MASSACHUSETTS

MEDICARE HMO BLUE℠ (HMO)
MEDICARE PPO BLUE℠ (PPO)

2020 PRIOR AUTHORIZATION CRITERIA FOR

MEDICARE HMO BLUE℠ (HMO)
MEDICARE PPO BLUE℠ (PPO)

Definition of Prior Authorization

For certain drugs your doctor or health care provider will need to contact us before you fill your prescription.

The following list of Prescription Drugs are subject to the Prior Authorization.

Blue Cross and Blue Shield of Massachusetts is an HMO and PPO Plan with a Medicare contract.
Enrollment in Blue Cross Blue Shield of Massachusetts depends on contract renewal.

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association.

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ABIRATERONE ACETATE (ZYTIGA)

Products Affected

- abiraterone
- Zytiga oral tablet 500 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ACTEMRA

Products Affected

- Actemra

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid arthritis: failure/contraindication to two of the following: Enbrel, Humira, Orencia, Rinvoq, or Xeljanz. Systemic/polyarticular juvenile idiopathic arthritis: failure/contraindication to two of the following: Enbrel, Humira or Orencia.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a rheumatologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ADAKVEO

Products Affected

- Adakveo

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ADEMPAS

Products Affected

- Adempas

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) WHO Group 1, patients who are not currently taking Adempas or another agent indicated for WHO Group 1 PAH: previous right-heart catheterization to confirm the diagnosis of PAH to ensure appropriate medical assessment. PAH WHO Group 1, patients currently on Adempas or another agent indicated for WHO Group 1 PAH: may continue therapy without confirmation of a right-heart catheterization.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a cardiologist, or a pulmonologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ADVAIR

Products Affected

- Advair HFA

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For a diagnosis of asthma: Previous treatment/contraindication with Dulera or Symbicort.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

AFINITOR

Products Affected

- everolimus (antineoplastic)

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a nephrologist, neurologist, or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

AIMOVIG

Products Affected

- Aimovig Autoinjector

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For a diagnosis of migraine headache: Documentation that the requested medication is being used for migraine prophylaxis and previous treatment with or contraindication to 2 generic migraine prophylactic medications including: beta blockers, topiramate, divalproex sodium, non-steroidal anti-inflammatories, and serotonin receptor agonists.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ALECENSA

Products Affected

- Alecensa

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history. Non-Small Cell Lung Cancer: Documented diagnosis of Non-Small Cell Lung Cancer for the treatment of anaplastic lymphoma kinase (ALK)-positive, metastatic non-small cell lung cancer (NSCLC) as detected by an approved test.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist or pulmonologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ALGLUCERASE

Products Affected

- Cerezyme intravenous recon soln 400 unit

PA Criteria	Criteria Details
Exclusion Criteria	We do not cover Alglucerase therapy for patients who have Gaucher disease but do not have at least a minimal level of disease severity, because treatment has not been proven to improve health outcomes for patients without signs or symptoms of disease. We do not cover Alglucerase therapy for patients who have Type 2 or Type 3 Gaucher disease, because alglucerase therapy has not been proven to improve the nerve problems associated with these types of Gaucher disease.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ALPHA-1 ANTITRYPSIN

Products Affected

- Aralast NP intravenous recon soln
- Glassia
- Prolastin-C intravenous recon soln
- Prolastin-C intravenous solution

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Alpha-1 antitrypsin plasma levels less than 80mg/dL (11 umol/L) and FEV1/FVC less than 70%
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ALUNBRIG

Products Affected

- Alunbrig

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist or pulmonologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

AMBRISENTAN

Products Affected

- ambrisentan

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) WHO Group 1, patients who are not currently taking ambrisentan or another agent indicated for WHO Group 1 PAH: previous right-heart catheterization to confirm the diagnosis of PAH to ensure appropriate medical assessment. PAH WHO Group 1, patients currently on ambrisentan or another agent indicated for WHO Group 1 PAH: may continue therapy without confirmation of a right-heart catheterization.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a cardiologist, or a pulmonologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ANABOLIC STEROIDS

Products Affected

- Anadrol-50
- oxandrolone

PA Criteria	Criteria Details
Exclusion Criteria	Weight gain for cosmetic reasons.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ARIKAYCE

Products Affected

- Arikayce

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with an infectious disease physician, or a pulmonologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ARMODAFINIL

Products Affected

- armodafinil

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	A documented diagnosis of Narcolepsy, Obstructive Sleep Apnea, or Shift Work Sleep Disorder.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

AUBAGIO

Products Affected

- Aubagio

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	The patient has a documented diagnosis of a relapsing form of Multiple Sclerosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist or MS specialist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

AYVAKIT

Products Affected

- Ayvakit

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a gastroenterologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

BALVERSA

Products Affected

- Balversa

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist or urologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

BOSENTAN

Products Affected

- bosentan
- Tracleer oral tablet for suspension

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) WHO Group 1, patients who are not currently taking bosentan or another agent indicated for WHO Group 1 PAH: previous right-heart catheterization to confirm the diagnosis of PAH to ensure appropriate medical assessment. PAH WHO Group 1, patients currently on bosentan or another agent indicated for WHO Group 1 PAH: may continue therapy without confirmation of a right-heart catheterization.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a cardiologist or a pulmonologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

BOSULIF

Products Affected

- Bosulif

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

BOTOX

Products Affected

- Botox

PA Criteria	Criteria Details
Exclusion Criteria	Botox will not be approved if used for cosmetic reasons.
Required Medical Information	For a diagnosis of migraine headache: episodes of migraine greater than or equal to 15 days per month with duration of greater than or equal to 4 hours per day and previous treatment with or contraindication to 2 migraine prophylactic medications including: beta blockers, topiramate, divalproex sodium, non-steroidal anti-inflammatories, and serotonin receptor agonists.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

BRUKINSA

Products Affected

- Brukinsa

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

CABOMETYX

Products Affected

- Cabometyx

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an endocrinologist, hepatologist, nephrologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

CALQUENCE

Products Affected

- Calquence

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

CAPRELSA

Products Affected

- Caprelsa

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an endocrinologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

CHORIONIC GONADOTROPINS (HCG)

Products Affected

- chorionic gonadotropin, human
- Novarel

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

CIMZIA

Products Affected

- Cimzia
- Cimzia Powder for Reconst

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Crohn's disease: failure/contraindication to Humira and Stelara. Rheumatoid arthritis: failure/contraindication to two of the following: Enbrel, Humira, Orencia, Rinvoq, or Xeljanz. Psoriatic arthritis: failure/contraindication to two of the following: Cosentyx, Enbrel, Humira, Orencia, Otezla, Stelara, or Xeljanz. Ankylosing Spondylitis: failure/contraindication to two of the following: Cosentyx, Enbrel, or Humira. Plaque Psoriasis: failure/contraindication to two of the following: Cosentyx, Enbrel, Humira, Otezla, Skyrizi, or Stelara.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a rheumatologist, gastroenterologist, or dermatologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

CLOMIPHENE

Products Affected

- clomiphene

PA Criteria	Criteria Details
Exclusion Criteria	Coverage is not provided for infertility treatment.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

COMETRIQ

Products Affected

- Cometriq

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an endocrinologist, hepatologist, nephrologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

COPIKTRA

Products Affected

- Copiktra

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

CORLANOR

Products Affected

- Corlanor

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, medical history, medication use.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

COSENTYX

Products Affected

- Cosentyx (2 Syringes)
- Cosentyx Pen (2 Pens)

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a dermatologist or rheumatologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

COTELLIC

Products Affected

- Cotellic

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a dermatologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

