of schizophrenia: 1) The patient experienced an inadequate treatment response, intolerance, or 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 contraindication to one of the following brand products: Latuda, Rexulti, Secuado, Vraylar. For treatment of depressive episodes associated with bipolar I: 1) The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following generic products: olanzapine, quetiapine, AND 2) The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following brand products: Latuda, Vraylar. For treatment of depressive episodes associated with bipolar II: The patient experienced an inadequate treatment response, intolerance, or contraindication to generic quetiapine.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	CAPRELSA
<b><i>Drug Names</i></b>	CAPRELSA
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Differentiated thyroid carcinoma: papillary, follicular, and Hurthle cell.
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	CARBAGLU
<b><i>Drug Names</i></b>	CARBAGLU, CARGLUMIC ACID
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For N-acetylglutamate synthase (NAGS) deficiency: Diagnosis of NAGS deficiency was confirmed by enzymatic or genetic testing.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	CAYSTON
<b><i>Drug Names</i></b>	CAYSTON
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></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><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<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 Gaucher disease, the diagnosis was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing. The patient's CYP2D6 metabolizer status has been established using an FDA-cleared test. The 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>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, the 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>Prior Authorization Group</b>	CHANTIX
<b>Drug Names</b>	CHANTIX STARTING MONTH PA, VARENICLINE STARTING MONT, VARENICLINE TARTRATE
<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>	6 months
<b>Other Criteria</b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	CLOBAZAM
<b><i>Drug Names</i></b>	CLOBAZAM
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	2 years of age or older
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	CLOMIPRAMINE
<b><i>Drug Names</i></b>	CLOMIPRAMINE HCL
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Depression, Panic Disorder
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	1) The requested drug is being prescribed for one of the following: Obsessive-Compulsive Disorder (OCD) or Panic Disorder AND 2) 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) or a selective serotonin reuptake inhibitor (SSRI) OR 3) The requested drug is being prescribed for Depression AND 4) 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><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	CLORAZEPATE
<b><i>Drug Names</i></b>	CLORAZEPATE DIPOTASSIUM
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For all indications: the prescriber must acknowledge the benefit of therapy with the requested drug outweighs the potential risks for the patient. (Note: The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) 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) OR b) serotonin-norepinephrine reuptake inhibitors (SNRIs).
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Short-term relief anxiety-1 month, Anxiety Disorders-4 months, All other Diagnoses-Plan Year
<b><i>Other Criteria</i></b>	This Prior Authorization requirement only applies to patients 65 years of age or older.
<b><i>Prior Authorization Group</i></b>	CLOZAPINE ODT
<b><i>Drug Names</i></b>	CLOZAPINE ODT
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	COMETRIQ
<b><i>Drug Names</i></b>	COMETRIQ
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Non-small cell lung cancer (NSCLC), differentiated thyroid carcinoma: papillary, follicular, and Hurthle cell.
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For NSCLC: The requested medication is used for NSCLC when the patient's disease expresses rearranged during transfection (RET) gene rearrangements.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	COPIKTRA
<b><i>Drug Names</i></b>	COPIKTRA
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-



# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	COTELLIC
<b><i>Drug Names</i></b>	COTELLIC
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Central nervous system (CNS) cancer (i.e., glioma, meningioma, astrocytoma)
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For adjuvant treatment of melanoma, and central nervous system (CNS) cancer (i.e., glioma, meningioma, astrocytoma): The patient must meet both of the following criteria: 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. For unresectable or metastatic melanoma: The patient must meet both of the following criteria: 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 (with or without atezolizumab).
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	CYSTADROPS
<b><i>Drug Names</i></b>	CYSTADROPS
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For cystinosis: 1) Diagnosis of cystinosis was confirmed by the presence of increased cystine concentration in leukocytes or by genetic testing, and 2) Patient has corneal cystine crystal accumulation.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	CYSTAGON
<b><i>Drug Names</i></b>	CYSTAGON
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For nephropathic cystinosis: Diagnosis of nephropathic cystinosis was confirmed by the presence of increased cystine concentration in leukocytes or by genetic testing.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	CYSTARAN
<b><i>Drug Names</i></b>	CYSTARAN
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For cystinosis: 1) Diagnosis of cystinosis was confirmed by the presence of increased cystine concentration in leukocytes or by genetic testing, and 2) Patient has corneal cystine crystal accumulation.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	DALFAMPRIDINE
<b><i>Drug Names</i></b>	DALFAMPRIDINE ER
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For multiple sclerosis, patient must meet the following: For new starts, prior to initiating therapy, patient meets the following: patient demonstrates sustained walking impairment. For continuation of therapy, patient meets the following: patient must have experienced an improvement in walking speed OR other objective measure of walking ability since starting the requested drug.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	DAURISMO
<b><i>Drug Names</i></b>	DAURISMO
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Post induction therapy following response to previous therapy with the same regimen for acute myeloid leukemia (AML). Relapsed/refractory AML as a component of repeating the initial successful induction regimen.
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For acute myeloid leukemia: 1) the requested medication 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 medication will be used as treatment for induction therapy, post-induction therapy, or relapsed or refractory disease.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	DEFERASIROX
<b><i>Drug Names</i></b>	DEFERASIROX
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For chronic iron overload due to blood transfusions: pretreatment serum ferritin level is greater than 1000 mcg/L.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	DEMSER
<b><i>Drug Names</i></b>	METYROSINE
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	DESVENLAFAXINE
<b><i>Drug Names</i></b>	DESVENLAFAXINE ER
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	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><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	DEXMETHYLPHENIDATE
<b><i>Drug Names</i></b>	DEXMETHYLPHENIDATE HCL, DEXMETHYLPHENIDATE HYDROC
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Cancer-related fatigue
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></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><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	DHE NASAL
<b><i>Drug Names</i></b>	DIHYDROERGOTAMINE MESYLAT
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	1) The patient has experienced an inadequate treatment response to one triptan 5-HT1 receptor agonist OR 2) The patient has experienced an intolerance to one triptan 5-HT1 receptor agonist OR 3) The patient has a contraindication that would prohibit a trial of triptan 5-HT1 receptor agonists.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	DIACOMIT
<b><i>Drug Names</i></b>	DIACOMIT
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	DIAZEPAM
<b><i>Drug Names</i></b>	DIAZEPAM, DIAZEPAM INTENSOL
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For all indications: the prescriber must acknowledge the benefit of therapy with the requested drug outweighs the potential risks for the patient. (Note: The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) 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><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Short-term relief anx-1 mo, skeletal muscle spasm-3 mo, Anx Disorders-4 mo, Other Diagnoses-PlanYR
<b><i>Other Criteria</i></b>	This Prior Authorization requirement only applies to patients 65 years of age or older.
<b><i>Prior Authorization Group</i></b>	DICLOFENAC GEL 1%
<b><i>Drug Names</i></b>	DICLOFENAC SODIUM
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	The patient has osteoarthritis pain in joints susceptible to topical treatment such as feet, ankles, knees, hands, wrists, or elbows.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	DOPTELET
<b><i>Drug Names</i></b>	DOPTELET
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For thrombocytopenia associated with chronic liver disease: Baseline platelet count prior to a scheduled procedure is less than 50,000/mcL. For chronic immune thrombocytopenia (ITP): 1) For new starts: a) Patient has had an inadequate response or is intolerant to a prior therapy such as corticosteroids or immunoglobulins, AND b) Untransfused platelet count at any point prior to the initiation of the requested medication is less than 30,000/mcL OR 30,000 to 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 and hypertension, anticoagulation therapy, profession or lifestyle that predisposes patient to trauma). 2) For continuation of therapy, platelet count response to the requested drug: a) Current platelet count is less than or equal to 200,000/mcL OR b) Current platelet count is greater than 200,000/mcL and less than or equal to 400,000/mcL and dosing will be adjusted to a platelet count sufficient to avoid clinically important bleeding.
<b><i>Age Restrictions</i></b>	18 years of age or older
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Chronic liver disease: 1 month, ITP initial: 6 months, ITP reauthorization: Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	DRIZALMA
<b><i>Drug Names</i></b>	DRIZALMA SPRINKLE
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Cancer pain, chemotherapy-induced neuropathic pain
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	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><i>Age Restrictions</i></b>	Generalized Anxiety Disorder - 7 years of age or older
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<i>Prior Authorization Group</i>	EMSAM
<i>Drug Names</i>	EMSAM
<i>PA Indication Indicator</i>	All FDA-approved Indications
<i>Off-label Uses</i>	-
<i>Exclusion Criteria</i>	-
<i>Required Medical Information</i>	1) 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) Patient is unable to swallow oral formulations.
<i>Age Restrictions</i>	-
<i>Prescriber Restrictions</i>	-
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	-



# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	ENBREL
<b><i>Drug Names</i></b>	ENBREL, ENBREL MINI, ENBREL SURECLICK
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Hidradenitis suppurativa
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For moderately to severely active rheumatoid arthritis (new starts only): 1) Inadequate response, intolerance or contraindication to methotrexate (MTX) OR 2) Inadequate 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) Inadequate response to a non-steroidal anti-inflammatory drug (NSAID) trial, OR 2) Intolerance or contraindication to NSAIDs. For moderate to severe plaque psoriasis (new starts only): 1) At least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis, AND 2) Patient meets any of the following: a) Patient has experienced an inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, OR b) Pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated, OR c) Patient has severe psoriasis that warrants a biologic DMARD as first-line therapy (i.e. at least 10% of the BSA or crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected). For hidradenitis suppurativa (new starts only): patient has severe, refractory disease.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	ENDARI
<b><i>Drug Names</i></b>	ENDARI
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	5 years of age or older
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	EPCLUSA
<b><i>Drug Names</i></b>	EPCLUSA
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></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, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Criteria will be applied consistent with current AASLD-IDSa guidance.
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	EPIDIOLEX
<b><i>Drug Names</i></b>	EPIDIOLEX
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	ERGOTAMINE
<b><i>Drug Names</i></b>	ERGOTAMINE TARTRATE/CAFFE
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	ERIVEDGE
<b><i>Drug Names</i></b>	ERIVEDGE
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Adult medulloblastoma
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For adult medulloblastoma: patient has received chemotherapy previously AND has tumor(s) with mutations in the sonic hedgehog pathway
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	ERLEADA
<b><i>Drug Names</i></b>	ERLEADA
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	The requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<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 or advanced non-small cell lung cancer (NSCLC), recurrent chordoma, relapsed or stage IV renal cell carcinoma (RCC), brain metastases from NSCLC.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For NSCLC (including brain metastases from NSCLC): 1) the disease is recurrent, advanced, or metastatic and 2) the patient has sensitizing EGFR mutation-positive disease. For pancreatic cancer: the disease is locally advanced, unresectable, or metastatic.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	ESBRIET
<b>Drug Names</b>	ESBRIET, 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 (Initial Review Only): 1) a high-resolution computed tomography (HRCT) study of the chest or a lung biopsy reveals the usual interstitial pneumonia (UIP) pattern, OR 2) 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>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	EVEROLIMUS
<b><i>Drug Names</i></b>	AFINITOR, AFINITOR DISPERZ, EVEROLIMUS
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Classic Hodgkin lymphoma, thymomas and thymic carcinomas, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, soft tissue sarcoma (perivascular epithelioid cell tumors (PEComa) and lymphangi leiomyomatosis subtypes), gastrointestinal stromal tumors, neuroendocrine tumors of the thymus, thyroid carcinoma (papillary, Hurthle cell, and follicular), endometrial carcinoma.
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For breast cancer: 1) The disease is recurrent or metastatic hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, AND 2) The requested medication is prescribed in combination with exemestane, fulvestrant, or tamoxifen, AND 3) The requested medication 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.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	EXKIVITY
<b><i>Drug Names</i></b>	EXKIVITY
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	FABRAZYME
<b><i>Drug Names</i></b>	FABRAZYME
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	Diagnosis of Fabry disease was confirmed by an enzyme assay demonstrating a deficiency of alpha-galactosidase enzyme activity or by genetic testing, or the patient is a symptomatic obligate female carrier.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	FANAPT
<b><i>Drug Names</i></b>	FANAPT, FANAPT TITRATION PACK
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For treatment of schizophrenia: 1) The patient experienced an inadequate treatment response, intolerance, or 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 contraindication to one of the following brand products: Latuda, Rexulti, Secuado, Vraylar.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	FASENRA
<b><i>Drug Names</i></b>	FASENRA, FASENRA PEN
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For severe asthma: For 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 at optimized doses: a) inhaled corticosteroid and b) additional controller (long-acting beta2-agonist, leukotriene modifier, or sustained-release theophylline). For 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.
<b><i>Age Restrictions</i></b>	12 years of age or older
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	FENTANYL PATCH
<b><i>Drug Names</i></b>	FENTANYL
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	1) 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 2) The requested drug is being prescribed for pain severe enough to require daily, around-the-clock, long-term treatment in a patient who has been taking an opioid AND 3) 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 4) The patient has been evaluated and the patient will be monitored for the development of opioid use disorder AND 5) 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><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	FETZIMA
<b><i>Drug Names</i></b>	FETZIMA, FETZIMA TITRATION PACK
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	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><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-



# HEALTH | CHOICE

GENERATIONS

<i>Prior Authorization Group</i>	FINTEPLA
<i>Drug Names</i>	FINTEPLA
<i>PA Indication Indicator</i>	All FDA-approved Indications
<i>Off-label Uses</i>	-
<i>Exclusion Criteria</i>	-
<i>Required Medical Information</i>	-
<i>Age Restrictions</i>	-
<i>Prescriber Restrictions</i>	-
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	-

<i>Prior Authorization Group</i>	FLUCYTOSINE
<i>Drug Names</i>	FLUCYTOSINE
<i>PA Indication Indicator</i>	All FDA-approved Indications
<i>Off-label Uses</i>	-
<i>Exclusion Criteria</i>	-
<i>Required Medical Information</i>	-
<i>Age Restrictions</i>	-
<i>Prescriber Restrictions</i>	-
<i>Coverage Duration</i>	6 weeks
<i>Other Criteria</i>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	FORTEO
<b><i>Drug Names</i></b>	FORTEO
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For postmenopausal osteoporosis: patient has ONE of the following (1 or 2): 1) a history of fragility fracture, OR 2) A pre-treatment T-score of less than or equal to -2.5 or pre-treatment T-score greater than -2.5 and less than -1 with a high pre-treatment Fracture Risk Assessment Tool (FRAX) fracture probability AND patient has ANY of the following: a) indicators for higher fracture risk (e.g., advanced age, frailty, glucocorticoid therapy, very low T-scores, or increased fall risk), OR b) patient has failed prior treatment with or is intolerant to a previous injectable osteoporosis therapy OR c) patient has had an oral bisphosphonate trial of at least 1-year duration or there is a clinical reason to avoid treatment with an oral bisphosphonate. For primary or hypogonadal osteoporosis in men: patient has one of the following: 1) a history of osteoporotic vertebral or hip fracture, OR 2) pre-treatment T-score of less than or equal to -2.5, OR 3) pre-treatment T-score greater than -2.5 and less than -1 with a high pre-treatment FRAX fracture probability. For glucocorticoid-induced osteoporosis: Patient has had an oral bisphosphonate trial of at least 1-year duration unless patient has a contraindication or intolerance to an oral bisphosphonate, AND patient meets ANY of the following: 1) patient has a history of fragility fracture, OR 2) a pre-treatment T-score of less than or equal to -2.5, OR 3) pre-treatment T-score greater than -2.5 and less than -1 with a high pre-treatment FRAX fracture probability.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	24 months total unless the patient remains at high risk for fracture and benefit outweighs risk
<b><i>Other Criteria</i></b>	Patient has high FRAX fracture probability if the 10 year probability is either greater than or equal to 20 percent for any major osteoporotic fracture or greater than or equal to 3 percent for hip fracture. If glucocorticoid treatment is greater than 7.5 mg (prednisone equivalent) per day, the estimated risk score generated with FRAX should be multiplied by 1.15 for major osteoporotic fracture and 1.2 for hip fracture.

