ABOBOTULINUMTOXINA

Products Affected

- DYSPORT

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Conservative treatments, for example, physical therapy, oral medications, etc, have been tried or considered, have failed and/or are contraindicated
Age Restrictions	Must be 2 years of age or older
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	Maximum billing unit(s) equals 1500 units

AFLIBERCEPT

Products Affected

- EYLEA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	The patient has tried and failed or is intolerant to bevacizumab, the patient does not have an active ocular or periocular infection, and the patient does not have an active intraocular inflammation. Renewable if the patient continues to meet the criteria for medical necessity.
Age Restrictions	The patient is 18 years of age or older
Prescriber Restrictions	Ophthalmologist
Coverage Duration	6 months
Other Criteria	Appropriate site modifiers are LT, RT or 50 (bilateral).

ALGLUCOSIDASE ALFA

Products Affected

- LUMIZYME

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For the initial authorization, the following supporting documentation must be submitted: Subjective findings (complaints), Objective findings (exams, lab results), Physical examination, Complications (for example, bony changes or kidney failure), Quality of life issues (for example, severe, unremitting pain or extreme fatigue), Identified licensed practitioner who will administer infusion therapy, coordinate care, and their Plan: Include the treatment plan including the genetic evaluation and counseling information for the patient and family members and Goal: Include specific information about the desired outcome
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with a neurologist, geneticist or other physician with specialty in treating Pompe disease
Coverage Duration	6 months
Other Criteria	The recommended dose is 20 mg/kg every two weeks

ANTINEOPLASTIC

Products Affected

- ADCETRIS
- ADRIAMYCIN
- ADRUCIL
- CAMPTOSAR
- *carboplatin*
- *cisplatin*
- *cyclophosphamide*
- *docetaxel*
- *doxorubicin*
- *fluorouracil*
- *gemcitabine*
- HERZUMA
- *irinotecan*
- KADCYLA
- KANJINTI
- KEYTRUDA
- MVASI
- OGIVRI
- ONTRUZANT
- OPDIVO
- *oxaliplatin*
- *paclitaxel*
- PARAPLATIN
- PERJETA
- POLIVY
- TRAZIMERA
- YERVOY
- ZEPZELCA
- ZIRABEV

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Must meet "1" of the following requirements: i. Confirmed diagnosis of FDA labeled indication, OR ii. Confirmed NCCN recommended regimen of category 2B or above AND b. Request for off-labeled use and/or non-preferred NCCN regimen requires clinical review by IEHP pharmacist
Age Restrictions	
Prescriber Restrictions	Specialist (e.g., Oncologist, Hematologist, Dermatologist, etc.)
Coverage Duration	6 months
Other Criteria	Reauthorization Criteria: a. Must meet the following requirement: i. Review by Clinical Pharmacist

BEVACIZUMAB

Products Affected

- AVASTIN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D. For chemotherapy-related indications, please refer to PA ANTINEOPLASTIC.
Exclusion Criteria	
Required Medical Information	For intraocular injections, ICD-10s covered: B39.4, B39.5, B39.9, E08.311, E08.319, E08.3211, E08.3212, E08.3213, E08.3291, E08.3292, E08.3293, E08.3311, E08.3312, E08.3313, E08.3391, E08.3392, E08.3393, E08.3411, E08.3412, E08.3413, E08.3491, E08.3492, E08.3493, E08.3511, E08.3512, E08.3513, E08.3521, E08.3522, E08.3523, E08.3531, E08.3532, E08.3533, E08.3541, E08.3542, E08.3543, E08.3551, E08.3552, E08.3553, E08.3591, E08.3592, E08.3593, E08.37X1, E08.37X2, E08.37X3, E09.311, E09.319, E09.3211, E09.3212, E09.3213, E09.3291, E09.3292, E09.3293, E09.3311, E09.3312, E09.3313, E09.3391, E09.3392, E09.3393, E09.3411, E09.3412, E09.3413, E09.3491, E09.3492, E09.3493, E09.3511, E09.3512, E09.3513, E09.3521, E09.3522, E09.3523, E09.3531, E09.3532, E09.3533, E09.3541, E09.3542, E09.3543, E09.3551, E09.3552, E09.3553, E09.3591, E09.3592, E09.3593, E09.37X1, E09.37X2, E09.37X3, E10.311, E10.319, E10.3211, E10.3212, E10.3213, E10.3291, E10.3292, E10.3293, E10.3311, E10.3312, E10.3313, E10.3391, E10.3392, E10.3393, E10.3411, E10.3412, E10.3413, E10.3491, E10.3492, E10.3493, E10.3511, E10.3512, E10.3513, E10.3521, E10.3522, E10.3523, E10.3531, E10.3532, E10.3533, E10.3541, E10.3542, E10.3543, E10.3551, E10.3552, E10.3553, E10.3591, E10.3592, E10.3593, E10.37X1, E10.37X2, E10.37X3, E11.311, E11.319, E11.3211
Age Restrictions	
Prescriber Restrictions	Ophthalmologist
Coverage Duration	6 months