DAKLINZA

Products Affected

- Daklinza oral tablet 30 mg, 60 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Hep C genotype, concurrent medications, medication history.
Age Restrictions	18 years of age and older.
Prescriber Restrictions	Prescribed by, or in consultation with a gastroenterologist, hepatologist, infectious disease physician, or a liver transplant physician.
Coverage Duration	Authorizations will be approved according to the AASLD/IDSA treatment guidelines.
Other Criteria	For genotype 1, patients must have a trial with Epclusa or Harvoni unless Epclusa and Harvoni are not specifically listed as an alternative therapy for a specific patient population in the guidelines. For genotype 3, patients must have a trial with Epclusa unless Epclusa is not specifically listed as an alternative therapy for a specific patient population in the guidelines.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

DALFAMPRIDINE

Products Affected

- dalfampridine

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

DAURISMO

Products Affected

- Daurismo

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

DUPIXENT

Products Affected

- Dupixent

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Asthma: Documentation that Dupixent is being used as add-on maintenance treatment of patients with moderate to severe asthma with an eosinophilic phenotype or with oral corticosteroid dependent asthma. Atopic dermatitis: A documented diagnosis of moderate-to-severe atopic dermatitis whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable. Rhinosinusitis: Documentation that Dupixent is being used as an add-on maintenance treatment in adult patients with inadequately controlled chronic rhinosinusitis with nasal polyposis.
Age Restrictions	Asthma: 12 years of age and older. Atopic dermatitis: 12 years of age and older. Rhinosinusitis: 18 years of age and older.
Prescriber Restrictions	Prescribed by, or in consultation with, an allergist, immunologist, dermatologist, ENT specialist, or pulmonologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

DYSPORT

Products Affected

- Dysport

PA Criteria	Criteria Details
Exclusion Criteria	Dysport will not be approved if used for cosmetic reasons.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

EGRIFTA

Products Affected

- Egrifta

PA Criteria	Criteria Details
Exclusion Criteria	Weight loss management.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

EMGALITY

Products Affected

- Emgality Pen
- Emgality Syringe subcutaneous syringe 100 mg/mL, 120 mg/mL

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For a diagnosis of migraine headache: Documentation that the requested medication is being used for migraine prophylaxis and previous treatment with or contraindication to 2 generic migraine prophylactic medications including: beta blockers, topiramate, divalproex sodium, non-steroidal anti-inflammatories, and serotonin receptor agonists.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ENBREL

Products Affected

- Enbrel mini
- Enbrel subcutaneous recon soln
- Enbrel subcutaneous syringe
- Enbrel SureClick

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a dermatologist or rheumatologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ENTYVIO

Products Affected

- Entyvio

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Adult Crohn's disease: failure/contraindication to Humira and Stelara. Adult Ulcerative Colitis: failure/contraindication to one of the following: Humira, Stelara or Xeljanz/Xeljanz XR.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a gastroenterologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

EPCLUSA

Products Affected

- Epclusa

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Hepatitis C genotype, concurrent medications, medication history.
Age Restrictions	6 years of age and older.
Prescriber Restrictions	Prescribed by, or in consultation with a gastroenterologist, hepatologist, infectious disease physician, or a liver transplant physician.
Coverage Duration	Authorizations will be approved according to the AASLD/IDSA treatment guidelines.
Other Criteria	For genotype 4, patients must have a trial with Harvoni unless Harvoni is not specifically listed as an alternative therapy for a specific patient population in the guidelines.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ERIVEDGE

Products Affected

- Erivedge

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a dermatologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ERLEADA

Products Affected

- Erleada

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ERLOTINIB

Products Affected

- erlotinib

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history. Non-Small Cell Lung Cancer: Documented diagnosis of Non-Small Cell Lung Cancer for the treatment of metastatic non-small cell lung cancer (NSCLC) in tumors with epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations as detected by an approved test either as first-line, maintenance, or as second or greater line treatment after progression following at least 1 prior chemotherapy regimen.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist, nephrologist or pulmonologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ERYTHROPOIETIN

Products Affected

- Retacrit

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Current hemoglobin level within the previous 30 days less than or equal to 10g/dL. Anemic surgical patients must meet the following criteria: surgery must be elective, non-cardiac, and non-vascular, target hemoglobin level between 10 and 13 g/dL, and not willing to donate blood.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	Part B versus Part D determination will be made at time of prior authorization review per CMS guidance to establish if the drug prescribed is to be used for an End-Stage Renal Disease (ESRD)-related condition.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Anemia due to ribavirin therapy in the treatment of Hepatitis C and Myelodysplastic Syndromes.

ESBRIET

Products Affected

- Esbriet

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	A documented diagnosis of Idiopathic Pulmonary Fibrosis.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by, or in consultation with, a pulmonologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

EVENITY

Products Affected

- Evenity

PA Criteria	Criteria Details
Exclusion Criteria	Duration of use for Evenity is limited to 12 monthly doses.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorizations will be approved for 12 months of therapy.
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

FARYDAK

Products Affected

- Farydak

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

FASENRA

Products Affected

- Fasenra

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation that Fasenra is being used as add-on maintenance treatment of patients with severe asthma with an eosinophilic phenotype.
Age Restrictions	12 years of age and older
Prescriber Restrictions	Prescribed by, or in consultation with an allergist, immunologist, or pulmonologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

FENTANYL, ORAL TRANSMUCOSAL

Products Affected

- fentanyl citrate buccal lozenge on a handle

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	We cover Fentanyl, oral/transmucosal when the patient is already receiving and is tolerant to other opioids. Opioid tolerance defined as taking one or more of the following medications at or above the listed doses for at least one week: oral morphine 60mg/day, transdermal fentanyl 25mcg/hr, oral hydromorphone 8mg/day or any equianalgesic dose of another opioid.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

GALAFOLD

Products Affected

- Galafold

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Fabry disease: a confirmed diagnosis of Fabry disease and an amenable galactosidase alpha gene (GLA) variant based on in vitro assay data.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

GAMIFANT

Products Affected

- Gamifant

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

GATTEX

Products Affected

- Gattex 30-Vial

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

GILENYA

Products Affected

- Gilenya oral capsule 0.5 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	The patient has a documented diagnosis of a relapsing form of Multiple Sclerosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist or MS specialist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

GILOTRIF

Products Affected

- Gilotrif

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history. Non-Small Cell Lung Cancer: Documented diagnosis of Non-Small Cell Lung Cancer for first-line treatment of metastatic non-small cell lung cancer (NSCLC) in patients whose tumors have nonresistant epidermal growth factor receptor (EGFR) mutations as detected by an approved test, or for the treatment of previously treated metastatic squamous cell NSCLC that has progressed following platinum-based chemotherapy.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist or pulmonologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

GIVLAARI

Products Affected

- Givlaari

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

GROWTH HORMONE

Products Affected

- Omnitrope
- Serostim subcutaneous recon soln 4 mg, 5 mg, 6 mg
- Zorbtive

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

GROWTH HORMONE (INSULIN LIKE GROWTH FACTOR)

Products Affected

- Increlex

PA Criteria	Criteria Details
Exclusion Criteria	We do not cover Insulin like Growth Factor for secondary forms of IGF-1 deficiency to include (but not limited to): GH deficiency, malnutrition, hypothyroidism, or for chronic treatment with pharmacologic doses of anti-inflammatory steroids.
Required Medical Information	Height standard deviation score less than or equal to -3 for age and sex, basal IGF-1 standard deviation score less than or equal to -3 for age and sex, and normal or elevated growth hormone (defined as stimulated serum GH peak level of greater than 10 ng/ml or basal (unstimulated) serum GH level greater than 5ng/ml).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

HARVONI

Products Affected

- Harvoni

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Hepatitis C genotype, concurrent medications, medication history.
Age Restrictions	3 years of age and older.
Prescriber Restrictions	Prescribed by, or in consultation with a gastroenterologist, hepatologist, infectious disease physician, or a liver transplant physician.
Coverage Duration	Authorizations will be approved according to the AASLD/IDSA treatment guidelines.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

