ABALOPARATIDE (TYMLOS)

MEDICATION(S)
TYMLOS

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
2 years

OTHER CRITERIA
N/A

APREMILAST

MEDICATION(S)
OTEZLA, OTEZLA/OTEZLA XR INITIATION PK, OTEZLA XR

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

BELIMUMAB

MEDICATION(S)
BENLYSTA 200 MG/ML SOLN A-INJ, BENLYSTA 200 MG/ML SOLN PRSYR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

BEMPEDOIC ACID

MEDICATION(S)
NEXLETOL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

BEXAROTENE (TARGRETIN)

MEDICATION(S)
BEXAROTENE 1 % GEL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

C1 ESTERASE INHIBITOR

MEDICATION(S)
CINRYZE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

CANNABIDIOL (EPIDIOLEX)

MEDICATION(S)
EPIDIOLEX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

DALFAMPRIDINE (AMPYRA)

MEDICATION(S)
DALFAMPRIDINE ER

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

DARBEPOETIN (ARANESP)

MEDICATION(S)
ARANESP (ALBUMIN FREE)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 months

OTHER CRITERIA
N/A

DENOSUMAB (XGEVA)

MEDICATION(S)
BILPREVDA, WYOST

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

DEXTROMETHORPHAN/QUINIDINE (NUEDEXTA)

MEDICATION(S)
NUEDEXTA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

DICLOFENAC EPOLAMINE

MEDICATION(S)
DICLOFENAC EPOLAMINE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

DICLOFENAC (SOLARAZE)

MEDICATION(S)
DICLOFENAC SODIUM 3 % GEL

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

DRONABINOL

MEDICATION(S)
DRONABINOL 2.5 MG CAP, DRONABINOL 5 MG CAP, DRONABINOL

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

DULAGLUTIDE

MEDICATION(S)
TRULICITY

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

DULOXETINE (DRIZALMA SPRINKLE)

MEDICATION(S)
DRIZALMA SPRINKLE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

DUPILUMAB

MEDICATION(S)
DUPIXENT 200 MG/1.14ML SOLN A-INJ, DUPIXENT 200 MG/1.14ML SOLN PRSYR, DUPIXENT 300 MG/2ML SOLN A-INJ, DUPIXENT 300 MG/2ML SOLN PRSYR

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

EPOETIN (EPOGEN)

MEDICATION(S)
RETACRIT

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 months

OTHER CRITERIA
N/A

FILGRASTIM (NEUPOGEN)

MEDICATION(S)
NIVESTYM

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
not for afebrile neutropenia

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
6 months

OTHER CRITERIA
N/A

FREMANEZUMAB (AJOVY)

MEDICATION(S)
AJOVY

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

GLECAPREVIR/PIBRENTASVIR (MAVYRET)

MEDICATION(S)

MAVYRET 100-40 MG TAB

PENDING CMS APPROVAL

ISAVUCONAZONIUM SULFATE

MEDICATION(S)
CRESEMBA 186 MG CAP, CRESEMBA 74.5 MG CAP

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

LEDIPASVIR/SOFOSBUVIR (HARVONI)

MEDICATION(S)
LEDIPASVIR-SOFOSBUVIR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 weeks in patients without cirrhosis, 24 weeks in patients with cirrhosis

OTHER CRITERIA
Documentation of medical necessity and inability to use BOTH of the following preferred agents: sofosbuvir-velpatasvir or glecaprevir-pibrentasvir

LIDOCAINE

MEDICATION(S)
LIDOCAINE 5 % PATCH, TRIDACAINE, TRIDACAINE II, TRIDACAINE III, TRIDACAINE XL

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

LOMITAPIDE

MEDICATION(S)
JUXTAPID 10 MG CAP, JUXTAPID 20 MG CAP, JUXTAPID 30 MG CAP, JUXTAPID 5 MG CAP

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

MACITENTAN

MEDICATION(S)
OPSUMIT

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

MEPOLIZUMAB (NUCALA)

MEDICATION(S)
NUCALA

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

METHYLNALTREXONE (RELISTOR)

MEDICATION(S)
RELISTOR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

MIFEPRISTONE

MEDICATION(S)
MIFEPRISTONE 300 MG TAB

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

MODAFINIL

MEDICATION(S)
MODAFINIL 100 MG TAB, MODAFINIL 200 MG TAB

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

OMALIZUMAB

MEDICATION(S)
XOLAIR

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

PART D VS PART B

MEDICATION(S)

