

MedStar Family Choice Prior Authorization and Step Therapy Table

Disclaimer: Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), and the Drug Package Insert (PPI).

Generic Medication (Brand Name) <small>Bolded medication specifies whether Brand or Generic is on Formulary with PA requirement</small>	Approval Criteria & Submission Requirements	Additional Considerations
acalabrutinib (Calquence) tablets 100mg	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • Treatment of adult patients with chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL). • Treatment of adult patients with mantle cell lymphoma (MCL) who have received at least one prior therapy. 2. Medication ordered by an Oncologist. 	<ul style="list-style-type: none"> • Continued approval for the MCL indication of MCL may be contingent upon verification and description of clinical benefit in confirmatory trials.
adagrasib (Krazati) tablets 200mg	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • To treat <i>KRAS</i> G12C-mutated locally advanced or metastatic non–small cell lung cancer (NSCLC), as determined by an approved test, in adults who have received at least 1 prior systemic therapy. 2. Test results confirming presence of <i>KRAS</i> G12C mutation in tumor or plasma specimens. 3. Medication ordered by an Oncologist. 	<ul style="list-style-type: none"> • This indication is approved under accelerated approval; continued approval for this indication may be contingent upon verification and description of a clinical benefit in a confirmatory trial.
alectinib (Alecensa) capsule 150mg	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • Treatment of patients with anaplastic lymphoma kinase (ALK)- positive metastatic non-small cell lung cancer (NSCLC) as detected by an FDA-approved test. 2. Medication ordered by an Oncologist. 	
alpelisib (Piqray; Vijoice) tablets Piqray: 200 mg, 250 mg, 300 mg dose Vijoice: 50mg, 125mg, 250 mg dose	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • Vijoice: Treatment of adult and pediatric patients ≥ 2 years of age with severe manifestations of PIK3CA-Related Overgrowth Spectrum (PROS) who require systemic therapy. • Piqray: treatment of men or postmenopausal women in 	<ul style="list-style-type: none"> • This indication is approved under accelerated approval; continued approval for this indication may be contingent upon verification and description of a clinical benefit in a confirmatory trial.

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	<p>combination with fulvestrant and men, with 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 following progression on or after an endocrine-based regimen.</p> <p>2. Medication ordered by an oncologist</p>	
amivantamab-vmjw (Rybrevent) solution 350mg/7ml	<p>1. Ordered for an approved indication for use:</p> <ul style="list-style-type: none"> treatment of adult patients with locally advanced or metastatic non-small cell lung cancer (NSCLC) with epidermal growth factor receptor (EGFR) exon 20 insertion mutations, as detected by an FDA-approved test, whose disease has progressed on or after platinum-based chemotherapy. <p>2. Medication ordered by an oncologist</p>	<ul style="list-style-type: none"> This indication is approved under accelerated approval; continued approval for this indication may be contingent upon verification and description of a clinical benefit in a confirmatory trial.
anifrolumab-fnia (Saphnelo) solution 300mg/2ml	<p>1. Ordered for an approved indication for use:</p> <ul style="list-style-type: none"> treatment of adult patients with moderate to severe systemic lupus erythematosus (SLE), who are receiving standard therapy. <p>2. Member must have documented evidence of trial/intolerance of Benlysta first.</p> <p>3. Lab report showing autoantibodies (e.g., ANA, anti-ds, anti-Sm)</p> <p>4. Current therapy for SLE alone or in combination with:</p> <ul style="list-style-type: none"> Glucocorticoid (e.g. prednisone, methylprednisone, dexamethasone) Antimalarials (e.g. hydroxychloroquine) Immunosuppressants (e.g. azathioprine, methotrexate, mycophenolate, cyclosporine, cyclophosphamide) 	<p>Limitations of Use:</p> <ul style="list-style-type: none"> Efficacy of Saphnelo has not been evaluated in patients with severe active lupus nephritis or severe active central nervous system lupus. Use is not recommended in these situations. Excluded use with Benlysta
aspirin (Vazalore) capsules 81mg, 325mg	<p>1. Ordered for an approved indication for use:</p> <ul style="list-style-type: none"> Pain relief Reduce fever 	