PA Criteria	Criteria Details
Other Criteria	For intraocular injections, additional ICD-10s covered: E11.3212, E11.3213, E11.3291, E11.3292, E11.3293, E11.3311, E11.3312, E11.3313, E11.3391, E11.3392, E11.3393, E11.3411, E11.3412, E11.3413, E11.3491, E11.3492, E11.3493, E11.3511, E11.3512, E11.3513, E11.3521, E11.3522, E11.3523, E11.3531, E11.3532, E11.3533, E11.3541, E11.3542, E11.3543, E11.3551, E11.3552, E11.3553, E11.3591, E11.3592, E11.3593, E11.37X1, E11.37X2, E11.37X3, E13.311, E13.319, E13.3211, E13.3212, E13.3213, E13.3291, E13.3292, E13.3293, E13.3311, E13.3312, E13.3313, E13.3391, E13.3392, E13.3393, E13.3411, E13.3412, E13.3413, E13.3491, E13.3492, E13.3493, E13.3511, E13.3512, E13.3513, E13.3521, E13.3522, E13.3523, E13.3531, E13.3532, E13.3533, E13.3541, E13.3542, E13.3543, E13.3551, E13.3552, E13.3553, E13.3591, E13.3592, E13.3593, E13.37X1, E13.37X2, E13.37X3, H21.1X1, H21.1X2, H21.1X3, H32, H33.001, H33.002, H33.003, H33.011, H33.012, H33.013, H33.021, H33.022, H33.023, H33.031, H33.032, H33.033, H33.041, H33.042, H33.043, H33.051, H33.052, H33.053, H33.101, H33.102, H33.103, H33.111, H33.112, H33.113, H33.121, H33.122, H33.123, H33.191, H33.192, H33.193, H33.21, H33.22, H33.23, H33.301, H33.302, H33.303, H33.311, H33.312, H33.313, H33.321, H33.322, H33.323, H33.331, H33.332, H33.333, H33.41, H33.42, H33.43, H33.8, H34.8110, H34.8111, H34.8112, H34.8120, H34.8121, H34.8122, H34.8130, H34.8131, H34.8132, H34.8310, H34.8311, H34.8312, H34.8320, H34.8321, H34.8322, H34.8330, H34.8331, H34.8332, H34.9, H35.051, H35.052, H35.053, H35.071, H35.072, H35.073, H35.21, H35.22, H35.23, H35.3210, H35.3211, H35.3212, H35.3213, H35.3220, H35.3221, H35.3222, H35.3223, H35.3230, H35.3231, H35.3232, H35.3233, H35.341, H35.342, H35.343, H35.351, H35.352, H35.353, H35.81, H35.82, H40.89, H44.2A1, H44.2A2, H44.2A3, H44.2B1, H44.2B2, H44.2B3, H44.2C1, H44.2C2, H44.2C3, H44.2D1, H44.2D2, H44.2D3, H44.2E1, H44.2E2, H44.2E3. Providers may bill for the quantity that is equal to the amount given to the patient plus the amount wasted up to a total dose of 10 mg (one unit). Maximum reimbursement will not exceed 10 mg (one unit), per patient, per date of service when bevacizumab is used as an intravitreal injection. This limitation applies only to the intravitreal use of bevacizumab. Appropriate site modifiers are LT, RT or 50 (bilateral).