ACETYLCYSTEINE 10 % SOLUTION, ACETYLCYSTEINE 20 % SOLUTION, ACYCLOVIR SODIUM, ALBUTEROL SULFATE 0.63 MG/3ML NEBU SOLN, ALBUTEROL SULFATE 1.25 MG/3ML NEBU SOLN, ALBUTEROL SULFATE 2.5 MG/0.5ML NEBU SOLN, ALBUTEROL SULFATE (2.5 MG/3ML) 0.083% NEBU SOLN, ALBUTEROL SULFATE (5 MG/ML) 0.5% NEBU SOLN, AMPHOTERICIN B 50 MG RECON SOLN, AMPHOTERICIN B LIPOSOME, APREPITANT, ARALAST NP, ASTAGRAF XL, AZATHIOPRINE 100 MG TAB, AZATHIOPRINE 50 MG TAB, AZATHIOPRINE 75 MG TAB, AZATHIOPRINE 50 MG TAB, BUDESONIDE 0.25 MG/2ML SUSPENSION, BUDESONIDE 0.5 MG/2ML SUSPENSION, BUDESONIDE 1 MG/2ML SUSPENSION, CINACALCET HCL, CLINIMIX/DEXTROSE (4.25/10), CLINIMIX/DEXTROSE (4.25/5), CLINIMIX/DEXTROSE (5/15), CLINIMIX/DEXTROSE (5/20), CLINIMIX E/DEXTROSE (2.75/5), CLINIMIX E/DEXTROSE (4.25/10), CLINIMIX E/DEXTROSE (4.25/5), CLINIMIX E/DEXTROSE (5/15), CLINIMIX E/DEXTROSE (5/20), CLINISOL SF, CROMOLYN SODIUM 20 MG/2ML NEBU SOLN, CYCLOPHOSPHAMIDE 25 MG CAP, CYCLOPHOSPHAMIDE 50 MG CAP, CYCLOPHOSPHAMIDE 50 MG TAB, CYCLOSPORINE 100 MG CAP, CYCLOSPORINE 25 MG CAP, CYCLOSPORINE MODIFIED 100 MG CAP, CYCLOSPORINE MODIFIED 25 MG CAP, CYCLOSPORINE MODIFIED 50 MG CAP, CYCLOSPORINE MODIFIED, ELIGARD, ENGERIX-B, ENVARSUS XR, EVEROLIMUS 0.25 MG TAB, EVEROLIMUS 0.5 MG TAB, EVEROLIMUS 0.75 MG TAB, EVEROLIMUS 1 MG TAB, GAMMAGARD 2.5 GM/25ML SOLUTION, GAMMAGARD S/D LESS IGA, GAMMAPLEX 10 GM/100ML SOLUTION, GAMMAPLEX 10 GM/200ML SOLUTION, GAMMAPLEX 20 GM/200ML SOLUTION, GAMMAPLEX 5 GM/50ML SOLUTION, GAMUNEX-C 1 GM/10ML SOLUTION, GLASSIA, HEPARIN SODIUM (PORCINE) 10000 UNIT/ML SOLUTION, HEPARIN SODIUM (PORCINE) 1000 UNIT/ML SOLUTION, HEPARIN SODIUM (PORCINE) PF 1000 UNIT/ML SOLUTION, HEPLISAV-B, INTRALIPID, IPRATROPIUM-ALBUTEROL, IPRATROPIUM BROMIDE 0.02 % SOLUTION, LEVALBUTEROL HCL 0.31 MG/3ML NEBU SOLN, LEVALBUTEROL HCL 0.63 MG/3ML NEBU SOLN, LEVALBUTEROL HCL 1.25 MG/0.5ML NEBU SOLN, LEVALBUTEROL HCL 1.25 MG/3ML NEBU SOLN, LUPRON DEPOT, MYCOPHENOLATE MOFETIL 200 MG/ML RECON SUSP, MYCOPHENOLATE MOFETIL 250 MG CAP, MYCOPHENOLATE MOFETIL 500 MG TAB, MYCOPHENOLATE SODIUM, MYCOPHENOLIC ACID, NUTRILIPID, ONDANSETRON 4 MG TAB DISP, ONDANSETRON 8 MG TAB DISP, ONDANSETRON HCL 2 MG/2.5ML SOLUTION, ONDANSETRON HCL 4 MG/5ML SOLUTION, ONDANSETRON HCL 4 MG TAB, ONDANSETRON HCL 8 MG TAB, PENTAMIDINE ISETHIONATE, PREMASOL, PRIVIGEN 20 GM/200ML SOLUTION, PROGRAF 0.2 MG PACKET, PROGRAF 1 MG PACKET, PROLASTIN-C, PROSOL, PULMOZYME, RECOMBIVAX HB, SIROLIMUS 0.5 MG TAB, SIROLIMUS 1 MG/ML SOLUTION, SIROLIMUS 1 MG TAB, SIROLIMUS 2 MG TAB, TACROLIMUS 0.5 MG CAP, TACROLIMUS 1 MG CAP, TACROLIMUS 5 MG CAP,