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	FOTIVDA
<b><i>Drug Names</i></b>	FOTIVDA
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For advanced renal cell carcinoma: The following criteria must be met: 1) The disease is relapsed or refractory, 2) The requested medication must be used after at least two prior systemic therapies, and 3) The patient has experienced disease progression or an intolerable adverse event with a trial of cabozantinib.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	FYCOMPA
<b><i>Drug Names</i></b>	FYCOMPA
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For treatment of partial-onset seizures: 1) The patient experienced an inadequate treatment response, intolerance, or contraindication to a generic anticonvulsant AND 2) The patient has experienced an inadequate treatment response, intolerance, or contraindication to any of the following: Aptiom, Vimpat, Xcopri, Spritam. For adjunctive treatment of primary generalized tonic-clonic seizures: 1) The patient experienced an inadequate treatment response, intolerance, or contraindication to a generic anticonvulsant AND 2) The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following: Vimpat, Spritam.
<b><i>Age Restrictions</i></b>	Partial-onset seizures: 4 years of age or older. Primary generalized tonic-clonic seizures: 12 years of age or older
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	GATTEX
<b><i>Drug Names</i></b>	GATTEX
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For short bowel syndrome (SBS) initial therapy: Adult patients were dependent on parenteral support for at least 12 months. For SBS continuation: Requirement for parenteral support has decreased from baseline while on therapy with the requested medication.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	GAVRETO
<b><i>Drug Names</i></b>	GAVRETO
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Recurrent or advanced rearranged during transfection (RET) rearrangement-positive non-small cell lung cancer
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></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><i>Age Restrictions</i></b>	Non-small cell lung cancer: 18 years of age or older. Medullary thyroid cancer and thyroid cancer: 12 years of age or older.
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	GILENYA
<b><i>Drug Names</i></b>	GILENYA
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	GILOTRIF
<b><i>Drug Names</i></b>	GILOTRIF
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For non-small cell lung cancer (NSCLC): Patient meets either of the following: 1) Patient has metastatic squamous NSCLC that progressed after platinum-based chemotherapy, OR 2) Patient has sensitizing EGFR mutation-positive disease.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	GLATIRAMER
<b><i>Drug Names</i></b>	GLATIRAMER ACETATE, GLATOPA
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b>Prior Authorization Group</b>	GROWTH HORMONE
<b>Drug Names</b>	GENOTROPIN, GENOTROPIN MINIQUICK
<b>PA Indication Indicator</b>	All Medically-accepted Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	Pediatric patients with closed epiphyses (except in patients with PWS).
<b>Required Medical Information</b>	Pediatric growth hormone deficiency (GHD): Patient (pt) 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, CNS tumors, congenital structural abnormalities) and pre-tx insulin-like growth factor-1 (IGF-1) more than 2 SD below mean, OR 3) pt is a neonate or was diagnosed with GHD as a neonate. Turner syndrome: 1) Confirmed by karyotyping AND 2) pre-tx ht is less than the 5th percentile for age. Small for gestational age (GA): 1) Birth weight (wt) less than 2500g at 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. SGA: 2 years of age or older
<b>Age Restrictions</b>	SGA: 2 years of age or older
<b>Prescriber Restrictions</b>	Endocrinologist, pediatric endocrinologist, pediatric nephrologist, infectious disease specialist, gastroenterologist/nutritional support specialist, 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. (Note: Stimulation tests include: a) insulin tolerance test [ITT] [peak GH less than or equal to 5 ng/ml], or b) Macrelin-stimulation test [peak GH level less than 2.8ng/ml], or c) glucagon-stimulation test [GST] [peak GH level less than or equal to 3 ng/ml] for pt with a body mass index [BMI] 25-30 kg/m <sup>2</sup> and high pretest probability of GHD [e.g., acquired structural abnormalities] or BMI less than 25 kg/m <sup>2</sup> , or d) GST [peak GH level less than or equal to 1 ng/ml] in pt with BMI 25-30 kg/m <sup>2</sup> and low pretest probability of GHD or BMI greater than 30 kg/m <sup>2</sup> ), 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. Renewal for pediatric GHD, TS, SGA, and adult GHD: Patient is experiencing improvement.

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	HAEGARDA
<b><i>Drug Names</i></b>	HAEGARDA
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	The requested drug is being used for the prevention of acute angioedema attacks. Patient has hereditary angioedema (HAE) with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing OR patient has hereditary angioedema with normal C1 inhibitor confirmed by laboratory testing. For patients with HAE with normal C1 inhibitor, EITHER 1) Patient tested positive for an F12, angiotensin-1, plasminogen, or kininogen-1 (KNG1) gene mutation OR 2) Patient has a family history of angioedema and the angioedema was refractory to a trial of an antihistamine for at least one month.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	Immunologist, allergist, rheumatologist
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	HARVONI
<b><i>Drug Names</i></b>	HARVONI
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></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, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Criteria applied consistent w/ current AASLD-IDSA guidance. Reminder for 8wk option if appropriate.
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	HERCEPTIN
<b><i>Drug Names</i></b>	HERCEPTIN
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></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, HER2-positive esophageal and esophagogastric junction cancer, HER2-positive advanced or recurrent uterine serous carcinoma, HER2-amplified colorectal cancer in combination with pertuzumab or lapatinib.
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Neoadjuvant therapy for breast cancer: 6 months. Other: Plan Year.
<b><i>Other Criteria</i></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. 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.
<b><i>Prior Authorization Group</i></b>	HERCEPTIN HYLECTA
<b><i>Drug Names</i></b>	HERCEPTIN HYLECTA
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent or advanced unresectable HER2-positive breast cancer.
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Neoadjuvant therapy for breast cancer: 6 months, Other: Plan Year.
<b><i>Other Criteria</i></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.



# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	HERZUMA
<b><i>Drug Names</i></b>	HERZUMA
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></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, HER2-positive esophageal and esophagogastric junction cancer, HER2-positive advanced or recurrent uterine serous carcinoma, HER2-amplified colorectal cancer in combination with pertuzumab or lapatinib.
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Neoadjuvant therapy for breast cancer: 6 months. Other: Plan Year.
<b><i>Other Criteria</i></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. 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.
<b><i>Prior Authorization Group</i></b>	HETLIOZ
<b><i>Drug Names</i></b>	HETLIOZ
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For Non-24-Hour Sleep-Wake Disorder: 1) for initial therapy and continuation of therapy: 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 experiences improvement in the quality of sleep since starting therapy.
<b><i>Age Restrictions</i></b>	Non-24: 18 years of age or older. SMS: 16 years of age or older
<b><i>Prescriber Restrictions</i></b>	Sleep disorder specialist or neurologist
<b><i>Coverage Duration</i></b>	Initiation: 6 Months, Renewal: Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	HRM-ANTICONVULSANTS
<b><i>Drug Names</i></b>	PHENOBARBITAL, PHENOBARBITAL SODIUM
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Epilepsy
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient.

# HEALTH CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	HRM-ANTIPARKINSON
<b><i>Drug Names</i></b>	BENZTROPINE MESYLATE, TRIHEXYPHENIDYL HCL, TRIHEXYPHENIDYL HYDROCHLO
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></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.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient.

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	HRM-CYPROHEPTADINE
<b><i>Drug Names</i></b>	CYPROHEPTADINE HCL, CYPROHEPTADINE HYDROCHLOR
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Pruritus, spasticity due to spinal cord injury
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></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.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) The prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient.
<b><i>Prior Authorization Group</i></b>	HRM-DIPYRIDAMOLE
<b><i>Drug Names</i></b>	DIPYRIDAMOLE
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient.

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	HRM-GUANFACINE ER
<b><i>Drug Names</i></b>	GUANFACINE ER, GUANFACINE HYDROCHLORIDE
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient.

<b><i>Prior Authorization Group</i></b>	HRM-GUANFACINE IR
<b><i>Drug Names</i></b>	GUANFACINE HCL, GUANFACINE HYDROCHLORIDE
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient.

<b><i>Prior Authorization Group</i></b>	HRM-HYDROXYZINE
<b><i>Drug Names</i></b>	HYDROXYZINE HCL, HYDROXYZINE HYDROCHLORIDE, HYDROXYZINE PAMOATE
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></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. 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><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient.

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	HRM-HYDROXYZINE INJ
<b><i>Drug Names</i></b>	HYDROXYZINE HCL, HYDROXYZINE HYDROCHLORIDE
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	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. 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><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient.

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	HRM-HYPNOTICS
<b><i>Drug Names</i></b>	ESZOPICLONE, ZALEPLON, ZOLPIDEM TARTRATE
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	1) The patient has a contraindication to the non-HRM (non-High Risk Medication) alternative drug doxepin (3 mg or 6 mg) OR 2) The non-HRM (non-High Risk Medication) alternative drug doxepin (3 mg or 6 mg) has been tried AND 3) The patient experienced an inadequate treatment response OR intolerance to the non-HRM (non-High Risk Medication) alternative drug doxepin (3 mg or 6 mg) AND 4) 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><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient. APPLIES TO GREATER THAN CUMULATIVE 90 DAYS OF THERAPY PER YEAR.



<b><i>Prior Authorization Group</i></b>	HRM-PROMETHAZINE
<b><i>Drug Names</i></b>	PROMETHAZINE HCL, PROMETHAZINE HCL PLAIN, PROMETHAZINE HYDROCHLORID
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></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.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient.
<b><i>Prior Authorization Group</i></b>	HRM-SCOPOLAMINE
<b><i>Drug Names</i></b>	SCOPOLAMINE
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Excessive salivation
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient.

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	HRM-SKELETAL MUSCLE RELAXANTS
<b><i>Drug Names</i></b>	CARISOPRODOL, CYCLOBENZAPRINE HYDROCHLO, METHOCARBAMOL, VANADOM
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	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><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	3 months
<b><i>Other Criteria</i></b>	This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient.