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	<ul style="list-style-type: none"> • Anti-inflammatory • Cardiovascular event prevention <p>2. Patient must have significant side effects (GERD, PUD, persistent nausea and vomiting, abdominal pain, etc.) with standard enteric coated aspirin. Side effects must be documented in the medical record that is submitted to MFC.</p>	
atogepant (Qulipta) tablets 10mg, 30mg, 60mg	<p>1. Ordered for an approved indication for use:</p> <ul style="list-style-type: none"> • preventive treatment of migraine in adults <p>2. Trial and failure or intolerance to at least three of the following agents: beta blockers, topiramate, Aimovig, and Ubrelvy, in medical documentation submitted.</p> <p>3. Patient must have at least 4 headache days per month on average.</p>	
avapritinib (Ayvakit) tablets 100mg, 200mg, 300mg	<p>1. Ordered for an approved indication for use:</p> <ul style="list-style-type: none"> • <u>Gastrointestinal Stromal Tumor (GIST)</u> <ul style="list-style-type: none"> ○ Treatment of adults with unresectable or metastatic GIST harboring a platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation, including PDGFRA D842V mutations. • <u>Advanced Systemic Mastocytosis (AdvSM)</u> <ul style="list-style-type: none"> ○ Treatment of adult patients with AdvSM. AdvSM includes patients with aggressive systemic mastocytosis (ASM), systemic mastocytosis with an associated hematological neoplasm (SMAHN), and mast cell leukemia (MCL). • <u>Indolent Systemic Mastocytosis (ISM)</u> <ul style="list-style-type: none"> ○ Treatment of adult patients with ISM. 	<p>Limitations of Use:</p> <ul style="list-style-type: none"> • AYVAKIT is not recommended for the treatment of patients with AdvSM with platelet counts of less than 50 X 10⁹ /L
avatrombopag (Doptelet) tablets 20mg	<p>1. Ordered for an approved indication for use:</p> <ul style="list-style-type: none"> • thrombocytopenia in adult patients with chronic liver disease who are scheduled to undergo a procedure. • thrombocytopenia in adult patients with chronic immune 	

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	<p>thrombocytopenia who have had an insufficient response to a previous treatment.</p> <ol style="list-style-type: none"> A recent (less than 1 month old) platelet count must be supplied with Medication ordered by a Hematologist 	
Axicabtagene ciloleucel (Yescarta) Injection	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> treatment of adult patients with large B- cell lymphoma that is refractory to first-line chemotherapy. The treatment facility that dispenses and administers Yescarta is enrolled and complies with the Risk Evaluation and Mitigation Strategy; AND Medication ordered by an Oncologist. 	Limitations of Use: <ul style="list-style-type: none"> Yescarta is not indicated for the treatment of patients with primary central nervous system lymphoma.
Azacitadine (Onureg) tablets 200mg, 300mg	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> Continued treatment of adult patients with acute myeloid leukemia who achieved first complete remission or complete remission with incomplete blood count recovery following intensive induction chemotherapy and are not able to complete intensive curative therapy. Medication ordered by an Oncologist. 	<ul style="list-style-type: none"> Do not substitute ONureg (azacitidine) for intravenous or subcutaneous azacitidine.
Bedaquiline (Sirturo) tablets 20mg, 100mg	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> as part of combination therapy in adult and pediatric patients ≥ 5 years of age and weighing at least 15 kg with pulmonary multi-drug resistant tuberculosis (MDR-TB). [Reserved for use when an effective treatment regimen cannot otherwise be provided. Medication ordered by infectious disease 	Limitations of Use: <ul style="list-style-type: none"> Do not use for the treatment of latent, extra pulmonary, or drug-sensitive tuberculosis.
belimumab (Benlysta) Inj 200mg/ml	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> patients ≥ 5 years of age with active systemic lupus erythematosus (SLE) who are receiving standard therapy. Patients ≥ 5 years of age with active lupus nephritis who are receiving standard therapy. 	Limitations of Use: <ul style="list-style-type: none"> The efficacy of BENLYSTA has not been evaluated in patients with severe active central nervous

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		system lupus. Use of BENLYSTA is not recommended in this situation.
Belumosudil (Rezurock) tablets 200mg	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> treatment of adult and pediatric patients 12 years and older with chronic graft-versus-host disease (chronic GVHD) after failure of at least two prior lines of systemic therapy. Member must have tried and failed, have intolerance or medical contraindication to at least three of these medications: cyclosporine, methotrexate, mycophenolate, sirolimus, and glucocorticoids. 	
benralizumab (Fasenra) Pen 30mg/ml	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> add-on maintenance treatment of patients ≥ 12 years of age with severe asthma and with an eosinophilic phenotype. Medication ordered by a Pulmonologist or Allergist 	Limitations of Use: <ul style="list-style-type: none"> Not for treatment of other eosinophilic conditions. Not for relief of acute bronchospasm or status asthmaticus.
berotralstat (Orladeyo) capsules 110mg, 150mg	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> prophylaxis to prevent attacks of hereditary angioedema (HAE) in adults and pediatric patients 12 years and older. Prescriber attestation that all baseline evaluations have been done, prophylactic therapy is medically necessary, and no contraindications to use. Prescriber attests that subsequent appropriate evaluation and monitoring will be done based on the package insert. Quantity limit of 1 capsule per day Initial approval duration: 6 months Prescriber is a hematologist, immunologist, or allergist. 	Requires MFC Physician or Pharmacist review prior to approval. Limitations of Use: <ul style="list-style-type: none"> Orladeyo should not be used for the treatment of acute HAE attacks. Renewal Criteria: <ul style="list-style-type: none"> Documentation of clinical response (decrease in the number of attacks). Renewal Approval Duration: 12 months
binimetinib (Mektovi) tablets 15mg	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> In combination with encorafenib, for the treatment of patients with unresectable or metastatic melanoma with a 	