TOBRAMYCIN 300 MG/4ML NEBU SOLN, TOBRAMYCIN 300 MG/5ML NEBU SOLN, TRAVASOL, TROPHAMINE, VORICONAZOLE 200 MG RECON SOLN, ZEMAIRA

DETAILS

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

PIMAVANSERIN TARTRATE (NUPLAZID)

MEDICATION(S)
NUPLAZID

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

RIOCIGUAT

MEDICATION(S)
ADEMPAS

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

SARGRAMOSTIM (LEUKINE)

MEDICATION(S)
LEUKINE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
2 months

OTHER CRITERIA
N/A

SEMAGLUTIDE (OZEMPIC)

MEDICATION(S)
OZEMPIC (0.25 OR 0.5 MG/DOSE) 2 MG/3ML SOLN PEN, OZEMPIC (1 MG/DOSE), OZEMPIC (2 MG/DOSE)

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

SILDENAFIL CITRATE (REVATIO)

MEDICATION(S)
SILDENAFIL CITRATE 20 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

SODIUM OXYBATE

MEDICATION(S)
SODIUM OXYBATE

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

SOFOSBUVIR AND VELPATASVIR (EPCLUSA)

MEDICATION(S)
SOFOSBUVIR-VELPATASVIR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 weeks

OTHER CRITERIA
Criteria will be applied consistent with current AASLD/IDSA guidance

SOFOSBUVIR (SOLVALDI)

MEDICATION(S)
SOVALDI 400 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
Criteria will be applied consistent with current AASLD-IDSA guidance

OTHER CRITERIA
Criteria will be applied consistent with current AASLD-IDSA guidance

SOFOSBUVIR/VELPATASVIR/VOXILAPREVIR (VOSEVI)

MEDICATION(S)
VOSEVI

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 weeks

OTHER CRITERIA
Criteria will be applied consistent with current AASLD/IDSA guidance

SOMATROPIN

MEDICATION(S)
GENOTROPIN, GENOTROPIN MINIQUICK, HUMATROPE, NORDITROPIN FLEXPRO 10 MG/1.5ML SOLN PEN, NORDITROPIN FLEXPRO 15 MG/1.5ML SOLN PEN, NORDITROPIN FLEXPRO 5 MG/1.5ML SOLN PEN, OMNITROPE, SEROSTIM

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

SOTATERCEPT-CSRK

MEDICATION(S)
WINREVAIR

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

TADALAFIL 5MG

MEDICATION(S)
TADALAFIL 5 MG TAB

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

TADALAFIL (ADCIRCA)

MEDICATION(S)
TADALAFIL (PAH)

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

TASIMELTEON

MEDICATION(S)
HETLIOZ LQ, TASIMELTEON

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

TEDUGLUTIDE (GATTEX)

MEDICATION(S)
GATTEX

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
12 months

OTHER CRITERIA
N/A

TERIPARATIDE (FORTEO)

MEDICATION(S)
TERIPARATIDE

PA INDICATION INDICATOR
1 - All FDA-Approved Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
2 years

OTHER CRITERIA
N/A

TIRZEPATIDE (MOUNJARO)

MEDICATION(S)
MOUNJARO

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A

TOFACITINIB

MEDICATION(S)
XELJANZ, XELJANZ XR

PA INDICATION INDICATOR
3 - All Medically-Accepted Indications

OFF LABEL USES
N/A

EXCLUSION CRITERIA
N/A

REQUIRED MEDICAL INFORMATION
N/A

AGE RESTRICTION
N/A

PRESCRIBER RESTRICTION
N/A

COVERAGE DURATION
1 year

OTHER CRITERIA
N/A