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	HUMIRA
<b><i>Drug Names</i></b>	HUMIRA, HUMIRA PEDIATRIC CROHNS D, HUMIRA PEN, HUMIRA PEN-CD/UC/HS START, HUMIRA PEN-PEDIATRIC UC S, HUMIRA PEN-PS/UV STARTER
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Axial spondyloarthritis, Behcet's syndrome
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For moderately to severely active rheumatoid arthritis (new starts only): 1) Inadequate response, intolerance or contraindication to methotrexate (MTX) OR 2) Inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. For active ankylosing spondylitis and axial spondyloarthritis (new starts only): 1) Inadequate response to a non-steroidal anti-inflammatory drug (NSAID) trial OR 2) Intolerance or contraindication to NSAIDs. For moderate to severe plaque psoriasis (new starts only): 1) At least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis, AND 2) Patient meets any of the following: a) Patient has experienced an inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, OR b) Pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated, OR c) Patient has severe psoriasis that warrants a biologic DMARD as first-line therapy (i.e. at least 10% of the BSA or crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected). For moderately to severely active Crohn's disease (new starts only): 1) Inadequate response to at least one conventional therapy (e.g., corticosteroids), OR 2) Intolerance or contraindication to conventional therapy. For moderately to severely active ulcerative colitis (new starts only): 1) Inadequate response to at least one conventional therapy (e.g., corticosteroids), OR 2) Intolerance or contraindication to conventional therapy.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	HYPNOTIC BENZODIAZEPINES
<b><i>Drug Names</i></b>	TEMAZEPAM
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	Prescriber must acknowledge the benefit of therapy with the requested drug outweighs the potential risks for the patient. (Note: The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to doxepin (3 mg or 6 mg).
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	This Prior Authorization requirement only applies to patients 65 years of age or older. APPLIES TO GREATER THAN CUMULATIVE 90 DAYS OF THERAPY PER YEAR.
<b><i>Prior Authorization Group</i></b>	IBRANCE
<b><i>Drug Names</i></b>	IBRANCE
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Unresectable well-differentiated/dedifferentiated liposarcoma of the retroperitoneum.
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	ICATIBANT
<b><i>Drug Names</i></b>	ICATIBANT ACETATE, SAJAZIR
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For hereditary angioedema (HAE): The requested drug is being used for the treatment of acute angioedema attacks. Patient has HAE with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing OR patient has HAE with normal C1 inhibitor confirmed by laboratory testing. For patients with HAE with normal C1 inhibitor, EITHER 1) Patient tested positive for an F12, angiotensin-1, plasminogen, or kininogen-1 (KNG1) gene mutation OR 2) Patient has a family history of angioedema and the angioedema was refractory to a trial of an antihistamine for at least one month.
<b><i>Age Restrictions</i></b>	18 years of age or older
<b><i>Prescriber Restrictions</i></b>	Immunologist, allergist, rheumatologist
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	ICLUSIG
<b><i>Drug Names</i></b>	ICLUSIG
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Therapy after hematopoietic stem cell transplant (HSCT) for chronic myeloid leukemia (CML) and acute lymphoblastic leukemia (ALL) patients
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For chronic myeloid leukemia (CML) or acute lymphoblastic leukemia (ALL): diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For 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 or dasatinib, OR 3) patient is positive for the T315I mutation.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<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 a physiologic age of 60 years or older with newly-diagnosed AML and meets one of the following: a) patient is not a candidate for intensive induction therapy, or b) patient declines intensive induction chemotherapy, OR 2) patient has a physiologic age of 60 years or older and 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.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	IMATINIB
<b>Drug Names</b>	IMATINIB MESYLATE
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Desmoid tumors, pigmented villonodular synovitis/tenosynovial giant cell tumor (PVNS/TGCT), recurrent chordoma, melanoma, AIDS-related Kaposi sarcoma, chronic myelomonocytic leukemia, chronic graft versus host disease (cGVHD), T-cell acute lymphoblastic leukemia, aggressive systemic mastocytosis when eosinophilia is present with FIP1L1-PDGFR $\alpha$ fusion gene
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For chronic myeloid leukemia (CML) or Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL): 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 melanoma: c-Kit mutation is positive.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	IMBRUVICA
<b><i>Drug Names</i></b>	IMBRUVICA
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Hairy cell leukemia, lymphoplasmacytic lymphoma, follicular lymphoma, primary central nervous system lymphoma, AIDS-related B-cell lymphoma, histologic transformation of nodal marginal zone lymphoma to diffuse large B-cell lymphoma, diffuse large B-cell lymphoma, post-transplant lymphoproliferative disorders, high-grade B-cell lymphoma.
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For mantle cell lymphoma: 1) the requested drug will be used in a patient who has received at least one prior 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. For marginal zone lymphoma (including gastric mucosa-associated lymphoid tissue [MALT] lymphoma, non-gastric MALT lymphoma, nodal marginal zone lymphoma, and splenic marginal zone lymphoma): the patient has received at least one prior therapy. For hairy cell leukemia: the requested drug will be used as a single agent for disease progression. For primary central nervous system lymphoma: 1) the disease is relapsed or refractory OR 2) the requested drug is used for induction therapy as a single agent. For histologic transformation of nodal marginal zone lymphoma to diffuse large B-cell lymphoma: the requested drug will be used in patients who have received prior chemoimmunotherapy. For diffuse large B-cell lymphoma: the requested drug will be used as second-line or subsequent therapy. For AIDS-related B-cell lymphoma: the requested drug will be used as a single agent and as second-line or subsequent therapy for relapsed disease. For post-transplant lymphoproliferative disorders: the requested drug will be used in patients who have received prior chemoimmunotherapy. For high-grade B-cell lymphoma: the requested drug will be used as second-line or subsequent therapy. For follicular lymphoma: the requested drug will be used as a single agent.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	INCRELEX
<b><i>Drug Names</i></b>	INCRELEX
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	Pediatric patients with closed epiphyses
<b><i>Required Medical Information</i></b>	For growth failure due to severe primary insulin-like growth factor-1 (IGF-1) deficiency or growth hormone gene deletion in patients who have developed neutralizing antibodies to growth hormone, must meet 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 renewal, patient is experiencing improvement.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	INGREZZA
<b><i>Drug Names</i></b>	INGREZZA
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-



# HEALTH | CHOICE

GENERATIONS

<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, Hurthle cell, or follicular).
<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>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>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
<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>Prior Authorization Group</b>	IR BEFORE ER
<b>Drug Names</b>	HYDROCODONE BITARTRATE ER, HYSINGLA 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>	1) 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 2) The requested drug is being prescribed for pain severe enough to require daily, around-the-clock, long-term treatment in a patient who has been taking an opioid AND 3) 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 4) The patient has been evaluated and the patient will be monitored for the development of opioid use disorder AND 5) 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>Prior Authorization Group</b>	IRESSA
<b>Drug Names</b>	IRESSA
<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 or advanced non-small cell lung cancer (NSCLC).
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For NSCLC: 1) disease must be metastatic, advanced, or recurrent and 2) patient must have a sensitizing EGFR mutation.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

# HEALTH | CHOICE

GENERATIONS

<b>Prior Authorization Group</b>	ISOTRETINOIN
<b>Drug Names</b>	ACUTANE, AMNESTEEM, CLARAVIS, ISOTRETINOIN, MYORISAN, ZENATANE
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Refractory 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>Prior Authorization Group</b>	ITRACONAZOLE
<b>Drug Names</b>	ITRACONAZOLE
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Coccidioidomycosis, Coccidioidomycosis prophylaxis in HIV infection, Cryptococcosis, Histoplasmosis prophylaxis in HIV infection, invasive fungal infection prophylaxis in liver transplant patients, Microsporidiosis, Talaromycosis (formerly Penicilliosis), Pityriasis versicolor/Tinea versicolor, Sporotrichosis, Tinea corporis, Tinea cruris, Tinea capitis, Tinea manuum, Tinea pedis
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	If for the treatment of onychomycosis due to dermatophytes (Tinea unguium), the diagnosis has been confirmed by a fungal diagnostic test (e.g., potassium hydroxide [KOH] preparation, fungal culture, or nail biopsy).
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Disseminated/CNS histoplasmosis, Histoplasmosis/Coccidioidomycosis ppx: 12 mths. Others: 6 mths
<b>Other Criteria</b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	IVERMECTIN TAB
<b><i>Drug Names</i></b>	IVERMECTIN
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Ascariasis, Cutaneous larva migrans, Mansonelliasis, Scabies, Gnathostomiasis, Pediculosis
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	The requested drug is not being prescribed for the prevention or treatment of coronavirus disease 2019 (COVID-19).
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	1 month
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	IVIG
<b><i>Drug Names</i></b>	BIVIGAM, FLEBOGAMMA DIF, GAMMAGARD LIQUID, GAMMAGARD S/D IGA LESS TH, GAMMAKED, GAMMAPLEX, GAMUNEX-C, OCTAGAM, PANZYGA, PRIVIGEN
<b><i>PA Indication Indicator</i></b>	All Medically-accepted Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></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><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></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>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 phase myelofibrosis, blast phase myelofibrosis/acute myeloid leukemia, acute lymphoblastic leukemia (ALL), chronic myelomonocytic leukemia (CMML)-2, BCR-ABL negative atypical chronic myeloid leukemia (aCML), essential thrombocythemia, and myeloid, lymphoid or mixed lineage neoplasms with eosinophilia and JAK2 rearrangement
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For polycythemia vera: patient had an inadequate response or intolerance to interferon therapy or hydroxyurea. 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 BCR-ABL negative aCML: 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>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 (CF): The requested medication will not be used in combination with other medications containing ivacaftor.
<b>Age Restrictions</b>	4 months of age or older
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	KANJINTI
<b><i>Drug Names</i></b>	KANJINTI
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></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, HER2-positive esophageal and esophagogastric junction cancer, HER2-positive advanced or recurrent uterine serous carcinoma, HER2-amplified colorectal cancer in combination with pertuzumab or lapatinib.
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Neoadjuvant therapy for breast cancer: 6 months. Other: Plan Year.
<b><i>Other Criteria</i></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. 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.
<b><i>Prior Authorization Group</i></b>	KESIMPTA
<b><i>Drug Names</i></b>	KESIMPTA
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	KETOCONAZOLE
<b><i>Drug Names</i></b>	KETOCONAZOLE
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Cushing's syndrome
<b><i>Exclusion Criteria</i></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><i>Required Medical Information</i></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><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	6 months
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	KEYTRUDA
<b><i>Drug Names</i></b>	KEYTRUDA
<b><i>PA Indication Indicator</i></b>	All Medically-accepted Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	KISOALI
<b><i>Drug Names</i></b>	KISOALI, KISOALI FEMARA 200 DOSE, KISOALI FEMARA 400 DOSE, KISOALI FEMARA 600 DOSE
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	For treatment of breast cancer using Kisqali (ribociclib) in combination with an aromatase inhibitor or Kisqali Femara Co-Pack (ribociclib and letrozole) as initial endocrine-based therapy, one of the following criteria must be met: 1) the patient is pre- or peri-menopausal OR 2) the patient is postmenopausal OR male AND the patient has experienced an intolerable adverse event to Ibrance (palbociclib) AND Verzenio (abemaciclib) or has a contraindication to Ibrance (palbociclib) AND Verzenio (abemaciclib). For treatment of breast cancer with Kisqali (ribociclib) in combination with fulvestrant, one of the following criteria must met: 1) the requested drug is being used with fulvestrant as initial endocrine-based therapy in a postmenopausal patient or in a male, OR 2) the requested drug is being used following disease progression on endocrine therapy in a postmenopausal patient or in a male and the patient has experienced an intolerable adverse event to Ibrance (palbociclib) AND Verzenio (abemaciclib) OR has a contraindication to Ibrance (palbociclib) AND Verzenio (abemaciclib).
<b><i>Prior Authorization Group</i></b>	KORLYM
<b><i>Drug Names</i></b>	KORLYM
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	Endocrinologist
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-



# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	KYNMOBI
<b><i>Drug Names</i></b>	KYNMOBI
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For continuation treatment of off episodes in Parkinson's disease: The patient is experiencing improvement on the requested drug.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	LAPATINIB
<b><i>Drug Names</i></b>	LAPATINIB DITOSYLATE
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Brain metastases from human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent epidermal growth factor receptor (EGFR)-positive chordoma, HER2-amplified and RAS and BRAF wild-type colorectal cancer in combination with trastuzumab.
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For HER2-positive breast cancer, the requested drug will be used in combination with any of the following: 1) aromatase inhibitor, 2) capecitabine, OR 3) trastuzumab.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

<b><i>Prior Authorization Group</i></b>	LENVIMA
<b><i>Drug Names</i></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><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Medullary thyroid carcinoma, recurrent endometrial carcinoma, thymic carcinoma
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For differentiated thyroid cancer (follicular, papillary, or Hurthle cell): disease is not amenable to radioactive iodine therapy and unresectable, locally recurrent, persistent, or metastatic. For hepatocellular carcinoma: disease is unresectable or inoperable, local, metastatic or with extensive liver tumor burden. For renal cell carcinoma, the disease is advanced, relapsed, or stage IV. For endometrial carcinoma, the patient meets ALL of the following: 1) The disease is advanced, recurrent, or metastatic, 2) The patient experienced disease progression following prior systemic therapy, AND 3) The patient is not a candidate for curative surgery or radiation.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	LEUPROLIDE
<b><i>Drug Names</i></b>	LEUPROLIDE ACETATE
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Use in combination with growth hormone for children with growth failure and advancing puberty, recurrent androgen receptor positive salivary gland tumors.
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	LIDOCAINE PATCHES
<b><i>Drug Names</i></b>	LIDOCAINE
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></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><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	LONSURF
<b><i>Drug Names</i></b>	LONSURF
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For colorectal cancer: The disease is advanced or metastatic. For gastric or gastroesophageal junction adenocarcinoma, all of the following criteria must be met: 1) The disease is unresectable locally advanced, recurrent, or metastatic, and 2) The patient has been previously treated with at least two prior lines of chemotherapy.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	LORBRENA
<b><i>Drug Names</i></b>	LORBRENA
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Anaplastic lymphoma kinase (ALK)-positive recurrent or advanced non-small cell lung cancer (NSCLC). Repressor of silencing (ROS)-1 rearrangement-positive recurrent, advanced, or metastatic NSCLC following progression on crizotinib, entrectinib, or ceritinib.
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	LUMAKRAS
<b><i>Drug Names</i></b>	LUMAKRAS
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	LUMIZYME
<b><i>Drug Names</i></b>	LUMIZYME
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	Diagnosis of Pompe disease was confirmed by an enzyme assay demonstrating a deficiency of acid alpha-glucosidase (GAA) enzyme activity or by genetic testing.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b>Prior Authorization Group</b>	LUPRON PED
<b>Drug Names</b>	LUPRON DEPOT-PED (1-MONTH), LUPRON DEPOT-PED (3-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, 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>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, malignant sex cord-stromal tumors, epithelial ovarian cancer/fallopian tube cancer/primary peritoneal cancer
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For uterine fibroids, patient must meet one of the following: 1) Diagnosis of anemia (e.g., 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.
<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><i>Prior Authorization Group</i></b>	LYNPARZA
<b><i>Drug Names</i></b>	LYNPARZA
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Recurrent HER2-negative, BRCA 1/2-germline mutated breast cancer, recurrent or metastatic HER2-positive, BRCA 1/2-germline mutated breast cancer
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For recurrent or metastatic breast cancer: the disease is BRCA 1/2-germline mutated. For prostate cancer: The patient has progressed on prior treatment with an androgen receptor-directed therapy. For epithelial ovarian, fallopian tube, or primary peritoneal cancer: 1) The requested drug is used for maintenance therapy for stage II-IV or recurrent disease who are in complete or partial response to chemotherapy OR 2) The patient has deleterious or suspected deleterious germline BRCA-mutated advanced, recurrent, or persistent disease after two or more prior chemotherapy regimens.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	LYRICA CR
<b><i>Drug Names</i></b>	PREGABALIN ER
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	The patient has experienced an inadequate treatment response to gabapentin, or the patient has experienced an intolerance to gabapentin, or the patient has a contraindication to gabapentin.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	MAVYRET
<b><i>Drug Names</i></b>	MAVYRET
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	Decompensated cirrhosis/moderate or severe hepatic impairment (Child Turcotte Pugh [CTP] class B or C).
<b><i>Required Medical Information</i></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, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current American Association for the Study of Liver Diseases (AASLD) treatment guidelines.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Criteria will be applied consistent with current AASLD-IDSA guidance
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	MEGESTROL
<b><i>Drug Names</i></b>	MEGESTROL ACETATE
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Cancer-related cachexia in adults
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	Patient has experienced an inadequate treatment response or intolerance to megestrol 40 mg/mL oral suspension.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<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>	Brain metastases from melanoma, uveal melanoma, central nervous system (CNS) cancer (i.e., glioma, meningioma, astrocytoma), low grade serous ovarian cancer.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For brain metastasis from melanoma, adjuvant treatment of melanoma, and central nervous system (CNS) cancer (i.e., glioma, meningioma, astrocytoma): 1) The tumor is positive for a BRAF V600 activating mutation (e.g., V600E or V600K), and 2) The requested drug will be used in combination with dabrafenib. For unresectable or metastatic 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 dabrafenib. For non-small cell lung cancer, anaplastic thyroid cancer, and solid tumors: 1) The tumor is positive for a BRAF V600E mutation, and 2) The requested drug will be used in combination with dabrafenib. For uveal melanoma, the requested drug will be used as a single agent. For low grade serous ovarian cancer: The requested drug will be used to treat persistent or recurrent disease.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<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 systemic therapy for cutaneous melanoma
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For cutaneous melanoma: The patient must meet all of the following criteria: 1) Tumor is positive for BRAF V600 activating mutation (e.g., V600E or V600K), 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 or metastatic disease, or b) adjuvant systemic therapy.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-