HETLIOZ

Products Affected

- Hetlioz

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documented diagnosis of blindness.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

HIGH RISK MEDICATIONS - BARBITURATES

Products Affected

- Ascomp with Codeine
- Butalbital Compound W/Codeine
- butalbital-acetaminop-caf-cod
- butalbital-acetaminophen
- butalbital-acetaminophen-caff oral capsule
- butalbital-acetaminophen-caff oral tablet 50-325-40 mg
- butalbital-aspirin-caffeine oral capsule
- butalbital-aspirin-caffeine oral capsule with codeine
- Phrenilin Forte(with caffeine)
- seconal sodium
- Tencon oral tablet 50-325 mg
- Zebutal oral capsule 50-325-40 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Additionally, the physician must have assessed risk versus benefit in prescribing the requested HRM for the patient and must confirm that he/she would still like to initiate/continue therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

HIGH RISK MEDICATIONS - BENZODIAZEPINES

Products Affected

- alprazolam
- Alprazolam Intensol
- amitriptyline-chlordiazepoxide
- chlordiazepoxide HCl
- clobazam
- clorazepate dipotassium
- diazepam injection
- diazepam intensol
- diazepam oral concentrate
- diazepam oral solution 5 mg/5 mL (1 mg/mL)
- diazepam oral tablet
- estazolam
- flurazepam
- lorazepam injection solution
- lorazepam injection syringe
- lorazepam intensol
- lorazepam oral
- oxazepam
- Sympazan
- temazepam
- triazolam

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

HIGH RISK MEDICATIONS - FIRST GENERATION ANTIHISTAMINES

Products Affected

- diphenhydramine hcl oral elixir
- hydroxyzine HCl oral solution 10 mg/5 mL
- hydroxyzine HCl oral tablet
- hydroxyzine pamoate
- promethazine oral

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For promethazine tablets/syrup, authorize use without a previous drug trial for all FDA-approved indications other than emesis, including cancer/chemo-related emesis. For hydroxyzine hydrochloride (tablets and syrup) or hydroxyzine pamoate (capsules), authorize use without a previous drug trial for all FDA-approved indications other than anxiety. For the treatment of non-cancer/chemo related emesis, approve promethazine hydrochloride tablets or syrup if the patient has previous treatment/contraindication with at least one other prescription oral anti-emetic agent (ondansetron, granisetron, dolasetron, palonosetron, aprepitant). Approve hydroxyzine hydrochloride (tablets and syrup) or hydroxyzine pamoate (capsules) if the patient has previous treatment/contraindication with at least two other FDA-approved products for the management of anxiety. Approve hydroxyzine hydrochloride (tablets and syrup) or hydroxyzine pamoate (capsules) for pruritis due to allergic and dermatological conditions. Additionally, the physician must have assessed risk versus benefit in prescribing the requested HRM for the patient and must confirm that he/she would still like to initiate/continue therapy.

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

HIGH RISK MEDICATIONS - PHENOBARBITAL/PENTOBARBITAL

Products Affected

- phenobarbital

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Additionally, the physician must have assessed risk versus benefit in prescribing the requested HRM for the patient and must confirm that he/she would still like to initiate/continue therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

HIGH RISK MEDICATIONS - SKELETAL MUSCLE RELAXANTS

Products Affected

- carisoprodol
- carisoprodol-ASA-codeine
- carisoprodol-aspirin
- carisoprodol compound
- carisoprodol-CPD-codeine
- chlorzoxazone oral tablet
- cyclobenzaprine
- Metaxall
- metaxalone
- methocarbamol injection
- methocarbamol oral
- orphenad-ASA-caff
- orphenadrine citrate oral

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Additionally, the physician must have assessed risk versus benefit in prescribing the requested HRM for the patient and must confirm that he/she would still like to initiate/continue therapy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

HIGH RISK MEDICATIONS - TERTIARY TRICYCLIC ANTIDEPRESSANTS

Products Affected

- amitriptyline
- clomipramine
- doxepin oral
- imipramine HCl
- imipramine pamoate
- perphenazine-amitriptyline
- trimipramine

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Additionally, the physician must have assessed risk versus benefit in prescribing the requested HRM for the patient and must confirm that he/she would still like to initiate/continue therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

HUMIRA

Products Affected

- Humira Pediatric Crohns Start
- Humira Pen
- Humira Pen Crohns-UC-HS Start
- Humira Pen Psor-Uveits-Adol HS
- Humira subcutaneous syringe kit 10 mg/0.2 mL, 20 mg/0.4 mL, 40 mg/0.8 mL
- Humira(CF) Pedi Crohns Starter subcutaneous syringe kit 80 mg/0.8 mL, 80 mg/0.8 mL-40 mg/0.4 mL
- Humira(CF) Pen Crohns-UC-HS
- Humira(CF) Pen Psor-Uv-Adol HS
- HUMIRA(CF) PEN SUBCUTANEOUS INJECTOR KIT 40 MG/0.4 ML
- Humira(CF) subcutaneous syringe kit 10 mg/0.1 mL, 20 mg/0.2 mL, 40 mg/0.4 mL

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a rheumatologist, gastroenterologist, dermatologist, or ophthalmologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

IBRANCE

Products Affected

- Ibrance

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ICLUSIG

Products Affected

- Iclusig

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

IDHIFA

Products Affected

- Idhifa

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history. Acute Myeloid Leukemia: Documented diagnosis of Acute Myeloid Leukemia for the treatment of relapsed or refractory Acute Myeloid Leukemia (AML) in patients with an isocitrate dehydrogenase-2 (IDH2) mutation as detected by an approved test.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

INREBIC

Products Affected

- Inrebic

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ILARIS

Products Affected

- Ilaris

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Systemic juvenile idiopathic arthritis: failure/contraindication to two of the following: Enbrel, Humira, or Orencia.
Age Restrictions	N/A
Prescriber Restrictions	For Systemic Juvenile Idiopathic Arthritis: prescribed by, or in consultation with, a rheumatologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

IMBRUVICA

Products Affected

- Imbruvica

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist, oncologist, or transplant specialist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

INBRIJA

Products Affected

- Inbrija inhalation capsule, w/inhalation device

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	A documented diagnosis of Parkinson's disease and Inbrija must be used for the intermittent treatment of off episodes in patients treated with carbidopa/levodopa.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

INFLECTRA

Products Affected

- Inflectra

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis: taken with methotrexate and failure/contraindication to two of the following: Enbrel, Humira, Orencia, Rinvoq, or Xeljanz. Psoriatic Arthritis: failure/contraindication to two of the following: Cosentyx, Enbrel, Humira, Orencia, Otezla, Stelara, or Xeljanz. Adult Crohn's disease: failure/contraindication to Humira and Stelara. Adult Ulcerative Colitis: failure/contraindication to one of the following: Humira, Stelara or Xeljanz/Xeljanz XR. Ankylosing Spondylitis: failure/contraindication to two of the following: Cosentyx, Enbrel, or Humira. Plaque Psoriasis: failure/contraindication to two of the following: Cosentyx, Enbrel, Humira, Otezla, Skyrizi, or Stelara.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a rheumatologist, gastroenterologist, or dermatologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

INLYTA

Products Affected

- Inlyta

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a nephrologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

INTERFERONS (INTERFERON ALPHA)

Products Affected

- Intron A injection

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

INTERFERONS (INTERFERON GAMMA)

Products Affected

- Actimmune

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

INTERLEUKIN-S (IL-2)

Products Affected

- Proleukin

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

IRESSA

Products Affected

- Iressa

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history. Non-Small Cell Lung Cancer: Documented diagnosis of metastatic Non-Small Cell Lung Cancer (NSCLC), using as a first-line treatment in tumors with epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations as detected in tumors or plasma specimen by an approved test.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist or pulmonologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