CAR-T

Products Affected

- ABECMA
- BREYANZI
- BREYANZI CD4 COMPONENT (2OF 2)
- BREYANZI CD8 COMPONENT (1OF 2)
- KYMRIAH
- TECARTUS
- YESCARTA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Treatment supported by National Comprehensive Cancer Network guidelines, e.g. confirmed genetic testing, prior therapy, treatment consistent with use as described by drug labeling, e.g. black box warnings, contraindications, precautions in specific populations, dosing and administration, no major medical conditions that may preclude use, e.g. inadequate organ and bone marrow function at time of treatment, no prior treatment with CD19-directed CAR-T cell therapy or is being considered for treatment with any other gene therapy, will be dispensed and administered at a Risk Evaluation and Mitigation Strategy (REMS) certified facility
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	ONE (1) single-dose of CD-19-direct CAR-T cell therapy is approved per lifetime

DENOSUMAB

Products Affected

- PROLIA
- XGEVA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. For Prolia: 60 mg subcutaneously every six months indicated for postmenopausal women with osteoporosis at high risk of fracture, to increase bone mass in men with osteoporosis at high risk for fracture, to increase bone mass in men at high risk for fracture receiving androgen deprivation therapy for nonmetastatic prostate cancer, to increase bone mass in women at high risk for fracture receiving adjuvant aromatase inhibitor therapy for breast cancer, and the recommended dose of denosumab. For Xgeva: The recommended dose for the prevention of skeletal related events in patients with bone metastases from solid tumors is 120 mg subcutaneously every four weeks in the upper arm, upper thigh or abdomen, for giant cell tumor of bone that is 120 mg subcutaneously every four weeks with additional 120 mg doses on days eight and 15 of the first month of therapy administered in the upper arm, upper thigh, or abdomen, for hypercalcemia of malignancy is 120 mg administered every four weeks with additional 120 mg doses on days eight and 15 of the first month of therapy.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	

ECULIZUMAB

Products Affected

- SOLIRIS

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Vaccination against Neisseria meningitides at least two weeks prior to initiation unless treatment cannot be delayed, and patient must have one of the following diagnoses: A diagnosis of Paroxysmal nocturnal hemoglobinuria (PNH) with documented baseline value for serum lactate dehydrogenase (LDH), patient is not on another terminal complement inhibitor, OR a diagnosis of Atypical hemolytic uremic syndrome (aHUS) with documented baseline value for serum lactate dehydrogenase (LDH), patient is 2 months of age or older and has a weight of at least five kilograms, patient does not have Shiga toxin E. coli related hemolytic uremic syndrome (STEC-HUS), patient is not on another terminal complement inhibitor, OR a diagnosis of generalized Myasthenia Gravis (gMG) with positive serologic test for anti-acetylcholine antibodies, Myasthenia Gravis Foundation of America (MGFA) Clinical Classification Class II to IV, documented baseline MG-Activities of Daily Living (MG-ADL) total score greater than or equal to 6, and patient has had an inadequate treatment response, intolerance or contraindication to two or more immunosuppressants such as azathioprine, cyclophosphamide, cyclosporine, mycophenolate, tacrolimus, methotrexate, etc, and has had an inadequate treatment response, intolerance, or contraindication to chronic IVIG therapy, OR a diagnosis of Neuromyelitis optica spectrum disorder (NMOSD) with positive serologic test for anti-aquaporin-4 immunoglobulin G (AQP4-IgG)/NMO-IgG antibodies. For reauthorization, patient must have a significant clinical response as evidenced by: documentation of a reduction in serum LDH from pretreatment baseline (PNH, aUHS), documentation of reduction of (MG-ADL) total score from baseline (gMG), or patient has had fewer relapses while on therapy (NMOSD)
Age Restrictions	Must be 2 months or older for aHUS diagnosis, must be 18 years of age or older for PNH, gMG or NMOSD diagnosis
Prescriber Restrictions	Prescriber must be enrolled in the Soliris REMS program