# HEALTH | CHOICE

GENERATIONS

<b>Prior Authorization Group</b>	MEMANTINE
<b>Drug Names</b>	MEMANTINE HCL TITRATION P, 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 edit only applies to patients less than 30 years of age.
<b>Prior Authorization Group</b>	METHYLPHENIDATE
<b>Drug Names</b>	METADATE ER, 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>Prior Authorization Group</b>	MIGLUSTAT
<b>Drug Names</b>	MIGLUSTAT
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For Gaucher disease: the 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>	-

# HEALTH | CHOICE

GENERATIONS

<b>Prior Authorization Group</b>	MONJUVI
<b>Drug Names</b>	MONJUVI
<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>Prior Authorization Group</b>	MVASI
<b>Drug Names</b>	MVASI
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Breast cancer, central nervous system (CNS) tumor types: adult low-grade (WHO Grade II) infiltrative supratentorial astrocytoma/oligodendroglioma, adult intracranial and spinal ependymoma, anaplastic gliomas, adult medulloblastoma, primary central nervous system lymphoma, meningiomas, limited and extensive brain metastases, metastatic spine tumors, malignant pleural mesothelioma, epithelial ovarian cancer/fallopian tube cancer/primary peritoneal cancer, including the following cancer types: carcinosarcoma (malignant mixed Mullerian tumors), clear cell carcinoma, mucinous carcinoma, grade 1 endometrioid carcinoma, low-grade serous carcinoma, ovarian borderline epithelial tumors (low malignant potential) with invasive implants, and malignant sex cord-stromal tumors, soft tissue sarcoma types: angiosarcoma and solitary fibrous tumor/hemangiopericytoma, uterine neoplasms, endometrial carcinoma, vulvar squamous cell carcinoma, 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, hepatocellular carcinoma, small bowel adenocarcinoma.
<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.

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	NAGLAZYME
<b><i>Drug Names</i></b>	NAGLAZYME
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For mucopolysaccharidosis VI disease: Diagnosis was confirmed by an enzyme assay demonstrating a deficiency of N-acetylgalactosamine 4-sulfatase (arylsulfatase B) enzyme activity or by genetic testing.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	NATPARA
<b><i>Drug Names</i></b>	NATPARA
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	Acute postsurgical hypoparathyroidism (within 6 months of surgery) and expected recovery from hypoparathyroidism.
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	NERLYNX
<b><i>Drug Names</i></b>	NERLYNX
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Recurrent human epidermal growth factor receptor 2 (HER2)-positive breast cancer, Brain metastases from HER2-positive breast cancer.
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b>Prior Authorization Group</b>	NEXAVAR
<b>Drug Names</b>	NEXAVAR, 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.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For thyroid carcinoma: Histology is follicular, papillary, Hurthle cell or medullary. For acute myeloid leukemia, any of the following criteria must be met: 1) The requested drug is used in combination with azacitidine or decitabine for low-intensity treatment induction or post-induction therapy AND the patient is 60 years of age or older with FLT3-ITD mutation, OR 2) The disease is relapsed/refractory AND the requested drug is a component of repeating the initial successful induction if late relapse (greater than or equal to 12 months), OR 3) The disease is relapsed/refractory AND the requested drug is used in combination with azacitidine or decitabine if the patient is FLT3-ITD mutation positive. For renal cell carcinoma, the patient meets ALL of the following: 1) The disease is advanced, AND 2) The patient has experienced disease progression or an intolerable adverse event with a trial of cabozantinib or axitinib.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<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>	Systemic light chain amyloidosis, Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For multiple myeloma: The requested drug will be used in combination with lenalidomide and dexamethasone OR pomalidomide and dexamethasone OR dexamethasone OR cyclophosphamide and dexamethasone OR as a single agent.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	NITISINONE
<b><i>Drug Names</i></b>	NITISINONE
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For hereditary tyrosinemia type 1: Diagnosis of hereditary tyrosinemia type 1 is confirmed by one of the following: 1) biochemical testing (e.g., detection of succinylacetone in urine) or 2) DNA testing (mutation analysis).
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	NORTHERA
<b><i>Drug Names</i></b>	DROXIDOPA
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For neurogenic orthostatic hypotension (nOH): Prior to 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 for nOH, patient experienced benefit from therapy (e.g., a sustained decrease in dizziness, lightheadedness, or feeling faint). For both initial and continuation of therapy for nOH, 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><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	3 months
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	NOXAFIL SUSP
<b><i>Drug Names</i></b>	NOXAFIL
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	The requested drug will be used orally. For treatment of oropharyngeal candidiasis: patient has experienced an inadequate treatment response, intolerance, or has a contraindication to fluconazole.
<b><i>Age Restrictions</i></b>	13 years of age or older
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Oropharyngeal candidiasis: 1 month. All other indications: 6 months
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	NUBEQA
<b><i>Drug Names</i></b>	NUBEQA
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	The requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	NUEDEXTA
<b><i>Drug Names</i></b>	NUEDEXTA
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	NUPLAZID
<b><i>Drug Names</i></b>	NUPLAZID
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></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><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	NURTEC
<b><i>Drug Names</i></b>	NURTEC
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	Acute migraine treatment: The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to at least one triptan 5-HT1 receptor agonist. Preventive treatment of episodic migraine: 1) The patient received at least 3 months of preventive treatment with the requested drug and the patient had a reduction in migraine days per month from baseline OR 2) The patient meets either of the following: a) The patient experienced an inadequate treatment response with a 4-week trial of any one of the following: Antiepileptic drugs (AEDs), Beta-adrenergic blocking agents, Antidepressants OR b) The patient experienced an intolerance or has a contraindication that would prohibit a 4-week trial of any one of the following: Antiepileptic drugs (AEDs), Beta-adrenergic blocking agents, Antidepressants.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Preventive treatment of migraine - initial: 3 months, All other indications: Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	OCTREOTIDE
<b><i>Drug Names</i></b>	OCTREOTIDE ACETATE
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Tumor control of thymomas and thymic carcinomas.
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></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. For tumor control of thymomas and thymic carcinomas, the requested drug will be used as second-line systemic therapy in patients with unresectable or extrathoracic metastatic disease.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	ODOMZO
<b><i>Drug Names</i></b>	ODOMZO
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-



# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	OFEV
<b><i>Drug Names</i></b>	OFEV
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	OGIVRI
<b><i>Drug Names</i></b>	OGIVRI
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></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, HER2-positive esophageal and esophagogastric junction cancer, HER2-positive advanced or recurrent uterine serous carcinoma, HER2-amplified colorectal cancer in combination with pertuzumab or lapatinib.
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Neoadjuvant therapy for breast cancer: 6 months. Other: Plan Year.
<b><i>Other Criteria</i></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. 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.

# HEALTH | CHOICE

GENERATIONS

<b>Prior Authorization Group</b>	OMNIPOD
<b>Drug Names</b>	OMNIPOD 5 G6 INTRO KIT (G, OMNIPOD 5 G6 PODS (GEN 5), OMNIPOD CLASSIC PDM START, OMNIPOD CLASSIC PODS (GEN, 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>	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>	For continuation of therapy with an insulin pump, the patient has stable or improved glycemic control.
<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, HER2-positive esophageal and esophagogastric junction cancer, HER2-positive advanced or recurrent uterine serous carcinoma, HER2-amplified colorectal cancer in combination with pertuzumab or lapatinib.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	-
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Neoadjuvant therapy for breast cancer: 6 months. Other: 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. 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.

# HEALTH | CHOICE

GENERATIONS

<i>Prior Authorization Group</i>	ONUREG
<i>Drug Names</i>	ONUREG
<i>PA Indication Indicator</i>	All FDA-approved Indications
<i>Off-label Uses</i>	-
<i>Exclusion Criteria</i>	-
<i>Required Medical Information</i>	-
<i>Age Restrictions</i>	-
<i>Prescriber Restrictions</i>	-
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	-
<i>Prior Authorization Group</i>	OPSUMIT
<i>Drug Names</i>	OPSUMIT
<i>PA Indication Indicator</i>	All FDA-approved Indications
<i>Off-label Uses</i>	-
<i>Exclusion Criteria</i>	-
<i>Required Medical Information</i>	For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): Diagnosis was confirmed by right heart catheterization. For PAH 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 3 Wood units.
<i>Age Restrictions</i>	-
<i>Prescriber Restrictions</i>	-
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	ORAL-INTRANASAL FENTANYL
<b><i>Drug Names</i></b>	FENTANYL CITRATE ORAL TRA
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	1) The requested drug is indicated for the treatment of breakthrough CANCER-related pain only. The requested drug is being prescribed for the management of breakthrough pain in a CANCER patient with underlying CANCER pain AND 2) The International Classification of Diseases (ICD) diagnosis code provided supports the CANCER-RELATED diagnosis. [Note: For drug coverage approval, ICD diagnosis code provided MUST support the CANCER-RELATED diagnosis.] AND 3) The patient is currently receiving, and will continue to receive, around-the-clock opioid therapy for underlying CANCER pain AND 4) The requested drug is intended only for use in opioid tolerant patients. The patient can safely take the requested dose based on their current opioid use history. [Note: Patients considered opioid tolerant are those who are taking around-the-clock medicine consisting of at least 60 mg of oral morphine per day, at least 25 mcg per hour of transdermal fentanyl, at least 30 mg of oral oxycodone per day, at least 60 mg of oral hydrocodone per day, at least 8 mg of oral hydromorphone per day, at least 25 mg of oral oxymorphone per day, or an equianalgesic dose of another opioid medication daily for one week or longer.].
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	ORGOVYX
<b><i>Drug Names</i></b>	ORGOVYX
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	ORKAMBI
<b><i>Drug Names</i></b>	ORKAMBI
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For cystic fibrosis (CF): The requested medication will not be used in combination with other medications containing ivacaftor.
<b><i>Age Restrictions</i></b>	1 year of age or older
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	OTEZLA
<b><i>Drug Names</i></b>	OTEZLA
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For plaque psoriasis (new starts only): Patient meets either of the following: 1) Inadequate response or intolerance to ANY of the following: a) a topical therapy (e.g., a topical corticosteroid, calcineurin inhibitor, vitamin D analog), b) phototherapy (e.g., UVB, PUVA), or c) pharmacologic treatment with methotrexate, cyclosporine, or acitretin OR 2) pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	OXANDROLONE
<b><i>Drug Names</i></b>	OXANDROLONE
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Cachexia associated with AIDS (HIV wasting), To enhance growth in patients with Turners Syndrome
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Turners Syndrome: Plan Year, All other diagnoses: 6 months
<b><i>Other Criteria</i></b>	Coverage will be denied if request is for an indication excluded from Medicare Part D.
<b><i>Prior Authorization Group</i></b>	PANRETIN
<b><i>Drug Names</i></b>	PANRETIN
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Topical treatment of cutaneous lesions in patients with non-AIDS-related Kaposi sarcoma
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	PAXIL SUSP
<b><i>Drug Names</i></b>	PAROXETINE HYDROCHLORIDE, PAXIL
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<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 low risk myelofibrosis), systemic mastocytosis, adult T-cell leukemia/lymphoma, mycosis fungoides/Sezary syndrome, primary cutaneous CD30+ T-cell lymphoproliferative disorders.
<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: 12-48 weeks depending on regimen. HBV: 48 weeks. All Other: Plan Year.
<b>Other Criteria</b>	-
<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>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 urea cycle disorder: Diagnosis of urea cycle disorder (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>	-

# HEALTH | CHOICE

GENERATIONS

**Prior Authorization Group** PHESGO  
**Drug Names** PHESGO  
**PA Indication Indicator** All FDA-approved Indications, Some Medically-accepted Indications  
**Off-label Uses** Recurrent human epidermal growth factor receptor 2 (HER2)-positive breast cancer  
**Exclusion Criteria** -  
**Required Medical Information** -  
**Age Restrictions** -  
**Prescriber Restrictions** -  
**Coverage Duration** Neoadjuvant therapy for breast cancer: 6 months. Other: Plan Year  
**Other Criteria** -

**Prior Authorization Group** PIQRAY  
**Drug Names** PIQRAY 200MG DAILY DOSE, PIQRAY 250MG DAILY DOSE, PIQRAY 300MG DAILY DOSE  
**PA Indication Indicator** All FDA-approved Indications, Some Medically-accepted Indications  
**Off-label Uses** Recurrent hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, PIK3CA-mutated breast cancer in combination with fulvestrant.  
**Exclusion Criteria** -  
**Required Medical Information** -  
**Age Restrictions** -  
**Prescriber Restrictions** -  
**Coverage Duration** Plan Year  
**Other Criteria** -



<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>	Systemic light chain amyloidosis, primary central nervous system (CNS) lymphoma, POEMS syndrome.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For multiple myeloma: The patient has previously received at least two prior therapies for multiple myeloma, including an immunomodulatory agent AND a proteasome inhibitor. For Kaposi sarcoma, patient meets one of the following: 1) patient has acquired immunodeficiency syndrome (AIDS), or 2) patient is negative for human immunodeficiency virus (HIV).
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-
<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.
<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>Prior Authorization Group</b>	PRALUENT
<b>Drug Names</b>	PRALUENT
<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><i>Prior Authorization Group</i></b>	PREGABALIN
<b><i>Drug Names</i></b>	PREGABALIN
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Cancer-Related Neuropathic Pain, Cancer Treatment-Related Neuropathic Pain
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	1) The requested drug is being prescribed for the management of postherpetic neuralgia, the management of neuropathic pain associated with diabetic peripheral neuropathy, cancer-related neuropathic pain, or cancer treatment-related neuropathic pain AND 2) The patient has experienced an inadequate treatment response, intolerance, or contraindication to gabapentin OR 3) The requested drug is being prescribed as adjunctive therapy for the treatment of partial onset seizures OR 4) The requested drug is being prescribed for the management of fibromyalgia or the management of neuropathic pain associated with spinal cord injury.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	PREVYMIS
<b><i>Drug Names</i></b>	PREVYMIS
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For prophylaxis of cytomegalovirus (CMV) infection and disease: 1) The patient is CMV-seropositive, 2) the patient is a recipient of an allogeneic hematopoietic stem cell transplant (HSCT), AND 3) The requested medication will not be used beyond Day 100 post-transplantation.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	6 months
<b><i>Other Criteria</i></b>	-

# HEALTH CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	PROCRIT
<b><i>Drug Names</i></b>	PROCRIT
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Anemia due to myelodysplastic syndromes (MDS), anemia in congestive heart failure (CHF), anemia in rheumatoid arthritis (RA), anemia due to hepatitis C treatment (ribavirin in combination with either interferon alfa or peginterferon alfa)
<b><i>Exclusion Criteria</i></b>	Patients receiving chemotherapy with curative intent. Patients with myeloid cancer.
<b><i>Required Medical Information</i></b>	Requirements regarding hemoglobin (Hgb) values exclude values due to a recent transfusion. For initial approval: 1) for all uses except anemia due to chemotherapy or myelodysplastic syndrome (MDS): patient has adequate iron stores AND 2) for all uses except surgery: pretreatment (no erythropoietin treatment in previous month) Hgb is less than 10 g/dL (less than 9 g/dL for anemia in congestive heart failure), AND 3) for MDS: pretreatment serum erythropoietin level is 500 international units/L or less. For reauthorizations (patient received erythropoietin treatment in previous month) in all uses except surgery: 1) patient has received at least 12 weeks of erythropoietin therapy, AND 2) patient responded to erythropoietin therapy, AND 3) current Hgb is less than 12 g/dL, AND 4) for all uses except anemia due to chemotherapy or MDS: patient has adequate iron stores.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	16 weeks
<b><i>Other Criteria</i></b>	Coverage includes use in anemia in patients whose religious beliefs forbid blood transfusions. 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 (e.g., used for treatment of anemia for a patient with chronic renal failure who is undergoing dialysis, or furnished from physician's supply incident to a physician service).