IVIG

Products Affected

- Gammagard Liquid
- Gammagard S-D (IgA < 1 mcg/mL)
- Gamunex-C injection solution (10 %)

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Part B versus D determination per CMS guidance to establish if drug used for PID in patients home.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

JAKAFI

Products Affected

- Jakafi

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist, or transplant specialist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

JUXTAPID

Products Affected

- Juxtapid

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documented diagnosis of Homozygous Familial Hypercholesterolemia. Juxtapid must also be used as an adjunct to lipid lowering therapies unless the patient has a documented contraindication to lipid-lowering therapies.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a cardiologist, endocrinologist, or a physician who focuses in the treatment of CV risk management and/or lipid disorders.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

KADCYLA

Products Affected

- Kadcyla

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

KALYDECO

Products Affected

- Kalydeco oral granules in packet 25 mg, 50 mg, 75 mg
- Kalydeco oral tablet

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation of one mutation in the CFTR gene that is responsive to Kalydeco as confirmed by an FDA-cleared cystic fibrosis mutation test.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

KEVZARA

Products Affected

- Kevzara

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis: failure/contraindication to two of the following: Enbrel, Humira, Orencia, Rinvoq, or Xeljanz.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a rheumatologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

KEYTRUDA

Products Affected

- Keytruda

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a dermatologist, gastroenterologist, gynecologist, hematologist, hepatologist, oncologist, pulmonologist, or urologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

KINERET

Products Affected

- Kineret

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid arthritis: failure/contraindication to two of the following: Enbrel, Humira, Orencia, Rinvoq, or Xeljanz.
Age Restrictions	N/A
Prescriber Restrictions	For Rheumatoid Arthritis: prescribed by, or in consultation with, a rheumatologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

KISQALI

Products Affected

- Kisqali
- Kisqali Femara Co-Pack

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

KYNAMRO

Products Affected

- Kynamro

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documented diagnosis of Homozygous Familial Hypercholesterolemia. Kynamro must also be used as an adjunct to lipid lowering therapies unless the patient has a documented contraindication to lipid-lowering therapies.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a cardiologist, endocrinologist, or a physician who focuses in the treatment of CV risk management and/or lipid disorders.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

KORLYM

Products Affected

- Korlym

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

LENVIMA

Products Affected

- Lenvima

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an endocrinologist, hepatologist, nephrologist, or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

LIBTAYO

Products Affected

- Libtayo

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a dermatologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

LIDOCAINE

Products Affected

- lidocaine topical adhesive patch,medicated

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off-Label Uses	Diabetic neuropathic pain.

LONG ACTING OPIOIDS

Products Affected

- buprenorphine transdermal patch weekly 10 mcg/hour, 15 mcg/hour, 20 mcg/hour, 5 mcg/hour
- hydrocodone bitartrate
- hydromorphone oral tablet extended release 24 hr
- methadone intensol
- methadone oral concentrate
- methadone oral solution
- methadone oral tablet
- methadose oral concentrate
- morphine oral capsule, ER multiphase 24 hr
- morphine oral capsule,extend.release pellets
- morphine oral tablet extended release
- oxycodone oral tablet,oral only,ext.rel.12 hr
- OxyContin oral tablet,oral only,ext.rel.12 hr
- oxymorphone oral tablet extended release 12 hr
- tramadol oral tablet extended release 24 hr
- tramadol oral tablet, ER multiphase 24 hr

PA Criteria	Criteria Details
Exclusion Criteria	Acute (i.e., non-chronic) pain
Required Medical Information	Pain type (chronic vs acute), prior pain medications/therapies tried, concurrent pain medications/therapies
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For pain severe enough to require daily, around-the-clock, long-term opioid treatment (with no cancer diagnosis, not in long term care facility and not in hospice), approve if all of the following criteria are met: 1) patient is not opioid naive, AND 2) non-opioid therapies have been optimized and are being used in conjunction with opioid therapy according to the prescribing physician, AND 3) the prescribing physician has checked the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP), AND 4) the prescribing physician has discussed risks (e.g., addiction, overdose) and realistic benefits of opioid therapy with the patient, AND 5) according to the prescribing physician there is a treatment plan (including goals for pain and function) in place and reassessments are scheduled at regular intervals.

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

LONSURF

Products Affected

- Lonsurf

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a gastroenterologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

LORBRENA

Products Affected

- Lorbrena

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist or pulmonologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

LUMOXITI

Products Affected

- Lumoxiti

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

LYNPARZA

Products Affected

- Lynparza

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a gynecologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

MAVENCLAD

Products Affected

- Mavenclad (10 tablet pack)
- Mavenclad (4 tablet pack)
- Mavenclad (5 tablet pack)
- Mavenclad (6 tablet pack)
- Mavenclad (7 tablet pack)
- Mavenclad (8 tablet pack)
- Mavenclad (9 tablet pack)

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	The patient has a documented diagnosis of a relapsing form of Multiple Sclerosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist or MS specialist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

MAVYRET

Products Affected

- Mavyret

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Hepatitis C genotype, concurrent medications, medication history.
Age Restrictions	12 years of age and older.
Prescriber Restrictions	Prescribed by, or in consultation with a gastroenterologist, hepatologist, infectious disease physician, or a liver transplant physician.
Coverage Duration	Authorizations will be approved according to the AASLD/IDSA treatment guidelines.
Other Criteria	For genotypes 1 and 4, patients must have a trial with Epclusa or Harvoni unless Epclusa and Harvoni are not specifically listed as an alternative therapy for a specific patient population in the guidelines. For genotypes 2 and 3, patients must have a trial with Epclusa unless Epclusa is not specifically listed as an alternative therapy for a specific patient population in the guidelines. For genotypes 5 and 6, patients must have a trial with Epclusa or Harvoni, unless Epclusa and Harvoni are not specifically listed as an alternative therapy for a specific patient population in the guidelines.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

MAYZENT

Products Affected

- Mayzent

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	The patient has a documented diagnosis of a relapsing form of Multiple Sclerosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist or MS specialist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

MEGESTROL SUSPENSION/TABLETS

Products Affected

- megestrol oral suspension 400 mg/10 mL (40 mg/mL), 625 mg/5 mL
- megestrol oral tablet

PA Criteria	Criteria Details
Exclusion Criteria	Coverage is not provided for weight gain for cosmetic reasons.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

MEKINIST

Products Affected

- Mekinist

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history. Melanoma: Documented diagnosis of Melanoma, used as an adjuvant treatment of melanoma (in combination with dabrafenib) in patients with a BRAF V600E or BRAF V600K mutation (as detected by an approved test), and lymph node involvement, following complete resection, or treatment of unresectable or metastatic melanoma in patients with a BRAF V600E or BRAF V600K mutation (as detected by an approved test), either as a single-agent or in combination with dabrafenib. Non-Small Cell Lung Cancer: Documented diagnosis of Non-Small Cell Lung Cancer for the treatment of metastatic non-small cell lung cancer (NSCLC) in patients with BRAF V600E mutation as detected by an approved test (in combination with dabrafenib).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a dermatologist, endocrinologist, oncologist, or pulmonologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

METHAMPHETAMINE (DESOXYN)

Products Affected

- methamphetamine

PA Criteria	Criteria Details
Exclusion Criteria	Weight loss.
Required Medical Information	Diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

MODAFINIL

Products Affected

- modafinil

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	A documented diagnosis of Narcolepsy, Obstructive Sleep Apnea, or Shift Work Sleep Disorder.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

NATPARA

Products Affected

- Natpara

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist.
Coverage Duration	1 year
Other Criteria	Chronic hypoparathyroidism - Before starting Natpara, serum calcium concentration is greater than 7.5 mg/dL and 25-hydroxyvitamin D stores are sufficient per the prescribing physician.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

NERLYNX

Products Affected

- Nerlynx

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

NEXAVAR

Products Affected

- Nexavar

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an endocrinologist, hepatologist, nephrologist, or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