PA Criteria	Criteria Details
Coverage Duration	6 months
Other Criteria	Frequency of billing = 900 mg/90 units weekly for the first four weeks, followed by 1,200 mg/120 units for the fifth dose one week later, then 1200 mg /120 units every two weeks thereafter, maximum billing unit(s) = 1,200 mg = 120 units

GROWTH HORMONE

Products Affected

- ZORBTIVE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Pending P&T review
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	

HYALURONAN

Products Affected

- DUROLANE
- EUFLEXXA
- GEL-ONE
- GELSYN-3
- HYALGAN
- MONOVISC
- ORTHOVISC
- SUPARTZ FX
- SYNOJOYNT
- TRILURON
- VISCO-3

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Must have documented failure, inadequate response, or intolerance to at least two of the following pharmacologic therapies: Two oral or topical anti-inflammatory drugs (NSAIDs), acetaminophen, one or more trials in the last 12 months of intra-articular steroid injections unless intolerant or contraindicated, and at least one course of physical therapy for knee osteoarthritis, no contraindications to the injections (active joint infection, bleeding disorder), For treatment continuation: Patient has successfully used hyaluronic acid derivatives in the same knee (there must be at least a six-month interval before approval of a repeat course)
Age Restrictions	Synojoynt, Durolane and Visco-3: Must be 22 years of age or older, Triluron, Hyalgan, Supartz and Euflexxa: Must be 18 years of age or older
Prescriber Restrictions	Orthopedics, Pain Management Specialist
Coverage Duration	6 months
Other Criteria	Must use modifiers RT, LT for applicable knee(s), Maximum billing units per knee per 180 days: 60 units (Durolane, Synojoynt, Triluron), 5 units (Hyalgan, Supartz), 3 units (Visco-3)

INCOBOTULINUMTOXINA

Products Affected

- XEOMIN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Conservative treatment, for example, physical therapy, oral medications, etc have been tried or considered, have failed, or are contra-indicated
Age Restrictions	Must be 18 years of age or older
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	Maximum billing unit(s) equals 400 units

INFLIXIMAB

Products Affected

- AVSOLA
- INFLECTRA
- RENFLEXIS

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. For chemotherapy-related indications, see PA ANTINEOPLASTIC
Exclusion Criteria	
Required Medical Information	Alternative, conventional therapy has been tried or considered, has failed, or is contra-indicated, patient was screened and showed absence of latent (untreated) tuberculosis prior to therapy initiation, patient has been screened for the presence of hepatitis B virus (HBV) prior to initiating treatment, and patient has no active infection, Reauthorization: This may be granted if: Patient continues to meet initial coverage criteria and patient has shown a positive clinical response such as symptoms improvement or lack of disease progression
Age Restrictions	Must be 6 years of age or older
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	

INTRAVENOUS IRON

Products Affected

- FERAHEME
- *ferumoxytol*
- INJECTAFER

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Trial and failure of oral iron supplementation, and labs indicating deficiency, e.g. anemia, low iron saturation, etc.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	

LEUCOVORIN CALCIUM

Products Affected

- *leucovorin calcium*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	The recommended dosage varies according to the clinical condition being treated. See the appropriate literature for dosing schedules. The maximum allowable dose is 400 mg daily. A dose greater than 400 mg will be allowed if documentation shows that the body surface area is greater than 2 m^2.