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	PROMACTA
<b><i>Drug Names</i></b>	PROMACTA
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For chronic or persistent immune thrombocytopenia (ITP): 1) For new starts: a) Patient has had an inadequate response or is intolerant to a prior therapy such as corticosteroids or immunoglobulins, b) 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 and hypertension, anticoagulation therapy, profession or lifestyle that predisposes patient to trauma) AND c) For chronic ITP only: patient has had an inadequate response or intolerance to avatrombopag. 2) For continuation of therapy, plt count response to the requested drug: a) Current plt count is less than or equal to 200,000/mcL OR b) 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: 1) For new starts: the requested drug is used for initiation and maintenance of interferon-based therapy. 2) For continuation of therapy: patient is receiving interferon-based therapy. For severe aplastic anemia (AA): For continuation of therapy following the initial 6 month approval for severe aplastic anemia: The patient must meet one of the following: 1) Current plt count is 50,000-200,000/mcL OR 2) Current plt count is less than 50,000/mcL and patient has not received appropriately titrated therapy for at least 16 weeks, OR 3) Current plt count is less than 50,000/mcL and patient 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.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	HCV: 6mo, ITP/AA initial: 6mo, ITP reauth: Plan Year, AA reauth: APR-Plan Year, IPR-16 wks
<b><i>Other Criteria</i></b>	APR: adequate platelet response (greater than 50,000/mcL), IPR: inadequate platelet response (less than 50,000/mcL).

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	PULMOZYME
<b><i>Drug Names</i></b>	PULMOZYME
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For cystic fibrosis: Diagnosis of cystic fibrosis was confirmed by appropriate diagnostic or genetic testing.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></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><i>Prior Authorization Group</i></b>	QINLOCK
<b><i>Drug Names</i></b>	QINLOCK
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	QUETIAPINE XR
<b><i>Drug Names</i></b>	QUETIAPINE FUMARATE ER
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Maintenance monotherapy treatment in bipolar I disorder, monotherapy treatment of generalized anxiety disorder, monotherapy treatment of major depressive disorder
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For schizophrenia, acute treatment of manic or mixed episodes associated with bipolar I disorder, both as monotherapy and as an adjunct to lithium or divalproex, the acute treatment of depressive episodes associated with bipolar disorder, maintenance treatment of bipolar I disorder, as an adjunct to lithium or divalproex, adjunctive treatment of major depressive disorder, or maintenance monotherapy treatment in bipolar I disorder: The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following generic products: A) aripiprazole, B) asenapine, C) olanzapine, D) quetiapine immediate-release, E) risperidone, F) ziprasidone. 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.].
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	QUININE SULFATE
<b><i>Drug Names</i></b>	QUININE SULFATE
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Babesiosis, uncomplicated Plasmodium vivax malaria
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	1 month
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b>Prior Authorization Group</b>	REGRANEX
<b>Drug Names</b>	REGRANEX
<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 lower extremity diabetic neuropathic ulcers that extend into the subcutaneous tissue or beyond and have an adequate blood supply.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	20 weeks
<b>Other Criteria</b>	-
<b>Prior Authorization Group</b>	RELISTOR INJ
<b>Drug Names</b>	RELISTOR
<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 prescribed for opioid-induced constipation in an adult patient with advanced illness or pain caused by active cancer who requires opioid dosage escalation for palliative care OR 2) The requested drug is being prescribed for opioid-induced constipation in an adult patient with chronic non-cancer pain, including chronic pain related to prior cancer or its treatment who does not require frequent (e.g., weekly) opioid dosage escalation AND 3) The patient is unable to tolerate oral medications OR 4) An oral drug indicated for opioid-induced constipation in an adult patient with chronic non-cancer pain (e.g., Movantik) has been tried AND 5) The patient experienced an inadequate treatment response or intolerance to an oral drug indicated for opioid-induced constipation in an adult patient with chronic non-cancer pain (e.g., Movantik) OR 6) The patient has a contraindication that would prohibit a trial of an oral drug indicated for opioid-induced constipation in an adult patient with chronic non-cancer pain (e.g., Movantik).
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	4 months
<b>Other Criteria</b>	-

# HEALTH | CHOICE

GENERATIONS

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



# HEALTH | CHOICE

GENERATIONS

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

HEALTH | CHOICE  
GENERATIONS

<b><i>Prior Authorization Group</i></b>	RETEVMO
<b><i>Drug Names</i></b>	RETEVMO
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Recurrent or advanced rearranged during transfection (RET)-rearrangement positive non-small cell lung cancer
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For non-small cell lung cancer, patient must meet all of the following: 1) The disease is recurrent, advanced or metastatic, and 2) Tumor is RET fusion-positive or RET rearrangement-positive.
<b><i>Age Restrictions</i></b>	Non-small cell lung cancer: 18 years of age or older. Medullary thyroid cancer and thyroid cancer: 12 years of age or older.
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	REVLIMID
<b><i>Drug Names</i></b>	LENALIDOMIDE, REVLIMID
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Systemic light chain amyloidosis, classical Hodgkin lymphoma, myelodysplastic syndrome without the 5q deletion cytogenetic abnormality, myelofibrosis-associated anemia, POEMS syndrome, myeloproliferative neoplasms, non-Hodgkin's lymphoma with the following subtypes: acquired immunodeficiency syndrome (AIDS)-related non-germinal center diffuse large B-cell lymphoma, primary central nervous system (CNS) lymphoma, monomorphic post-transplant lymphoproliferative disorder, chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL), diffuse large B-cell lymphoma, multicentric Castleman's disease, adult T-cell leukemia/lymphoma, mycosis fungoides (MF)/Sezary syndrome (SS), angioimmunoblastic T-cell lymphoma (AITL), peripheral T-cell lymphoma not otherwise specified (PTCL NOS), enteropathy-associated T-cell lymphoma, monomorphic epitheliotropic intestinal T-cell lymphoma, nodal peripheral T-cell lymphoma, primary cutaneous anaplastic large cell lymphoma (ALCL), hepatosplenic T-cell lymphoma, high-grade B-cell lymphomas, histologic transformation of nodal marginal zone lymphoma to diffuse large B-cell lymphoma, histologic transformation of follicular lymphoma to diffuse large B-cell lymphoma, AIDS-related Kaposi sarcoma, smoldering myeloma
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For myelodysplastic syndrome (MDS): 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><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<i>Prior Authorization Group</i>	REZUROCK
<i>Drug Names</i>	REZUROCK
<i>PA Indication Indicator</i>	All FDA-approved Indications
<i>Off-label Uses</i>	-
<i>Exclusion Criteria</i>	-
<i>Required Medical Information</i>	-
<i>Age Restrictions</i>	12 years of age or older
<i>Prescriber Restrictions</i>	-
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	-

# HEALTH CHOICE

GENERATIONS

<b>Prior Authorization Group</b>	RIABNI
<b>Drug Names</b>	RIABNI
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Non-Hodgkin's lymphoma subtypes [small lymphocytic lymphoma (SLL), mantle cell lymphoma, marginal zone lymphomas (nodal, splenic, gastric mucosa-associated lymphoid tissue [MALT], nongastric MALT), Burkitt lymphoma, primary cutaneous B-cell lymphoma, high-grade B-cell lymphoma with translocations of MYC and BCL2 and/or BCL6 (double/triple hit lymphoma), high-grade B-cell lymphoma not otherwise specified, histological transformation from follicular lymphoma to diffuse large B-cell lymphoma, histological transformation from nodal marginal zone lymphoma to diffuse large B-cell lymphoma, Castleman's disease, acquired immunodeficiency syndrome (AIDS)-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's macroglobulinemia/lymphoplasmacytic lymphoma, chronic graft-versus-host disease (GVHD), Sjogren syndrome, thrombotic thrombocytopenic purpura, refractory myasthenia gravis, Hodgkin's lymphoma (nodular lymphocyte-predominant), primary central nervous system (CNS) lymphoma, leptomeningeal metastases from lymphomas, acute lymphoblastic leukemia, prevention of Epstein-Barr virus (EBV)-related PTLD, multiple sclerosis, immune checkpoint inhibitor-related toxicities, moderately to severely active rheumatoid arthritis, pemphigus vulgaris, pediatric Burkitt-like lymphoma (BLL) and pediatric mature B-cell acute leukemia (B-AL).
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	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 response, intolerance, or contraindication to MTX OR b) inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. Hematologic malignancies must be CD20-positive. For multiple sclerosis: 1) patient has a diagnosis of relapsing remitting multiple sclerosis and 2) patient has had an inadequate response to two or more disease-modifying drugs indicated for multiple sclerosis despite adequate duration of treatment.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Immune checkpoint inhibitor-related toxicities: 3 months, All other: Plan Year
<b>Other Criteria</b>	The patient had an intolerable adverse event to both Truxima AND Ruxience and that adverse event was NOT attributed to the active ingredient as described in the prescribing information.

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	RINVOQ
<b><i>Drug Names</i></b>	RINVOQ
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For moderately to severely active rheumatoid arthritis (new starts only): patient has experienced an inadequate treatment response or intolerance to at least one tumor necrosis factor (TNF) inhibitor.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	RITUXAN
<b><i>Drug Names</i></b>	RITUXAN
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Non-Hodgkin's lymphoma subtypes [small lymphocytic lymphoma (SLL), mantle cell lymphoma, marginal zone lymphomas (nodal, splenic, gastric mucosa-associated lymphoid tissue [MALT], nongastric MALT), primary cutaneous B-cell lymphoma, high-grade B-cell lymphoma with translocations of MYC and BCL2 and/or BCL6 (double/triple hit lymphoma), high-grade B-cell lymphoma not otherwise specified, histological transformation from follicular lymphoma to diffuse large B-cell lymphoma, histological transformation from nodal marginal zone lymphoma to diffuse large B-cell lymphoma, Castleman's disease, acquired immunodeficiency syndrome (AIDS)-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's macroglobulinemia/lymphoplasmacytic lymphoma, chronic graft-versus-host disease (GVHD), Sjogren syndrome, thrombotic thrombocytopenic purpura, refractory myasthenia gravis, Hodgkin's lymphoma (nodular lymphocyte-predominant), primary central nervous system (CNS) lymphoma, leptomeningeal metastases from lymphomas, acute lymphoblastic leukemia, prevention of Epstein-Barr virus (EBV)-related PTLD, multiple sclerosis, and immune checkpoint inhibitor-related toxicities.
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	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 response, intolerance, or contraindication to MTX OR b) inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. Hematologic malignancies must be CD20-positive. For multiple sclerosis: 1) patient has a diagnosis of relapsing remitting multiple sclerosis and 2) patient has had an inadequate response to two or more disease-modifying drugs indicated for multiple sclerosis despite adequate duration of treatment.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Immune checkpoint inhibitor-related toxicities: 3 months, All other: Plan Year
<b><i>Other Criteria</i></b>	The patient had an intolerable adverse event to both Truxima AND Ruxience and that adverse event was NOT attributed to the active ingredient as described in the prescribing information.