NINLARO

Products Affected

- Ninlaro

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

NOURIANZ

Products Affected

- Nourianz

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	A documented diagnosis of Parkinson's disease and must be used as adjunctive treatment to levodopa/carbidopa in adult patients experiencing off episodes.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

NUBEQA

Products Affected

- Nubeqa

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

NUCALA

Products Affected

- Nucala

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation that Nucala is being used as add-on maintenance treatment of patients with severe asthma with an eosinophilic phenotype or eosinophilic granulomatosis with polyangiitis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an allergist, immunologist, pulmonologist, or rheumatologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

NUEDEXTA

Products Affected

- Nuedexta

PA Criteria	Criteria Details
Exclusion Criteria	Use in the management of neuropathic pain. Use in the management of heroin detoxification.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ODOMZO

Products Affected

- Odomzo

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a dermatologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

OFEV

Products Affected

- Ofev

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by, or in consultation with, a pulmonologist or rheumatologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ONPATTRO

Products Affected

- Onpattro

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

OPDIVO

Products Affected

- Opdivo

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with a dermatologist, gastroenterologist, hematologist, hepatologist, nephrologist, oncologist, pulmonologist, or urologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

OPSUMIT

Products Affected

- Opsumit

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) WHO Group 1, patients who are not currently taking Opsumit or another agent indicated for WHO Group 1 PAH: previous right-heart catheterization to confirm the diagnosis of PAH to ensure appropriate medical assessment. PAH WHO Group 1, patients currently on Opsumit or another agent indicated for WHO Group 1 PAH: may continue therapy without confirmation of a right-heart catheterization.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a cardiologist, or a pulmonologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ORENCIA

Products Affected

- Orencia (with maltose)
- Orencia ClickJect
- Orencia subcutaneous syringe 125 mg/mL, 50 mg/0.4 mL, 87.5 mg/0.7 mL

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a rheumatologist or dermatologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ORENITRAM

Products Affected

- Orenitram

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) WHO Group 1, patients who are not currently taking Orenitram or another agent indicated for WHO Group 1 PAH: previous right-heart catheterization to confirm the diagnosis of PAH to ensure appropriate medical assessment. PAH WHO Group 1, patients currently on Orenitram or another agent indicated for WHO Group 1 PAH: may continue therapy without confirmation of a right-heart catheterization.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a cardiologist, or a pulmonologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ORKAMBI

Products Affected

- Orkambi oral granules in packet
- Orkambi oral tablet

PA Criteria	Criteria Details
Exclusion Criteria	Combination therapy with Kalydeco. Patients who are heterozygous for the F508del mutation.
Required Medical Information	Documentation the patient is homozygous for the F508del mutation in the CFTR gene as confirmed by an FDA-cleared cystic fibrosis mutation test.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist or a physician who specializes in the treatment of cystic fibrosis.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

OTEZLA

Products Affected

- Otezla
- Otezla Starter oral tablets,dose pack 10 mg (4)-20 mg (4)-30 mg (47)

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a rheumatologist or dermatologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

OXBRYTA

Products Affected

- Oxbryta

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

OXERVATE

Products Affected

- Oxervate

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an ophthalmologist or optometrist.
Coverage Duration	8 weeks
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

PHOSPHODIESTERASE INHIBITORS (PULMONARY HYPERTENSION)

Products Affected

- Alyq
- sildenafil (Pulmonary Arterial Hypertension) intravenous solution
- sildenafil (Pulmonary Arterial Hypertension) oral
- tadalafil (pulmonary arterial hypertension) oral tablet 20 mg

PA Criteria	Criteria Details
Exclusion Criteria	We do not cover phosphodiesterase inhibitors for the treatment of erectile dysfunction.
Required Medical Information	Pulmonary arterial hypertension (PAH) WHO Group 1, patients who are not currently taking an agent indicated for WHO Group 1 PAH: previous right-heart catheterization to confirm the diagnosis of PAH to ensure appropriate medical assessment. PAH WHO Group 1, patients currently on an agent indicated for WHO Group 1 PAH: may continue therapy without confirmation of a right-heart catheterization.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

PIQRAY

Products Affected

- Piqray

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history. Advanced or Metastatic Breast Cancer: A documented diagnosis of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, PIK3CA-mutated, advanced or metastatic breast cancer as detected by an FDA-approved test in postmenopausal women, and men following progression on or after an endocrine-based regimen and Piqray must be used in combination with fulvestrant.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

POLIVY

Products Affected

- Polivy

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist, or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

POMALYST

Products Affected

- Pomalyst

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

PRALUENT

Products Affected

- Praluent Pen subcutaneous pen injector
  150 mg/mL, 75 mg/mL

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	LDL-C and response to other agents, prior therapies tried, medical history.
Age Restrictions	18 years of age and older.
Prescriber Restrictions	Prescribed by, or in consultation with, a cardiologist, endocrinologist, or a physician who focuses in the treatment of CV risk management and/or lipid disorders.
Coverage Duration	1 year
Other Criteria	For Primary Hyperlipidemia including pts with HeFH without ASCVD - approve if pt meets all of the following: A. Pt has been diagnosed with Primary Hyperlipidemia or HeFH, AND B. Pt tried TWO high intensity statins (i.e. atorvastatin greater than or equal to 40 mg daily and rosuvastatin greater than or equal to 20 mg daily) AND LDL-C remains greater than or equal to 70 mg/dL unless the patient is determined to be statin intolerant defined by experiencing statin related rhabdomyolysis or pt experienced skeletal-related muscle symptoms while receiving separate trials of atorvastatin and rosuvastatin and during both trials the skeletal-related symptoms resolved during discontinuation, AND C. If able to tolerate statins, the pt continues to receive the maximum tolerated dose of a statin while receiving Praluent therapy. Hyperlipidemia in pts with Clinical Atherosclerotic Cardiovascular Disease (ASCVD) with or without HeFH- approve if pt meets all of the following: A. Pt has an LDL-C greater than or equal to 70 mg/dL (after treatment with antihyperlipidemic agents but prior to PCSK9 therapy), AND B. Pt has one of the following conditions: prior MI, history of ACS, diagnosis of angina, history of stroke or TIA, PAD, undergone a coronary or other arterial revascularization procedure, AND C. Pt tried TWO high intensity statins (i.e. atorvastatin greater than or equal to 40 mg daily and rosuvastatin greater than or equal to 20 mg daily)

PA Criteria	Criteria Details
	AND LDL-C remains greater than or equal to 70 mg/dL unless the patient is determined to be statin intolerant defined by experiencing statin related rhabdomyolysis or pt experienced skeletal-related muscle symptoms while receiving separate trials of atorvastatin and rosuvastatin and during both trials the skeletal-related symptoms resolved during discontinuation, AND D. If able to tolerate statins, the pt continues to receive the maximum tolerated dose of a statin while receiving Praluent therapy.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

PROLIA

Products Affected

- Prolia

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	The patient has a documented diagnosis of osteoporosis, treatment of androgen deprivation-induced bone loss in men with prostate cancer, or treatment of aromatase inhibitor-induced bone loss in women with breast cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For a documented diagnosis of osteoporosis there must be evidence of a paid claim or physician documented use of one or more oral bisphosphonates (e.g. alendronate) or inability to swallow or inability to remain in an upright position during post oral bisphosphonate administration.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

REBLOZYL

Products Affected

- Reblozyl

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

RETINOIC ACID DERIVATIVES

Products Affected

- adapalene topical cream
- adapalene topical gel
- adapalene topical solution
- adapalene topical swab
- adapalene-benzoyl peroxide
- Avita topical cream
- clindamycin-tretinoin
- tazarotene
- Tazorac topical cream 0.05 %
- Tazorac topical gel
- tretinoin microspheres topical gel
- tretinoin topical