LUSPATERCEPT

Products Affected

- REBLOZYL

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Active hepatitis C (HCV) infection, active infectious hepatis B (HBV) as demonstrated by a positive HCV-RNA test of sufficient sensitivity, known human immunodeficiency virus (HIV) that is not controlled by antiretroviral (ART) therapy, recent deep vein thrombosis or stroke requiring medical intervention less than or equal to 24 weeks prior, major organ damage as evidenced by any of the following: Liver disease with an ALT greater than 3x the ULN or history of evidence of cirrhosis, Heart disease, heart failure NYHA classification three or higher, or significant arrhythmia requiring treatment, or recent myocardial infarction within six months of treatment, Lung disease, including pulmonary fibrosis or pulmonary hypertension which are clinically significant, that is, equal to or greater than Grade 3, Renal insufficiency such as creatinine clearance less than 60 mL/min
Required Medical Information	Patient has a clinically documented diagnosis of beta-thalassemia or Hemoglobin E/beta-thalassemia. Beta-thalassemia with mutation and/or multiplication of alpha globin is allowed. Patient is regularly transfused, defined as: 6-20 Red Blood Cell (RBC) units in the 24 weeks prior and no transfusion-free period for equal to or greater than 35 days during that period, patient does not have a diagnosis of Hemoglobin S/beta-thalassemia or alpha (a)-thalassemia (for example, Hemoglobin H), and patient is not pregnant or breastfeeding, Continuation of therapy: Patient continues to meet the initial coverage criteria, patient has experienced a clinically significant reduction in transfusion burden from baseline, patient has an absence of unacceptable toxicity from the drug such as severe thromboemobolic events or hypertension
Age Restrictions	Patient must be 18 years of age or older
Prescriber Restrictions	Must be prescribed by, or in consultation with, a hematologist, or other specialist with expertise in the diagnosis and treatment of thalassemia
Coverage Duration	6 months
Other Criteria	Frequency of billing equal to 1.25 mg/kg every three week

MEPOLIZUMAB

Products Affected

- NUCALA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Pending P&T Review
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	

NUSINERSEN

Products Affected

- SPINRAZA (PF)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Genetic testing results demonstrate homozygous SMN1 deletion, or any combination of SMN1 deletions or other mutations that result in the functional loss of all SMN1 genes. In addition to demonstrating loss of functional SMN1 genes, genetic test results include the number of copies of SMN2. Pre-symptomatic: Defined by genetic testing demonstrating a homozygous SMN1 deletion or mutation, and less than or equal to three copies of SMN2 OR Symptomatic: Patient with clinical signs of SMA with level of function necessary to preserve communication, for instance finger or eye movements in response to prompt by examiner. For nusinersen, it can be safely administered intrathecally, taking into consideration the patient's scoliosis status. Specifically, for older patients with SMA, the drug may only be authorized if beneficiary has any of the following: No scoliosis, scoliosis without spine surgery, scoliosis post spine surgery with preserved window of accessibility for intrathecal injection, under fluoroscopic or ultrasound guidance if needed, scoliosis post spine surgery for example, fusion) but with surgical placement of an indwelling catheter or establishment of a new window for IT accessibility, and the patient does not have a coexisting terminal condition or a condition with which the risk of nusinersen treatment outweighs the potential benefit.
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	6 months
Other Criteria	Medical note from neuromuscular specialist SCC containing: Patient demographics, including age of onset, results of genetic testing, including name of laboratory, number of copies of SMN2, and whether SMN1 sequencing was done, neurologic status, specifically if patient is non-sitter, sitter or walker, pulmonary status, nutrition and dietary status (with

PA Criteria	Criteria Details
	review by registered dietitian), and results of at least one neuromotor assessment with a score used to establish a clinical baseline, e.g. CHIP INTEND, HFMSE, TUG, RULM, that is appropriate for clinical status, e.g. non-sitters, sitters, walkers, and non-ambulatory older patients

OCRELIZUMAB

Products Affected

- OCREVUS

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Hepatitis B virus screening is required before the first dose.
Age Restrictions	
Prescriber Restrictions	Neurologist
Coverage Duration	6 months
Other Criteria	Start dose: 300 mg intravenous infusion, followed two weeks later by a second 300 mg intravenous infusion and subsequent doses: 600 mg intravenous infusion every six months

OMALIZUMAB

Products Affected

- XOLAIR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Pending P&T Review
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	