<b><i>Prior Authorization Group</i></b>	RITUXAN HYCELA
<b><i>Drug Names</i></b>	RITUXAN HYCELA
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Castleman's disease (CD), high-grade B-cell lymphoma, histologic transformation of nodal marginal zone lymphoma to diffuse large B-cell lymphoma, marginal zone lymphomas (nodal marginal zone lymphoma, gastric mucosa-associated lymphoid tissue (MALT) lymphoma, nongastric MALT lymphoma, and splenic marginal zone lymphoma), mantle cell lymphoma, post-transplant lymphoproliferative disorder (PTLD), primary cutaneous B-cell lymphoma (e.g., cutaneous marginal zone lymphoma or cutaneous follicle center lymphomas), hairy cell leukemia, small lymphocytic lymphoma (SLL).
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	Malignancies must be CD20 positive. Patient must receive at least one full dose of a rituximab product by intravenous infusion without experiencing severe adverse reactions.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	ROZLYTREK
<b><i>Drug Names</i></b>	ROZLYTREK
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Recurrent or advanced ROS1-positive non-small cell lung cancer (NSCLC), advanced, recurrent, or persistent neurotrophic tyrosine receptor kinase (NTRK) gene fusion-positive solid tumors, first-line treatment of NTRK gene fusion-positive solid tumors.
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For all neurotrophic tyrosine receptor kinase (NTRK) gene fusion-positive solid tumors, the disease is without a known acquired resistance mutation.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-



# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	RUBRACA
<b><i>Drug Names</i></b>	RUBRACA
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For metastatic castration-resistant prostate cancer with a deleterious breast cancer susceptibility gene (BRCA) mutation (germline and/or somatic): 1) patient has been treated with androgen receptor-directed therapy, 2) patient has been treated with a taxane-based chemotherapy or the patient is not fit for chemotherapy, 3) the requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy, and 4) patient experienced an unacceptable toxicity with a trial of Lynparza (olaparib). For maintenance treatment of patients with recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in a complete or partial response to platinum-based chemotherapy, patient experienced an unacceptable toxicity with a trial of Lynparza (olaparib). For treatment of patients with a deleterious breast cancer susceptibility gene (BRCA) mutation (germline and/or somatic)-associated epithelial ovarian, fallopian tube, or primary peritoneal cancer who have been treated with two or more chemotherapies: if prescribed for deleterious germline BRCA-mutated advanced ovarian cancer treated with two or more prior chemotherapies, the patient experienced an unacceptable toxicity with a trial of Lynparza (olaparib).
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH CHOICE

GENERATIONS

<b>Prior Authorization Group</b>	RUXIENCE
<b>Drug Names</b>	RUXIENCE
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Non-Hodgkin's lymphoma subtypes [small lymphocytic lymphoma (SLL), mantle cell lymphoma, marginal zone lymphomas (nodal, splenic, gastric mucosa-associated lymphoid tissue [MALT], nongastric MALT), Burkitt lymphoma, primary cutaneous B-cell lymphoma, high-grade B-cell lymphoma with translocations of MYC and BCL2 and/or BCL6 (double/triple hit lymphoma), high-grade B-cell lymphoma not otherwise specified, histological transformation from follicular lymphoma to diffuse large B-cell lymphoma, histological transformation from nodal marginal zone lymphoma to diffuse large B-cell lymphoma, Castleman's disease, acquired immunodeficiency syndrome (AIDS)-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's macroglobulinemia/lymphoplasmacytic lymphoma, chronic graft-versus-host disease (GVHD), Sjogren syndrome, thrombotic thrombocytopenic purpura, refractory myasthenia gravis, Hodgkin's lymphoma (nodular lymphocyte-predominant), primary central nervous system (CNS) lymphoma, leptomeningeal metastases from lymphomas, acute lymphoblastic leukemia, prevention of Epstein-Barr virus (EBV)-related PTLD, multiple sclerosis, immune checkpoint inhibitor-related toxicities, pemphigus vulgaris, pediatric Burkitt-like lymphoma (BLL), and pediatric mature B-cell acute leukemia (B-AL).
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	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 response, intolerance, or contraindication to MTX OR b) inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. Hematologic malignancies must be CD20-positive. For multiple sclerosis: 1) patient has a diagnosis of relapsing remitting multiple sclerosis and 2) patient has had an inadequate response to two or more disease-modifying drugs indicated for multiple sclerosis despite adequate duration of treatment.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Immune checkpoint inhibitor-related toxicities: 3 months, All other: Plan Year
<b>Other Criteria</b>	-

<b><i>Prior Authorization Group</i></b>	RXDAPT
<b><i>Drug Names</i></b>	RXDAPT
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Relapsed or refractory acute myeloid leukemia (AML), myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and FGFR1 or FLT3 rearrangements, post-remission maintenance therapy for acute myeloid leukemia (AML), re-induction in residual disease for acute myeloid leukemia (AML)
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For acute myeloid leukemia (AML): AML must be FLT3 mutation-positive. For myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and FGFR1 or FLT3 rearrangements: the disease is in chronic or blast phase.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	SAPROPTERIN
<b><i>Drug Names</i></b>	JAVYGTOR, SAPROPTERIN DIHYDROCHLORI
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For phenylketonuria: 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 (for example, reduction in blood phenylalanine levels, improvement in neuropsychiatric symptoms).
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Initial: 2 months. All others: Plan Year.
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	SCEMBLIX
<b><i>Drug Names</i></b>	SCEMBLIX
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For chronic myeloid leukemia (CML) in the chronic phase: 1) the diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene AND the patient meets either of the following: A) the patient has previously been treated with 2 or more tyrosine kinase inhibitors (TKIs) AND at least one of those was imatinib or dasatinib, OR B) the patient is positive for the T315I mutation.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	SIGNIFOR
<b><i>Drug Names</i></b>	SIGNIFOR
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	Endocrinologist
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	SILDENAFIL
<b><i>Drug Names</i></b>	SILDENAFIL CITRATE
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): Diagnosis was confirmed by right heart catheterization. For PAH 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 3 Wood units.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	SIRTURO
<b><i>Drug Names</i></b>	SIRTURO
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	Prescribed by or in consultation with an infectious disease specialist.
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	SKYRIZI
<b><i>Drug Names</i></b>	SKYRIZI, SKYRIZI PEN
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For moderate to severe plaque psoriasis (new starts only): 1) at least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis, AND 2) patient meets any of the following: a) patient has experienced an inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, or b) pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated, or c) patient has severe psoriasis that warrants a biologic disease-modifying antirheumatic drug (DMARD) as first-line therapy (i.e. at least 10% of the body surface area or crucial body areas [e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas] are affected). For moderately to severely active Crohn's disease (new starts only): 1) Inadequate response to at least one conventional therapy (e.g., corticosteroids), OR 2) Intolerance or contraindication to conventional therapy.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	SKYRIZI-CD
<b><i>Drug Names</i></b>	SKYRIZI
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For moderate to severe plaque psoriasis (new starts only): 1) at least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis, AND 2) patient meets any of the following: a) patient has experienced an inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, or b) pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated, or c) patient has severe psoriasis that warrants a biologic disease-modifying antirheumatic drug (DMARD) as first-line therapy (i.e. at least 10% of the body surface area or crucial body areas [e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas] are affected). For moderately to severely active Crohn's disease (new starts only): 1) Inadequate response to at least one conventional therapy (e.g., corticosteroids), OR 2) Intolerance or contraindication to conventional therapy.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	SOMATULINE DEPOT
<b><i>Drug Names</i></b>	SOMATULINE DEPOT
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Tumor control of neuroendocrine tumors (NETs) of the lung, thymus (carcinoid tumors) or unresected primary gastrinoma, and pheochromocytoma/paraganglioma.
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></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. For tumor control, the requested drug will be used for any of the following: 1) neuroendocrine tumor of the thymus or lung in patients with locoregional unresectable disease and/or distant metastatic disease, OR 2) unresected primary gastrinoma, OR 3) pheochromocytomas and paragangliomas, used for either of the following: a) symptomatic locally unresectable disease with somatostatin receptor positive imaging OR b) secreting tumor in metastatic disease.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	SOMAVERT
<b><i>Drug Names</i></b>	SOMAVERT
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></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><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-



# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	SPRYCEL
<b><i>Drug Names</i></b>	SPRYCEL
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Gastrointestinal stromal tumor (GIST), metastatic chondrosarcoma, recurrent chordoma, T-cell acute lymphoblastic leukemia (ALL), Philadelphia (Ph)-like B-ALL
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For chronic myeloid leukemia (CML), including patients who have received a hematopoietic stem cell transplant: diagnosis was confirmed by detection of the Philadelphia (Ph) chromosome or BCR-ABL gene. If patient experienced resistance to an alternative tyrosine kinase inhibitor for CML, patient is negative for T315I/A, F317L/V/I/C, and V299L mutations. For acute lymphoblastic leukemia (ALL), the patient has a diagnosis of one of the following: 1) Philadelphia chromosome positive ALL that has been confirmed by detection of the Ph chromosome or BCR-ABL gene, OR 2) Ph-like B-ALL with ABL-class kinase fusion, OR 3) relapsed or refractory T-cell ALL with ABL-class translocation. For GIST, patient must have progressed on imatinib, sunitinib, and regorafenib.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	STELARA
<b><i>Drug Names</i></b>	STELARA
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For moderate to severe plaque psoriasis (new starts only): 1) At least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis AND 2) Patient had an inadequate response, intolerance, or contraindication to two of the following products: Enbrel (etanercept), Humira (adalimumab), Otezla (apremilast), Skyrizi (risankizumab-rzaa). For active psoriatic arthritis (PsA) (new starts only): patient had an inadequate response, intolerance, or contraindication to two of the following products: Enbrel (etanercept), Humira (adalimumab), Otezla (apremilast), Rinvoq (upadacitinib), Skyrizi (risankizumab-rzaa), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release). For moderately to severely active Crohn's disease (new starts only): patient had an inadequate response, intolerance, or contraindication to one of the following products: Humira (adalimumab) or Skyrizi (risankizumab-rzaa). For moderately to severely active ulcerative colitis (new starts): patient had an inadequate response, intolerance, or contraindication to Humira (adalimumab).
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	STIVARGA
<b><i>Drug Names</i></b>	STIVARGA
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Progressive gastrointestinal stromal tumors (GIST), osteosarcoma, glioblastoma, angiosarcoma, retroperitoneal/intra-abdominal soft tissue sarcoma, rhabdomyosarcoma, solitary fibrous tumor, and soft tissue sarcomas of the extremities, body wall, head and neck, advanced colorectal cancer.
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For gastrointestinal stromal tumors: The disease is progressive, locally advanced, unresectable, or metastatic.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	SUTENT
<b><i>Drug Names</i></b>	SUNITINIB MALATE
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Thyroid carcinoma (follicular, medullary, papillary, and Hurthle cell), soft tissue sarcoma (angiosarcoma, solitary fibrous tumor, and alveolar soft part sarcoma subtypes), recurrent chordoma, thymic carcinoma.
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For renal cell carcinoma, the disease is relapsed, advanced, or stage IV.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	SYMDEKO
<b><i>Drug Names</i></b>	SYMDEKO
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	The requested medication will not be used in combination with other medications containing ivacaftor.
<b><i>Age Restrictions</i></b>	6 years of age or older
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	SYMPAZAN
<b><i>Drug Names</i></b>	SYMPAZAN
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	2 years of age or older
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	SYNRIBO
<b><i>Drug Names</i></b>	SYNRIBO
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Follow-up therapy for chronic myeloid leukemia (CML) patients after hematopoietic stem cell transplant (HSCT)
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	TABRECTA
<b><i>Drug Names</i></b>	TABRECTA
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Treatment of recurrent or advanced non-small cell lung cancer (NSCLC).
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For recurrent, advanced, or metastatic NSCLC: Tumor is positive for mesenchymal-epithelial transition (MET) exon 14 skipping mutation.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

HEALTH | CHOICE  
GENERATIONS

<b><i>Prior Authorization Group</i></b>	TAFINLAR
<b><i>Drug Names</i></b>	TAFINLAR
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Brain metastases from melanoma, thyroid carcinoma (papillary carcinoma, follicular carcinoma, and Hurthle cell carcinoma), central nervous system (CNS) cancer (i.e., glioma, meningioma, astrocytoma)
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For brain metastases from melanoma, adjuvant treatment of melanoma, and central nervous system (CNS) cancer (i.e., glioma, meningioma, astrocytoma): 1) The tumor is positive for a BRAF V600 activating mutation (e.g., V600E or V600K), and 2) The requested drug will be used in combination with trametinib. For unresectable or metastatic 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. For non-small cell lung cancer and solid tumors: 1) The tumor is positive for a BRAF V600E mutation, and 2) The requested drug will be used in combination with trametinib. For thyroid carcinoma with papillary, follicular, or Hurthle histology: The tumor is positive for BRAF activating mutation (e.g., V600E or V600K).
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

HEALTH | CHOICE  
GENERATIONS

<b><i>Prior Authorization Group</i></b>	TAGRISSO
<b><i>Drug Names</i></b>	TAGRISSO
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Sensitizing epidermal growth factor receptor (EGFR) mutation-positive recurrent or advanced non-small cell lung cancer (NSCLC), brain metastases from sensitizing EGFR mutation-positive NSCLC, leptomeningeal metastases from EGFR mutation-positive NSCLC
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For NSCLC, the requested drug is used in any of the following settings: 1) The patient meets both of the following: a) patient has metastatic, advanced, or recurrent NSCLC (including brain and/or leptomeningeal metastases from NSCLC) and b) patient has a sensitizing EGFR mutation OR 2) 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><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	TALTZ
<b><i>Drug Names</i></b>	TALTZ
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For moderate to severe plaque psoriasis (new starts only): 1) At least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis AND 2) The patient had an inadequate response, intolerance, or contraindication to one of the following products: Enbrel (etanercept), Humira (adalimumab), Otezla (apremilast), Skyrizi (risankizumab-rzaa). For active ankylosing spondylitis (new starts only): the patient had an inadequate response, intolerance, or contraindication to one of the following products: Enbrel (etanercept), Humira (adalimumab), Rinvoq (upadacitinib), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release). For active psoriatic arthritis (PsA) (new starts only): the patient had an inadequate response, intolerance, or contraindication to one of the following products: Enbrel (etanercept), Humira (adalimumab), Otezla (apremilast), Rinvoq (upadacitinib), Skyrizi (risankizumab-rzaa), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release). For active axial spondyloarthritis (new starts only): Patient meets any of the following: 1) has had an inadequate response to a non-steroidal anti-inflammatory drug (NSAID) trial or 2) has an intolerance or contraindication to NSAIDs.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	TALZENNA
<b><i>Drug Names</i></b>	TALZENNA
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Recurrent germline breast cancer susceptibility gene (BRCA)-mutated breast cancer
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For germline BRCA-mutated (gBRCAm) metastatic or recurrent breast cancer, the patient experienced an unacceptable toxicity with a trial of Lynparza (olaparib).
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	TARGRETIN TOPICAL
<b><i>Drug Names</i></b>	BEXAROTENE, TARGRETIN
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Mycosis fungoides, chronic or smoldering adult T-cell leukemia/lymphoma, primary cutaneous marginal zone lymphoma, primary cutaneous follicle center lymphoma.
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	TASIGNA
<b><i>Drug Names</i></b>	TASIGNA
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), gastrointestinal stromal tumor (GIST)
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For chronic myeloid leukemia (CML) or acute lymphoblastic leukemia (ALL), diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, including patients newly diagnosed with CML and patients who have received a hematopoietic stem cell transplant: patient has experienced resistance or intolerance to imatinib or dasatinib. 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 GIST, patient must have progressed on imatinib, sunitinib, and regorafenib.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-



# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	TAZAROTENE
<b><i>Drug Names</i></b>	TAZAROTENE, TAZORAC
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For plaque psoriasis: 1) The requested drug is being prescribed to treat less than 20 percent of the patient's body surface area 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><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	TAZVERIK
<b><i>Drug Names</i></b>	TAZVERIK
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	Epithelioid sarcoma: 16 years of age or older, Follicular lymphoma: 18 years of age or older
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	TECENTRIQ
<b><i>Drug Names</i></b>	TECENTRIQ
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Recurrent or advanced non-small cell lung cancer, PD-L1 positive triple negative recurrent breast cancer in combination with paclitaxel protein-bound
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For urothelial carcinoma, patient meets one of the following criteria: 1) Patient is ineligible for cisplatin therapy and tumors express PD-L1 (defined as PD-L1 stained tumor-infiltrating immune cells [IC] covering greater than or equal to 5 percent of the tumor area) OR 2) Patient is ineligible for any platinum containing chemotherapy. For non-small cell lung cancer (NSCLC): 1) the patient has recurrent, advanced or metastatic disease AND the requested drug will be used as any of the following: a) first-line treatment of tumors with high PD-L1 expression (defined as PD-L1 stained greater than or equal to 50 percent of tumor cells or PD-L1 stained tumor-infiltrating immune cells [IC] covering greater than or equal to 10 percent of the tumor area) and no EGFR or ALK genomic tumor aberrations, b) used in combination with carboplatin, paclitaxel, and bevacizumab, or in combination with carboplatin and albumin-bound paclitaxel for nonsquamous NSCLC, or c) the requested drug will be used as subsequent therapy or continuation maintenance therapy, OR 2) the patient has stage II to IIIA disease AND the requested drug will be used as adjuvant treatment following resection and platinum-based chemotherapy for tumors with PD-L1 expression on greater than or equal to 1 percent of tumor cells. For hepatocellular carcinoma, the requested drug will be used as initial treatment in combination with bevacizumab.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	TEMAZEPAM 30MG
<b><i>Drug Names</i></b>	TEMAZEPAM
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	Prescriber must acknowledge that the benefit of therapy with the requested drug outweighs the potential risks for the patient. (Note: The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to doxepin (3 mg or 6 mg).
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	This Prior Authorization requirement only applies to patients 65 years of age or older.
<b><i>Prior Authorization Group</i></b>	TEPMETKO
<b><i>Drug Names</i></b>	TEPMETKO
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	TESTOSTERONE CYPIONATE INJ
<b><i>Drug Names</i></b>	TESTOSTERONE CYPIONATE
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Gender Dysphoria
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	<p>Primary or hypogonadotropic hypogonadism: 1) Request is for continuation of testosterone therapy and the patient had a confirmed low morning testosterone level according to current practice guidelines or your standard lab reference values 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.] OR 2) Request is not for continuation of testosterone therapy and the patient has at least two confirmed low morning testosterone levels according to current practice guidelines or your standard lab reference values [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.].</p> <p>Gender dysphoria: The patient is able to make an informed decision to engage in hormone therapy.</p>
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	TESTOSTERONE ENANTHATE INJ
<b><i>Drug Names</i></b>	TESTOSTERONE ENANTHATE
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Gender Dysphoria
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	<p>Primary or hypogonadotropic hypogonadism: 1) Request is for continuation of testosterone therapy and the patient had a confirmed low morning testosterone level according to current practice guidelines or your standard lab reference values 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.] OR 2) Request is not for continuation of testosterone therapy and the patient has at least two confirmed low morning testosterone levels according to current practice guidelines or your standard lab reference values [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.].</p> <p>Gender dysphoria: The patient is able to make an informed decision to engage in hormone therapy.</p>
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	TETRABENAZINE
<b><i>Drug Names</i></b>	TETRABENAZINE
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Tic disorders, tardive dyskinesia, hemiballismus, chorea not associated with Huntington's disease.
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	<p>For treatment of chorea associated with Huntington's disease: The patient must have a prior inadequate response or intolerable adverse event with deutetrabenazine therapy.</p> <p>For treatment of tardive dyskinesia: The patient must have a prior inadequate response or intolerable adverse event with deutetrabenazine or valbenazine therapy.</p>
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	TETRACYCLINE
<b><i>Drug Names</i></b>	TETRACYCLINE HYDROCHLORID
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	The patient will use the requested drug orally.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	THALOMID
<b><i>Drug Names</i></b>	THALOMID
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Myelofibrosis-related anemia, recurrent aphthous stomatitis, recurrent human immunodeficiency virus (HIV)-associated aphthous ulcers, cachexia, HIV-associated diarrhea, acquired immunodeficiency syndrome (AIDS)-related Kaposi's sarcoma, Behcet's syndrome, chronic graft-versus-host disease, Crohn's disease, multicentric Castleman's disease.
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For cachexia: Cachexia must be due to cancer or HIV infection.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	TIBSOVO
<b><i>Drug Names</i></b>	TIBSOVO
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Conventional (grades 1-3) or dedifferentiated chondrosarcoma
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></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 has comorbidities that preclude use of intensive induction chemotherapy, or c) patient is 60 physiologic years of age or older and declines intensive induction chemotherapy, OR 2) patient is 60 physiologic years of age or older and 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. For unresectable or metastatic cholangiocarcinoma: the requested drug will be used as subsequent treatment for progression on or after systemic treatment.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	TOBRAMYCIN
<b><i>Drug Names</i></b>	TOBRAMYCIN
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Non-cystic fibrosis bronchiectasis
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For cystic fibrosis and non-cystic fibrosis bronchiectasis, the patient must meet one of the following: 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><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></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.

# HEALTH | CHOICE

GENERATIONS

<b>Prior Authorization Group</b>	TOPICAL LIDOCAINE
<b>Drug Names</b>	GLYDO, LIDOCAINE, LIDOCAINE HCL, LIDOCAINE HCL JELLY, LIDOCAINE/PRILOCAINE
<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>Prior Authorization Group</b>	TOPICAL TESTOSTERONES
<b>Drug Names</b>	ANDRODERM, 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>	Primary or hypogonadotropic hypogonadism: 1) Request is for continuation of testosterone therapy and the patient had a confirmed low morning testosterone level according to current practice guidelines or your standard lab reference values 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.] OR 2) Request is not for continuation of testosterone therapy and the patient has at least two confirmed low morning testosterone levels according to current practice guidelines or your standard lab reference values [Note: Safety and efficacy of testosterone products in patients with "age-related hypogonadism" (also referred to as "late-onset hypogonadism") have not been established.]. 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>	-



# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	TOPICAL TRETINOIN
<b><i>Drug Names</i></b>	AVITA, TRETINOIN
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	TRAZIMERA
<b><i>Drug Names</i></b>	TRAZIMERA
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></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, HER2-positive esophageal and esophagogastric junction cancer, HER2-positive advanced or recurrent uterine serous carcinoma, HER2-amplified colorectal cancer in combination with pertuzumab or lapatinib.
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Neoadjuvant therapy for breast cancer: 6 months. Other: Plan Year.
<b><i>Other Criteria</i></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.

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	TRELSTAR
<b><i>Drug Names</i></b>	TRELSTAR MIXJECT
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Gender dysphoria
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For gender dysphoria, patient meets either of the following (1 or 2): 1) the requested drug is used to suppress puberty and the patient is at Tanner stage 2 or greater, OR 2) patient is undergoing gender transition, and the patient will receive the requested drug concomitantly with gender-affirming hormones.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	TREPROSTINIL INJ
<b><i>Drug Names</i></b>	TREPROSTINIL
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For pulmonary arterial hypertension (World Health Organization [WHO] Group 1), 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 3 Wood units.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></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.

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	TRIENTINE
<b><i>Drug Names</i></b>	TRIENTINE HYDROCHLORIDE
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	TRIKAFTA
<b><i>Drug Names</i></b>	TRIKAFTA
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	The requested medication will not be used in combination with other medications containing ivacaftor.
<b><i>Age Restrictions</i></b>	6 years of age or older
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	TRUSELTIQ
<b><i>Drug Names</i></b>	TRUSELTIQ
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH CHOICE

GENERATIONS

<b>Prior Authorization Group</b>	TRUXIMA
<b>Drug Names</b>	TRUXIMA
<b>PA Indication Indicator</b>	All FDA-approved Indications, Some Medically-accepted Indications
<b>Off-label Uses</b>	Non-Hodgkin's lymphoma subtypes [small lymphocytic lymphoma (SLL), mantle cell lymphoma, marginal zone lymphomas (nodal, splenic, gastric mucosa-associated lymphoid tissue [MALT], nongastric MALT), Burkitt lymphoma, primary cutaneous B-cell lymphoma, high-grade B-cell lymphoma with translocations of MYC and BCL2 and/or BCL6 (double/triple hit lymphoma), high-grade B-cell lymphoma not otherwise specified, histological transformation from follicular lymphoma to diffuse large B-cell lymphoma, histological transformation from nodal marginal zone lymphoma to diffuse large B-cell lymphoma, Castleman's disease, acquired immunodeficiency syndrome (AIDS)-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's macroglobulinemia/lymphoplasmacytic lymphoma, chronic graft-versus-host disease (GVHD), Sjogren syndrome, thrombotic thrombocytopenic purpura, refractory myasthenia gravis, Hodgkin's lymphoma (nodular lymphocyte-predominant), primary central nervous system (CNS) lymphoma, leptomeningeal metastases from lymphomas, acute lymphoblastic leukemia, prevention of Epstein-Barr virus (EBV)-related PTLD, multiple sclerosis, immune checkpoint inhibitor-related toxicities, pemphigus vulgaris, pediatric Burkitt-like lymphoma (BLL), and pediatric mature B-cell acute leukemia (B-AL).
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	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 response, intolerance, or contraindication to MTX OR b) inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. Hematologic malignancies must be CD20-positive. For multiple sclerosis: 1) patient has a diagnosis of relapsing remitting multiple sclerosis and 2) patient has had an inadequate response to two or more disease-modifying drugs indicated for multiple sclerosis despite adequate duration of treatment.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Immune checkpoint inhibitor-related toxicities: 3 months, All other: Plan Year
<b>Other Criteria</b>	-

# HEALTH | CHOICE

GENERATIONS

<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, including patients with brain metastases, who have received one or more lines of prior HER2-targeted therapy in the metastatic setting.
<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>Prior Authorization Group</b>	TURALIO
<b>Drug Names</b>	TURALIO
<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>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>	The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to one triptan 5-HT1 receptor agonist.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	UCERIS
<b><i>Drug Names</i></b>	BUDESONIDE ER
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one 5-aminosalicylic acid (5-ASA) therapy.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	2 months
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	V-GO
<b><i>Drug Names</i></b>	V-GO 20, V-GO 30, V-GO 40
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	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><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	For continuation of therapy with an insulin pump, the patient has stable or improved glycemic control.

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	VALCHLOR
<b><i>Drug Names</i></b>	VALCHLOR
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Chronic or smoldering adult T-cell leukemia/lymphoma, Stage 2 or higher mycosis fungoides/Sezary syndrome, primary cutaneous marginal zone lymphoma, primary cutaneous follicle center lymphoma, lymphomatoid papulosis.
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	VELCADE
<b><i>Drug Names</i></b>	BORTEZOMIB, VELCADE
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Systemic light chain amyloidosis, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, multicentric Castleman's disease, adult T-cell leukemia/lymphoma, acute lymphoblastic leukemia, AIDS-related Kaposi's sarcoma, Hodgkin lymphoma, POEMS syndrome
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></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.

# HEALTH | CHOICE

GENERATIONS

<b>Prior Authorization Group</b>	VEMLIDY
<b>Drug Names</b>	VEMLIDY
<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>	For chronic hepatitis B virus infection, the requested drug will be used in a patient who meets either of the following (new starts only): 1) inadequate virologic response or intolerable adverse event to tenofovir disoproxil fumarate OR 2) bone loss and mineralization defects or is at risk for bone loss and mineralization defects (for example, history of fragility fractures, advanced age, frailty, chronic glucocorticoid use, low T-scores, or increased fall risk).
<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), AML in patients 60 physiologic years of age or older.
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For acute myeloid leukemia (AML), any of the following criteria must be met: 1) the patient's physiologic age is 60 years of age or older OR 2) the requested drug will be used as a component of repeating the initial successful induction regimen if late relapse OR 3) the patient has comorbidities that preclude use of intensive induction chemotherapy OR 4) the requested drug will be used for relapsed or refractory disease. For blastic plasmacytoid dendritic cell neoplasm (BPDCN), any of the following criteria must be met: 1) patient has systemic disease treated with palliative intent OR 2) patient has relapsed or refractory disease. For multiple myeloma, all of the following must be met: 1) the disease is relapsed or progressive AND 2) the requested drug will be used in combination with dexamethasone AND 3) patient has t(11:14) translocation.
<b>Age Restrictions</b>	-
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-



# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	VENTAVIS
<b><i>Drug Names</i></b>	VENTAVIS
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For pulmonary arterial hypertension (World Health Organization [WHO] Group 1), 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 3 Wood units.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></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><i>Prior Authorization Group</i></b>	VERSACLOZ
<b><i>Drug Names</i></b>	VERSACLOZ
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></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), 1) the patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following generic products: A) aripiprazole, B) asenapine, C) olanzapine, D) quetiapine, E) risperidone, F) ziprasidone AND 2) The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following brand products: A) Latuda, B) Rexulti, C) Secuado, D) Vraylar.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	VERZENIO
<b><i>Drug Names</i></b>	VERZENIO
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Recurrent hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative breast cancer in combination with fulvestrant or an aromatase inhibitor, or as a single agent if progression on prior endocrine therapy and prior chemotherapy in the metastatic setting.
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	VIGABATRIN
<b><i>Drug Names</i></b>	VIGABATRIN, VIGADRONE
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For complex partial seizures (CPS): patient had an inadequate response to at least 2 antiepileptic drugs for CPS.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	VITRAKVI
<b><i>Drug Names</i></b>	VITRAKVI
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Advanced, recurrent, or persistent neurotrophic tyrosine receptor kinase (NTRK) gene fusion-positive solid tumors, first-line treatment of NTRK gene fusion-positive solid tumors.
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For all neurotrophic tyrosine receptor kinase (NTRK) gene fusion-positive solid tumors, the disease is without a known acquired resistance mutation.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	VIZIMPRO
<b><i>Drug Names</i></b>	VIZIMPRO
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Recurrent or advanced non-small cell lung cancer (NSCLC).
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For non-small cell lung cancer (NSCLC): 1) the disease is recurrent, advanced or metastatic, and 2) the patient has sensitizing EGFR mutation-positive disease.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	VONJO
<b><i>Drug Names</i></b>	VONJO
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