PA Criteria	Criteria Details
Exclusion Criteria	Coverage for all ages is restricted to non-cosmetic purposes only.
Required Medical Information	Adapalene: Documented diagnosis of acne vulgaris. Tazarotene: Documented diagnosis of acne or psoriasis. Tretinoin: Documented diagnosis of acne or actinic keratosis.
Age Restrictions	Prior authorization is only required for patients over 29 years of age in order to evaluate for non-cosmetic uses.
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

REVLIMID

Products Affected

- Revlimid

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

RINVOQ

Products Affected

- Rinvoq

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a rheumatologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

RITUXAN

Products Affected

- Rituxan

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis: taken with methotrexate and failure/contraindication to two of the following: Enbrel, Humira, Orencia, Rinvoq, or Xeljanz.
Age Restrictions	N/A
Prescriber Restrictions	For Rheumatoid Arthritis: prescribed by, or in consultation with, a rheumatologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ROZLYTREK

Products Affected

- Rozlytrek

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist or pulmonologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

RUBRACA

Products Affected

- Rubraca

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history. Ovarian Cancer: Documented diagnosis of Ovarian Cancer for the treatment of deleterious germline and/or somatic BRCA mutation associated (as detected by an approved test) ovarian cancer (epithelial, fallopian tube, or primary peritoneal) in patients who have been treated with 2 or more prior lines of chemotherapy, or for maintenance treatment of recurrent ovarian cancer (epithelial, fallopian tube, or primary peritoneal) in patients who are in complete or partial response to platinum-based chemotherapy.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a gynecologist, or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

RYDAPT

Products Affected

- Rydapt

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history. Acute Myeloid Leukemia: Documented diagnosis of Acute Myeloid Leukemia for the treatment of adult patients with newly diagnosed FLT3 mutation-positive (as detected by an approved test) acute myeloid leukemia (AML), in combination with standard cytarabine and daunorubicin induction and cytarabine consolidation chemotherapy. Mast Cell Leukemia: Documented diagnosis of Mast Cell Leukemia for adult patients. Systemic Mastocytosis: Documented diagnosis of Systemic Mastocytosis for the treamtent of adult patients with aggressive systemic mastocytosis (ASM) or systemic mastocytosis with associated hematological neoplasm (SM-AHN).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, hematologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

SIMPONI

Products Affected

- Simponi ARIA
- Simponi subcutaneous pen injector 100 mg/mL, 50 mg/0.5 mL
- Simponi subcutaneous syringe 100 mg/mL, 50 mg/0.5 mL

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid arthritis: taken with methotrexate and failure/contraindication to two of the following: Enbrel, Humira, Orencia, Rinvoq, or Xeljanz. Psoriatic arthritis: taken alone, or in combination with methotrexate and failure/contraindication to two of the following: Cosentyx, Enbrel, Humira, Orencia, Otezla, Stelara, or Xeljanz. Ankylosing Spondylitis: failure/contraindication to two of the following: Cosentyx, Enbrel, or Humira. Ulcerative colitis: failure/contraindication to one of the following: Humira, Stelara or Xeljanz/Xeljanz XR.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a rheumatologist, gastroenterologist, or dermatologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

SKYRIZI

Products Affected

- Skyrizi

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a dermatologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

SOVALDI

Products Affected

- Sovaldi

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Hepatitis C genotype, concurrent medications, medication history.
Age Restrictions	Genotype 1 and 4: 18 years of age and older, Genotype 2 and 3: 3 years of age and older.
Prescriber Restrictions	Prescribed by, or in consultation with a gastroenterologist, hepatologist, infectious disease physician, or a liver transplant physician.
Coverage Duration	Authorizations will be approved according to the AASLD/IDSA treatment guidelines.
Other Criteria	For genotypes 1 and 4, patients must have a trial with Epclusa or Harvoni unless Epclusa and Harvoni are not specifically listed as an alternative therapy for a specific patient population in the guidelines. For genotypes 2 and 3, patients must have a trial with Epclusa unless Epclusa is not specifically listed as an alternative therapy for a specific patient population in the guidelines.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

SPRYCEL

Products Affected

- Sprycel

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

STELARA

Products Affected

- Stelara intravenous
- Stelara subcutaneous

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a rheumatologist, gastroenterologist, or dermatologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

STIVARGA

Products Affected

- Stivarga

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a gastroenterologist, hepatologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

SUTENT

Products Affected

- Sutent

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an endocrinologist, gastroenterologist, nephrologist, or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

SYMDEKO

Products Affected

- Symdeko oral tablets

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation that the patient has cystic fibrosis and is homozygous for the F508del mutation as confirmed by an FDA-cleared cystic fibrosis mutation test OR has at least one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to Symdeko based on in vitro data and/or clinical evidence.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a pulmonologist or a physician who specializes in the treatment of cystic fibrosis.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TADALAFIL (CIALIS)

Products Affected

- tadalafil oral tablet 2.5 mg, 5 mg

PA Criteria	Criteria Details
Exclusion Criteria	We do not cover tadalafil for the treatment of erectile dysfunction.
Required Medical Information	The patient must have a documented diagnosis of Benign Prostatic Hyperplasia (BPH).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TAFINLAR

Products Affected

- Tafinlar

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history. Melanoma: Documented diagnosis of Melanoma, use as an adjuvant treatment of melanoma (in combination with trametinib) in patients with a BRAF V600E or BRAF V600K mutation (as detected by an approved test), and lymph node involvement, following complete resection, or for the treatment of unresectable or metastatic melanoma in patients with a BRAF V600E mutation (single agent therapy) or in patients with BRAF V600E or BRAF V600K mutations (in combination with trametinib), confirm BRAF V600E or BRAF V600K mutation status with an approved test prior to treatment. Non-Small Cell Lung Cancer: Documented diagnosis of Non-Small Cell Lung Cancer for the treatment of metastatic non-small cell lung cancer (NSCLC) in patients with BRAF V600E mutation as detected by an approved test (in combination with trametinib).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a dermatologist, endocrinologist, oncologist, or pulmonologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TAGRISSO

Products Affected

- Tagrisso

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history. Non-Small Cell Lung Cancer: Documented diagnosis of Non-Small Cell Lung Cancer as a First-line treatment of metastatic non-small cell lung cancer (NSCLC) in patients whose tumors have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R mutations as detected in tumor or plasma specimen by an approved test, or for the treatment of metastatic EGFR T790M mutation-positive (as detected in tumor or plasma specimen by an approved test) NSCLC in patients whose disease has progressed on or after EGFR tyrosine kinase inhibitor therapy.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist or pulmonologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TALZENNA

Products Affected

- Talzenna

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history. Locally Advanced or Metastatic Breast Cancer: A documented diagnosis of human epidermal growth factor receptor 2 (HER2) negative locally advanced or metastatic breast cancer in adults with deleterious or suspected deleterious germline breast cancer susceptibility gene (BRCA) mutated (gBRCAm) as detected by an approved test.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TASIGNA

Products Affected

- Tasigna

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TAZVERIK

Products Affected

- Tazverik

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TECFIDERA

Products Affected

- Tecfidera

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	The patient has a documented diagnosis of a relapsing form of Multiple Sclerosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist or MS specialist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TEGSEDI

Products Affected

- Tegsedi

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TEPEZZA

Products Affected

- Tepezza

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TERIPARATIDE

Products Affected

- Forteo

PA Criteria	Criteria Details
Exclusion Criteria	Previous use of Tymlos and/or Forteo for a combined total no greater than 2 years duration during a patient's lifetime.
Required Medical Information	Documentation Forteo is being used in one the following patient populations at high risk for fracture (defined as a history of osteoporotic fracture, multiple risk factors for fracture, or patients who have failed or are intolerant to other available osteoporosis therapies): Postmenopausal women with osteoporosis, to increase bone mass in men with primary or hypogonadal osteoporosis, men and women with glucocorticoid-induced osteoporosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorizations will be approved for 2 years of therapy over a patient's lifetime.
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