ONABOTULINUMTOXINA

Products Affected

- BOTOX

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For prophylaxis of chronic migraine: Diagnosis of chronic migraine, defined by all of the following: Greater than or equal to 15 headache days per month, greater than or equal to 8 migraine days per month, headaches last 4 hours per day or longer, and trial and failure, unless contraindicated or intolerant, to prophylactic therapy with one agent from two of the following therapeutic classes: antidepressant, antiepileptic, and beta-blocker. For overactive bladder: Diagnosis of overactive bladder and one of the following symptoms: urge urinary incontinence, urgency, frequency, and trial and failure, unless contraindicated or intolerant, to two anticholinergic medications. For other conditions: The patient had been unresponsive to conventional methods of treatments such as medication, physical therapy and other appropriate methods used to control or treat this condition.
Age Restrictions	Must be 2 years of age or older
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	Maximum billing unit(s) equals 400 units

RASBURICASE

Products Affected

- ELITEK

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	Safety and efficacy has been established only for a single course of treatment once daily for 5 days

RIMABOTULINUMTOXINB

Products Affected

- MYOBLOC

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	The patient had been unresponsive to conventional methods of treatments such as medication, physical therapy and other appropriate methods used to control or treat this condition
Age Restrictions	Must be 18 years of age or older
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	Maximum billing unit(s) equals 5000 units

RITUXIMAB

Products Affected

- RIABNI
- RUXIENCE
- TRUXIMA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. For chemotherapy-related indications, refer to PA ANTINEOPLASTIC
Exclusion Criteria	
Required Medical Information	Alternative treatments have been tried or considered, have failed, or are contraindicated.
Age Restrictions	
Prescriber Restrictions	Specialist (e.g., Oncologist, Hematologist, Dermatologist, etc.)
Coverage Duration	6 months
Other Criteria	

ROMIPLOSTIM

Products Affected

- NPLATE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Insufficient response to therapy, as indicated by 1 or more of the following: Corticosteroids, Intravenous immunoglobulin (IVIG), or Splenectomy, Platelet count less than 30,000/mm3 (30 x109/L), and clinical condition increases risk of bleeding, Patient not breast-feeding or pregnant
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	

TEPROTUMUMAB

Products Affected

- TEPEZZA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Patient must have a clinical diagnosis of Graves disease associated with active thyroid eye disease (TED) with a clinical activity score (CAS) of greater than or equal to 4 for the most severely affected eye or patient has moderately to severely active TED, associated with at least one of the following: Lid retraction equal to or greater than 2 mm, moderate or severe soft tissue involvement, proptosis equal to or greater than 3 mm, diplopia, or corneal exposure, and Patient does not require surgical ophthalmological intervention, patient must not have poorly controlled diabetes, Diabetic patient must have well controlled disease (defined as HgbA1c less than 9.0 percent at most recent clinic visit), and patient has a contraindication, intolerance, or lack of response to glucocorticoids or a documented justification why the use of glucocorticoids is not appropriate
Age Restrictions	Patient must be 18 years of age or older
Prescriber Restrictions	Must be prescribed by or in consultation with an ophthalmologist, endocrinologist or a physician who specializes in treatment of thyroid eye disease
Coverage Duration	6 months
Other Criteria	Maximum of 8 infusions and frequency of billing equal to 10 mg/kg initial dose, then 20 mg/kg every 3 weeks for7 additional doses

ZOLEDRONIC ACID

Products Affected

- RECLAST
- *zoledronic ac-mannitol-0.9nacl*
- *zoledronic acid*
- *zoledronic acid-mannitol-water*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For Zometa: Patients with multiple myeloma and patients with documented bone metastases from solid tumors, in conjunction with standard antineoplastic therapy (monthly), prostate cancer should have progressed after treatment with at least one hormonal therapy. (every 6-12 months), or hypercalcemia of malignancy, For Reclast: Prevention of postmenopausal osteoporosis, osteoporosis in men, prevention of glucocorticoid-induced osteoporosis, or Paget's disease of bone in men and women
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	For the use of zoledronic acid in non-malignant conditions, coverage is limited to one 5 mg injection, once every 12 months.

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