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<b><i>Prior Authorization Group</i></b>	VORICONAZOLE
<b><i>Drug Names</i></b>	VORICONAZOLE
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	The patient will use the requested drug orally or intravenously.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	6 months
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	VOSEVI
<b><i>Drug Names</i></b>	VOSEVI
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	Decompensated cirrhosis/moderate or severe hepatic impairment (Child Turcotte Pugh class B or C)
<b><i>Required Medical Information</i></b>	For hepatitis C: 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 HIV coinfection, presence or absence of resistance-associated substitutions where applicable, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Criteria will be applied consistent with current AASLD-IDSa guidance.
<b><i>Other Criteria</i></b>	-

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<b><i>Prior Authorization Group</i></b>	VOTRIENT
<b><i>Drug Names</i></b>	VOTRIENT
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Thyroid carcinoma (follicular, papillary, Hurthle cell, or medullary), uterine sarcoma.
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For renal cell carcinoma: The disease is advanced, relapsed, or stage IV. For soft tissue sarcoma (STS): The patient does not have an adipocytic soft tissue sarcoma. For uterine sarcoma: The disease is recurrent or metastatic.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	WELIREG
<b><i>Drug Names</i></b>	WELIREG
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	XALKORI
<b><i>Drug Names</i></b>	XALKORI
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Recurrent non-small cell lung cancer (NSCLC), NSCLC with high-level MET amplification or MET exon 14 skipping mutation, inflammatory myofibroblastic tumors (IMT).
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For NSCLC, the requested drug is used in any of the following settings: 1) the patient has recurrent, advanced or metastatic ALK-positive NSCLC, 2) the patient has recurrent, advanced or metastatic ROS-1 positive NSCLC, or 3) the patient has NSCLC with high-level MET amplification or MET exon 14 skipping mutation. For IMT, the disease is ALK-positive. For anaplastic large cell lymphoma, the disease is relapsed or refractory and ALK-positive.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	XELJANZ
<b><i>Drug Names</i></b>	XELJANZ, XELJANZ XR
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For moderately to severely active rheumatoid arthritis (new starts only): patient has experienced an inadequate treatment response or intolerance to at least one tumor necrosis factor (TNF) inhibitor. For active psoriatic arthritis (new starts only): 1) Patient has experienced an inadequate treatment response or intolerance to at least one TNF inhibitor AND 2) The requested drug is used in combination with a nonbiologic DMARD. For moderately to severely active ulcerative colitis (new starts only): Inadequate response, intolerance or contraindication to a tumor necrosis factor (TNF) blocker.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

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<b><i>Prior Authorization Group</i></b>	XERMELO
<b><i>Drug Names</i></b>	XERMELO
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	XGEVA
<b><i>Drug Names</i></b>	XGEVA
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For hypercalcemia of malignancy: condition is refractory to intravenous (IV) bisphosphonate therapy or there is a clinical reason to avoid IV bisphosphonate therapy.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></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.

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<b><i>Prior Authorization Group</i></b>	XIFAXAN
<b><i>Drug Names</i></b>	XIFAXAN
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	1) The requested drug is being prescribed to reduce the risk of overt hepatic encephalopathy (HE) recurrence OR 2) The patient has the diagnosis of irritable bowel syndrome with diarrhea (IBS-D) AND 3) If the patient has previously received treatment with the requested drug, the patient has experienced a recurrence of symptoms AND 4) 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 OR 5) The patient has not previously received treatment with the requested drug.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Reduction in risk of overt HE recurrence: 6 months, IBS-D: 14 days
<b><i>Other Criteria</i></b>	-



<b>Prior Authorization Group</b>	XOLAIR
<b>Drug Names</b>	XOLAIR
<b>PA Indication Indicator</b>	All FDA-approved Indications
<b>Off-label Uses</b>	-
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For allergic asthma initial therapy: 1) Patient has positive skin test (or blood test) to at least 1 perennial aeroallergen, 2) Patient has baseline IgE level greater than or equal to 30 IU/mL, and 3) Patient has inadequate asthma control despite current treatment with both of the following medications at optimized doses: a) Inhaled corticosteroid, and b) Additional controller (long acting beta2-agonist, leukotriene modifier, or sustained-release theophylline) unless patient has an intolerance or contraindication to such therapies. For allergic asthma continuation therapy only: Patient's asthma control has improved on treatment with the requested drug since initiation of therapy. For chronic idiopathic urticaria (CIU) initial therapy: 1) Patient has been evaluated for other causes of urticaria, including bradykinin-related angioedema and IL-1-associated urticarial syndromes (auto-inflammatory disorders, urticarial vasculitis), and 2) Patient has experienced a spontaneous onset of wheals, angioedema, or both, for at least 6 weeks. For CIU continuation therapy: Patient has experienced a response (e.g., improved symptoms) since initiation of therapy.
<b>Age Restrictions</b>	For CIU: 12 years of age or older. For allergic asthma: 6 years of age or older. For nasal polyps: 18 years of age or older.
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Allergic asthma and nasal polyps: Plan Year. CIU initial: 6 months. CIU continuation: Plan Year
<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
<b>Exclusion Criteria</b>	-
<b>Required Medical Information</b>	For myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and FLT3 rearrangement: the disease is in chronic or blast phase.
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	-
<b>Coverage Duration</b>	Plan Year
<b>Other Criteria</b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	XPOVIO
<b><i>Drug Names</i></b>	XPOVIO, XPOVIO 100 MG ONCE WEEKLY, XPOVIO 40 MG ONCE WEEKLY, XPOVIO 40 MG TWICE WEEKLY, XPOVIO 60 MG ONCE WEEKLY, XPOVIO 60 MG TWICE WEEKLY, XPOVIO 80 MG ONCE WEEKLY, XPOVIO 80 MG TWICE WEEKLY
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	XTANDI
<b><i>Drug Names</i></b>	XTANDI
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	The requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	XYREM
<b><i>Drug Names</i></b>	XYREM
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	1) The requested drug is being prescribed for the treatment of excessive daytime sleepiness in a patient 7 years of age or older with narcolepsy AND 2) The diagnosis has been confirmed by sleep lab evaluation AND 3) The patient experienced an inadequate treatment response or intolerance to at least one central nervous system (CNS) stimulant drug (e.g., amphetamine, dextroamphetamine, or methylphenidate) OR has a contraindication that would prohibit a trial of central nervous system (CNS) stimulant drugs (e.g., amphetamine, dextroamphetamine, or methylphenidate) [Note: Coverage of amphetamines may require prior authorization.] AND 4) If the patient is 18 years of age or older, the patient experienced an inadequate treatment response or intolerance to at least one central nervous system (CNS) wakefulness promoting drug (e.g., armodafinil) OR has a contraindication that would prohibit a trial of central nervous system (CNS) wakefulness promoting drugs (e.g., armodafinil) [Note: coverage of armodafinil may require prior authorization.] OR 5) The requested drug is being prescribed for the treatment of cataplexy in a patient 7 years of age or older with narcolepsy AND 6) The diagnosis has been confirmed by sleep lab evaluation.
<b><i>Age Restrictions</i></b>	7 years of age or older
<b><i>Prescriber Restrictions</i></b>	Prescribed by or in consultation with a sleep disorder specialist or neurologist.
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	If the request is for a continuation of therapy, then the patient experienced a decrease in daytime sleepiness with narcolepsy or a decrease in cataplexy episodes with narcolepsy.

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<b><i>Prior Authorization Group</i></b>	ZARXIO
<b><i>Drug Names</i></b>	ZARXIO
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Neutropenia in myelodysplastic syndromes (MDS), agranulocytosis, neutropenia in aplastic anemia, human immunodeficiency virus (HIV)-related neutropenia, neutropenia related to renal transplant.
<b><i>Exclusion Criteria</i></b>	Use of the requested product within 24 hours prior to or following chemotherapy.
<b><i>Required Medical Information</i></b>	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><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	6 months
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	ZEJULA
<b><i>Drug Names</i></b>	ZEJULA
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	In combination with bevacizumab for persistent or recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer for platinum-sensitive disease.
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For ovarian, fallopian tube, or primary peritoneal cancer, the requested drug is used in any of the following settings: 1) as maintenance treatment of stage II-IV epithelial ovarian, fallopian tube, or primary peritoneal cancer in patients who are in a complete or partial response to first-line platinum-based chemotherapy AND if it is known that the patient has breast cancer susceptibility gene (BRCA)-mutated disease, the patient experienced an unacceptable toxicity with a trial of Lynparza (olaparib), 2) as maintenance treatment of recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer in patients who are in a complete or partial response to chemotherapy AND the patient experienced an unacceptable toxicity with a trial of Lynparza (olaparib), 3) as treatment of advanced, persistent, or recurrent ovarian, fallopian tube, or primary peritoneal cancer in patients treated with three or more prior chemotherapy regimens and whose cancer is associated with homologous recombination deficiency (HRD) positive status defined by either a) a deleterious or suspected deleterious BRCA mutation AND if prescribed for advanced, persistent, or recurrent ovarian cancer with deleterious or suspected deleterious germline BRCA mutation, the patient experienced an unacceptable toxicity with a trial of Lynparza (olaparib), or b) genomic instability and progression more than six months after response to the last platinum-based chemotherapy, or 4) in combination with bevacizumab for platinum-sensitive persistent or recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	ZELBORAF
<b><i>Drug Names</i></b>	ZELBORAF
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Non-small cell lung cancer, hairy cell leukemia, thyroid carcinoma (i.e., papillary carcinoma, follicular carcinoma, and Hurthle cell carcinoma), central nervous system cancer (i.e., glioma, meningioma, astrocytoma), adjuvant systemic therapy for cutaneous melanoma.
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For adjuvant treatment of melanoma, and central nervous system (CNS) cancer (i.e., glioma, meningioma, astrocytoma): 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 cobimetinib. For unresectable or metastatic 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 (with or without atezolizumab). For Erdheim-Chester Disease: Tumor is positive for BRAF V600 mutation. For non-small cell lung cancer: 1) Tumor is positive for the BRAF V600E mutation, and 2) The patient has recurrent, advanced, or metastatic disease. For thyroid carcinoma: 1) Tumor is positive for BRAF mutation, and 2) Patient has radioiodine refractory follicular, Hurthle cell, or papillary thyroid carcinoma. For hairy cell leukemia: The requested drug will be used for subsequent therapy.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

# HEALTH | CHOICE

GENERATIONS

<b><i>Prior Authorization Group</i></b>	ZIRABEV
<b><i>Drug Names</i></b>	ZIRABEV
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Breast cancer, central nervous system (CNS) tumor types: adult low-grade (WHO Grade II) infiltrative supratentorial astrocytoma/oligodendroglioma, adult intracranial and spinal ependymoma, anaplastic gliomas, adult medulloblastoma, primary central nervous system lymphoma, meningiomas, limited and extensive brain metastases, metastatic spine tumors, malignant pleural mesothelioma, epithelial ovarian cancer/fallopian tube cancer/primary peritoneal cancer, including the following cancer types: carcinosarcoma (malignant mixed Mullerian tumors), clear cell carcinoma, mucinous carcinoma, grade 1 endometrioid carcinoma, low-grade serous carcinoma, ovarian borderline epithelial tumors (low malignant potential) with invasive implants, and malignant sex cord-stromal tumors, soft tissue sarcoma types: angiosarcoma and solitary fibrous tumor/hemangiopericytoma, uterine neoplasms, endometrial carcinoma, vulvar squamous cell carcinoma, 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, hepatocellular carcinoma, small bowel adenocarcinoma.
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></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><i>Prior Authorization Group</i></b>	ZOLINZA
<b><i>Drug Names</i></b>	ZOLINZA
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Mycosis fungoides, Sezary syndrome.
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

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<b><i>Prior Authorization Group</i></b>	ZONISADE
<b><i>Drug Names</i></b>	ZONISADE
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></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><i>Age Restrictions</i></b>	16 years of age or older
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	ZTALMY
<b><i>Drug Names</i></b>	ZTALMY
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications
<b><i>Off-label Uses</i></b>	-
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	2 years of age or older
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-



# HEALTH | CHOICE

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<b><i>Prior Authorization Group</i></b>	ZYDELIG
<b><i>Drug Names</i></b>	ZYDELIG
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Relapsed or refractory chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL), relapsed or refractory follicular lymphoma, and marginal zone lymphomas [nodal marginal zone lymphoma, gastric mucosa associated lymphoid tissue (MALT) lymphoma, non-gastric MALT lymphoma, and splenic marginal zone lymphoma].
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	-
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-
<b><i>Prior Authorization Group</i></b>	ZYKADIA
<b><i>Drug Names</i></b>	ZYKADIA
<b><i>PA Indication Indicator</i></b>	All FDA-approved Indications, Some Medically-accepted Indications
<b><i>Off-label Uses</i></b>	Recurrent or advanced ALK-positive non-small cell lung cancer (NSCLC), recurrent, advanced, or metastatic ROS1-positive NSCLC, inflammatory myofibroblastic tumor (IMT), brain metastases from NSCLC.
<b><i>Exclusion Criteria</i></b>	-
<b><i>Required Medical Information</i></b>	For NSCLC: the patient has recurrent, advanced, or metastatic ALK-positive or ROS1-positive disease. For inflammatory myofibroblastic tumor: the disease is ALK-positive. For brain metastases from NSCLC: the patient has ALK-positive NSCLC.
<b><i>Age Restrictions</i></b>	-
<b><i>Prescriber Restrictions</i></b>	-
<b><i>Coverage Duration</i></b>	Plan Year
<b><i>Other Criteria</i></b>	-

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<i>Prior Authorization Group</i>	ZYPREXA RELPREVV
<i>Drug Names</i>	ZYPREXA RELPREVV
<i>PA Indication Indicator</i>	All FDA-approved Indications
<i>Off-label Uses</i>	-
<i>Exclusion Criteria</i>	-
<i>Required Medical Information</i>	Tolerability with oral olanzapine has been established.
<i>Age Restrictions</i>	-
<i>Prescriber Restrictions</i>	-
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	-