THALOMID

Products Affected

- Thalomid

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TOPICAL IMMUNOMODULATORS

Products Affected

- pimecrolimus
- tacrolimus topical

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documented treatment failure or contraindication with a prescription topical corticosteroid within the previous 90 days.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TOPIRAMATE/ZONISAMIDE

Products Affected

- Qudexy XR
- topiramate oral capsule, sprinkle
- topiramate oral tablet
- Trokendi XR
- zonisamide

PA Criteria	Criteria Details
Exclusion Criteria	Coverage is not provided for weight loss or smoking cessation.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TREPROSTINIL

Products Affected

- treprostinil

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) WHO Group 1, patients who are not currently taking treprostinil or another agent indicated for WHO Group 1 PAH: previous right-heart catheterization to confirm the diagnosis of PAH to ensure appropriate medical assessment. PAH WHO Group 1, patients currently on treprostinil or another agent indicated for WHO Group 1 PAH: may continue therapy without confirmation of a right-heart catheterization.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a cardiologist or a pulmonologist.
Coverage Duration	3 years
Other Criteria	Part B versus Part D determination will be made at time of prior authorization review per CMS guidance.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TRIKAFTA

Products Affected

- Trikafta

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, medical history, and any approved tests as required per the package insert.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a pulmonologist or a physician who specializes in the treatment of cystic fibrosis.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TYKERB

Products Affected

- Tykerb

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TYMLOS

Products Affected

- Tymlos

PA Criteria	Criteria Details
Exclusion Criteria	Previous use of Tymlos and/or Forteo for a combined total no greater than 2 years duration during a patient's lifetime.
Required Medical Information	Documentation Tymlos is being used for the treatment of postmenopausal women with osteoporosis at high risk for fracture defined as a history of osteoporotic fracture, multiple risk factors for fracture, or patients who have failed or are intolerant to other available osteoporosis therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorizations will be approved for 2 years of therapy over a patient's lifetime.
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

TYSABRI

Products Affected

- Tysabri

PA Criteria	Criteria Details
Exclusion Criteria	Tysabri will not be approved when used in combination with other immune modulating medications for the treatment of Multiple Sclerosis. Tysabri will not be approved when used in combination with immunosuppressants or TNF-α inhibitors for the treatment of Crohn's Disease.
Required Medical Information	Multiple Sclerosis: The patient must have a documented diagnosis of a relapsing form of Multiple Sclerosis. Crohn's Disease: The patient must have a documented diagnosis of Crohn's Disease and failure/contraindication to Humira and Stelara.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a gastroenterologist or neurologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

UPTRAVI

Products Affected

- Uptravi

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) WHO Group 1, patients who are not currently taking Uptravi or another agent indicated for WHO Group 1 PAH: previous right-heart catheterization to confirm the diagnosis of PAH to ensure appropriate medical assessment. PAH WHO Group 1, patients currently on Uptravi or another agent indicated for WHO Group 1 PAH: may continue therapy without confirmation of a right-heart catheterization.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a cardiologist, or a pulmonologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

VENCLEXTA

Products Affected

- Venclexta
- Venclexta Starting Pack

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

VERZENIO

Products Affected

- Verzenio

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

VIEKIRA

Products Affected

- Viekira Pak

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Hepatitis C genotype, concurrent medications, medication history.
Age Restrictions	18 years of age and older.
Prescriber Restrictions	Prescribed by, or in consultation with a gastroenterologist, hepatologist, infectious disease physician, or a liver transplant physician.
Coverage Duration	Authorizations will be approved according to the AASLD/IDSA treatment guidelines.
Other Criteria	For genotype 1, patients must have a trial with Epclusa or Harvoni, unless Epclusa or Harvoni are not specifically listed as an alternative therapy for a specific patient population in the guidelines.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

VITRAKVI

Products Affected

- Vitrakvi

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

VIZIMPRO

Products Affected

- Vizimpro

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history. Non-Small Cell Lung Cancer: Documented diagnosis of metastatic Non-Small Cell Lung Cancer with epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 L858R substitution mutations as detected by an approved test.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist or pulmonologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

VOSEVI

Products Affected

- Vosevi

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Hepatitis C genotype, concurrent medications, medication history.
Age Restrictions	18 years of age and older.
Prescriber Restrictions	Prescribed by, or in consultation with a gastroenterologist, hepatologist, infectious disease physician, or a liver transplant physician.
Coverage Duration	Authorizations will be approved according to the AASLD/IDSA treatment guidelines.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

VOTRIENT

Products Affected

- Votrient

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a nephrologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

VYNDAMAX

Products Affected

- Vyndamax

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

VYNDAQEL

Products Affected

- Vyndaqel

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

WIXELA

Products Affected

- fluticasone propion-salmeterol inhalation blister with device
- Wixela Inhub

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For a diagnosis of asthma: Previous treatment/contraindication with Dulera or Symbicort. For a diagnosis of COPD: Previous treatment/contraindication with Symbicort.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

XALKORI

Products Affected

- Xalkori

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history. Non-Small Cell Lung Cancer: Documented diagnosis of Non-Small Cell Lung Cancer for the treatment of metastatic non-small cell lung cancer (NSCLC) in patients whose tumors are anaplastic lymphoma kinase (ALK)-positive or are ROS1-positive (as detected by an approved test).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist or pulmonologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

XELJANZ

Products Affected

- Xeljanz
- Xeljanz XR

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis: previous failure/contraindication to methotrexate.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a gastroenterologist or rheumatologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

XEOMIN

Products Affected

- Xeomin

PA Criteria	Criteria Details
Exclusion Criteria	Xeomin will not be approved if used for cosmetic reasons.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

XGEVA

Products Affected

- Xgeva

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

XOLAIR

Products Affected

- Xolair

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Allergic mediated moderate to severe asthma: Asthma symptoms not adequately controlled by continuous therapy of inhaled steroids or oral steroids, recent IgE levels within the range of 30 to 1,300 IU/mL for children 6 to less than 12 years of age or IgE level within the range of 30 to 700 IU/mL for 12 years of age and older (recent defined as the previous 6 months), positive skin test or in vitro testing for one or more perennial aeroallergen. Chronic idiopathic urticaria: Symptoms remain despite H1 antihistamine treatment.
Age Restrictions	Allergic mediated moderate to severe asthma: 6 years of age and older. Chronic idiopathic urticaria: 12 years of age and older.
Prescriber Restrictions	Pulmonologist, allergist, dermatologist, or immunologist
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

XOSPATA

Products Affected

- Xospata

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history. Acute Myeloid Leukemia (AML): Documented diagnosis of relapsed or refractory Acute Myeloid Leukemia with a FLT3 mutation as detected by an FDA-approved test.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

XPOVIO

Products Affected

- Xpovio

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

XTANDI

Products Affected

- Xtandi

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

XYREM

Products Affected

- Xyrem

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Medication history
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a sleep specialist or neurologist.
Coverage Duration	1 year
Other Criteria	For Excessive daytime sleepiness (EDS) in patients with narcolepsy - approve if the patient has tried one CNS stimulant (e.g., methylphenidate or dextroamphetamine), modafinil, or armodafinil.
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

YONSA

Products Affected

- Yonsa

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ZEJULA

Products Affected

- Zejula

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a gynecologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ZELBORAF

Products Affected

- Zelboraf

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history. Melanoma: Documented diagnosis of Melanoma for the treatment of unresectable or metastatic melanoma in patients with a BRAFV600E mutation (as detected by an approved test). Erdheim-Chester Disease: Documented diagnosis of Erdheim-Chester Disease for patients with a BRAF V600 mutation.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a dermatologist, hematologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ZEPATIER

Products Affected

- Zepatier

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Hepatitis C genotype, concurrent medications, medication history.
Age Restrictions	18 years of age and older.
Prescriber Restrictions	Prescribed by, or in consultation with a gastroenterologist, hepatologist, infectious disease physician, or a liver transplant physician.
Coverage Duration	Authorizations will be approved according to the AASLD/IDSA treatment guidelines.
Other Criteria	For genotypes 1 and 4, patients must have a trial with Epclusa or Harvoni unless Epclusa and Harvoni are not specifically listed as an alternative therapy for a specific patient population in the guidelines.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ZINPLAVA

Products Affected

- Zinplava

PA Criteria	Criteria Details
Exclusion Criteria	Zinplava is not indicated for the treatment of Clostridium difficile infection (CDI).
Required Medical Information	Zinplava must be prescribed for patients who are receiving an antibacterial drug treatment regimen for CDI and must be at high risk for CDI recurrence.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a gastroenterologist or infectious disease physician.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off-Label Uses	N/A

ZYDELIG

Products Affected

- Zydelig

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a hematologist or oncologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ZYKADIA

Products Affected

- Zykadia

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, concurrent/past medications, and medical history. Non-Small Cell Lung Cancer: Documented diagnosis of Non-Small Cell Lung Cancer for the treatment of anaplastic lymphoma kinase (ALK)-positive (as detected by an approved test) metastatic non-small cell lung cancer (NSCLC).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist or pulmonologist.
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

PART B VERSUS PART D

Products Affected

- acetylcysteine
- acyclovir sodium intravenous solution
- albuterol sulfate inhalation solution for nebulization 0.63 mg/3 mL, 1.25 mg/3 mL, 2.5 mg /3 mL (0.083 %), 2.5 mg/0.5 mL
- AmBisome
- Aminosyn II 10 %
- Aminosyn II 15 %
- Aminosyn-PF 10 %
- Aminosyn-PF 7 % (sulfite-free)
- amphotericin B
- aprepitant
- Astagraf XL
- azathioprine
- Bethkis
- Brovana
- budesonide inhalation
- caspofungin
- Clinimix 5%/D15W Sulfite Free
- Clinimix 4.25%/D10W Sulf Free
- Clinimix 4.25%/D5W Sulfit Free
- Clinimix 5%-D20W(sulfite-free)
- Clinimix E 2.75%/D5W Sulf Free
- Clinimix E 4.25%/D10W Sul Free
- Clinimix E 4.25%/D5W Sulf Free
- Clinimix E 5%/D15W Sulfit Free
- Clinimix E 5%/D20W Sulfit Free
- Clinimix N14G30E 4.25%-D15W SF
- Clinimix N9G15E 2.75%-D7.5W SF
- Clinimix N9G20E 2.75%-D10W(SF)
- cromolyn inhalation
- cyclophosphamide oral capsule
- cyclosporine modified
- cyclosporine oral capsule
- cysteine (l-cysteine) intravenous solution
- deltasone oral tablet 20 mg
- demerol (pf) injection solution 100 mg/ml
- dronabinol
- Emend oral suspension for reconstitution
- Engerix-B (PF) intramuscular suspension
- Engerix-B (PF) intramuscular syringe
- Engerix-B Pediatric (PF) intramuscular syringe
- Envarsus XR
- Freamine HBC 6.9 %
- freamine iii 10 %
- Gengraf oral capsule 100 mg, 25 mg
- Gengraf oral solution
- granisetron HCl oral
- Hepatamine 8%
- Intralipid intravenous emulsion 20 %
- Intralipid intravenous emulsion 30 %
- ipratropium bromide inhalation
- ipratropium-albuterol
- levalbuterol HCl
- melphalan
- meperidine (PF) injection solution 100 mg/mL, 25 mg/mL, 50 mg/mL
- methotrexate sodium (PF) injection recon soln
- methotrexate sodium (PF) injection solution
- methotrexate sodium injection
- methotrexate sodium oral
- methylprednisolone oral tablet
- Millipred oral tablet
- mycophenolate mofetil
- mycophenolate sodium
- Nebupent
- Nephramine 5.4 %
- Nulojix
- ondansetron
- ondansetron HCl oral
- Plenamine
- prednisolone sodium phosphate oral tablet,disintegrating
- Prednisone Intensol
- prednisone oral tablet
- Premasol 10 %
- Premasol 6 %
- Procalamine 3%
- Prograf intravenous
- Prograf oral granules in packet
- Prosol 20 %

- Pulmozyme
- Recombivax HB (PF) intramuscular suspension 10 mcg/mL, 40 mcg/mL
- Recombivax HB (PF) intramuscular suspension 5 mcg/0.5 mL
- Recombivax HB (PF) intramuscular syringe 10 mcg/mL
- Recombivax HB (PF) intramuscular syringe 5 mcg/0.5 mL
- Simulect intravenous recon soln 10 mg
- Simulect intravenous recon soln 20 mg
- sirolimus
- Smoflipid
- Syndros
- tacrolimus oral
- tobramycin in 0.225 % NaCl
- Travasol 10 %
- trimethobenzamide oral
- TrophAmine 10 %
- Trophamine 6%
- Varubi oral
- Vectibix
- Ventavis
- Xatmep
- Zortress

Details

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

NONDISCRIMINATION NOTICE

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. It does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation or gender identity.

Blue Cross Blue Shield of Massachusetts provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print or other formats).
- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact the Medicare Advantage Appeals and Grievance Manager.

If you believe that Blue Cross Blue Shield of Massachusetts has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Medicare Advantage Appeals and Grievance Manager by mail at P.O. Box 55007, Boston, MA 02205; phone at **1-800-200-4255** (TTY: **711**) from April 1 through September 30, 8:00 a.m. to 8:00 p.m., Monday through Friday, or October 1 through March 31, 8:00 a.m. to 8:00 p.m., seven days a week; fax at **617-246-8506**; or email at **MedicareAdvantageRXAppeals@bcbsma.com**. You can file a grievance in person, by mail, fax, email, or you can call **1-800-200-4255** (TTY: **711**).

If you need help filing a grievance, the Medicare Advantage Appeals and Grievance Manager is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights online at **ocrportal.hhs.gov**; by mail at U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building Washington, DC 20201; by phone at **1-800-368-1019** or **1-800-537-7697** (TDD).

Complaint forms are available at **www.hhs.gov**.

TRANSLATION RESOURCES

Proficiency of Language Assistance Services

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-200-4255 (TTY: 711).

Spanish/Español: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-200-4255 (TTY: 711).

Portuguese/Português: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-200-4255 (TTY: 711).

Chinese/繁體中文: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-200-4255 (TTY: 711).

French Creole/Kreyòl Ayisyen: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-200-4255 (TTY: 711).

Vietnamese/Tiếng Việt: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-200-4255 (TTY: 711).

Russian/Русский: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-200-4255 (телетайп: 711).

Arabic/العربية:

ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-200-4255 (هاتف الصم والبكم: 711).

Mon-Khmer, Cambodian/ ខ្មែរ: ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-200-4255 (TTY: 711).

French/Français: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-200-4255 (ATS: 711).

Italian/Italiano: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-200-4255 (TTY: 711).

Korean/한국어**:** 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-200-4255 (TTY: 711) 번으로 전화해 주십시오.

Greek/λληνικά: ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-200-4255 (TTY: 711).

Polish/Polski: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-200-4255 (TTY: 711).

Hindi/ हिंदी: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-200-4255 (TTY: 711) पर कॉल करें।

Gujarati/ ગુજરાતી: સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-200-4255 (TTY: 711)

Blue Cross Blue Shield of Massachusetts is an HMO and PPO Plan with an Medicare contract. Enrollment in Blue Cross Blue Shield of Massachusetts depends on contract renewal.

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ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-800-200-4255** (TTY: **711**).

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