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	BRAF V600E or V600K mutation, as detected by an FDA-approved test. 2. Medication ordered by an Oncologist	
blinatumomab (Blincyto) Injection 35mcg	1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • B-cell precursor acute lymphoblastic leukemia (ALL) in first or second complete remission with minimal residual disease (MRD) greater than or equal to 0.1%. • Relapsed or refractory B-cell precursor acute lymphoblastic leukemia (ALL). 2. Medication ordered by an Oncologist.	Requires MFC Physician or Pharmacist review prior to approval. <ul style="list-style-type: none"> • Continued approval for this indication may be contingent upon verification and description of clinical benefit in the confirmatory trials.
bosutinib (Bosulif) tablets 100mg, 500mg	1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • Newly diagnosed chronic phase Ph+ chronic myelogenous leukemia (CML). • Chronic, accelerated, or blast phase Ph+ CML with resistance or intolerance to prior therapy. 2. Medication ordered by an Oncologist.	
brentuximab (Adcetris) injection 50mg	1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • Treatment of adult patients with newly diagnosed chronic phase Ph+ chronic myelogenous leukemia (CML). • Treatment of chronic, accelerated, or blast phase Ph+ CML with resistance or intolerance to prior therapy. 2. Medication ordered by oncologist or hematologist.	Requires MFC Physician or Pharmacist review prior to approval. <u>Limitations of use:</u> <ul style="list-style-type: none"> • Brentuximab cannot be used concurrently with Bosulif (bosutinib).
brigatinib (Alunbrig) tablets 30mg, 90mg, 180mg	1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • The treatment of adult patients with anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer (NSCLC) as detected by an FDA-approved test. 2. Medication ordered by an Oncologist.	
Budesonide delayed-release (Tarpeyo) capsules 4mg	1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • to reduce proteinuria in adults with primary immunoglobulin A nephropathy (IgAN) at risk of rapid 	<u>Limitations of Use:</u> <ul style="list-style-type: none"> • This indication is approved under accelerated approval based on a

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	<p>disease progression, generally a urine protein-to-creatinine ratio (UPCR) ≥ 1.5 g/g.</p> <ol style="list-style-type: none"> History of failure, contraindication or intolerance to a glucocorticoid. Patient is on a stable and maximally tolerated dose of a renin-angiotensin system (RAS) inhibitor (ACEI or ARB), for at least 3 months, unless contraindicated. Medication ordered by a nephrologist. 	<p>reduction in proteinuria. It has not been established whether TARPEYO slows kidney function decline in patients with IgAN. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory clinical trial.</p>
burosumab-twza (Crysvita) injection 10mg/ml, 20mg/ml, 30mg/ml	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> Treatment of X-linked hypophosphatemia (XLH) in adult and pediatric patients ≥ 6 months of age. Treatment of FGF23-related hypophosphatemia in tumor-induced osteomalacia (TIO) associated with phosphaturic mesenchymal tumors that cannot be curatively resected or localized in adult and pediatric patients ≥ 2 years of age. 	<p>Requires MFC Physician or Pharmacist review prior to approval.</p> <p>Limitations of Use:</p> <ul style="list-style-type: none"> Contraindicated with oral phosphate and/or active vitamin D analogs; Contraindicated when serum phosphate is within or above normal range for age; Contraindicated in patients with severe renal impairment or end stage renal disease.
c1 Inhibitor [Human] cinryze sol 500 unit haegarda injection 2000unit, 3000unit	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> Routine prophylaxis to prevent Hereditary Angioedema attacks in patients ≥ 6 years of age. 	<p>Requires MFC Physician or Pharmacist review prior to approval.</p>
cabotegravir sodium (Apretude ER); suspension 600mg/3 ml	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> At-risk adults and adolescents weighing at least 35 kg for PrEP to reduce the risk of sexually acquired HIV-1 infection. 	<p>Limitations of use:</p> <ul style="list-style-type: none"> Individuals with severe renal impairment (creatinine clearance

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	Individuals must have a negative HIV-1 test prior to initiating APRETUDE.	15 to <30mL/min) or end stage renal disease (creatinine clearance <15mL/min), increased monitoring for adverse effects is recommended). See Apretude PI for details.
cabotegravir and rilpivirine extended-release (Cabenuva) injectable suspensions 400mg-600mg, 600mg-900mg	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> A complete regimen for the treatment of HIV-1 infection in adults and adolescents 12 years of age and older and weighing at least 35 kg to replace the current antiretroviral regimen in those who are virologically suppressed (HIV-1 RNA <50 copies/mL) on a stable antiretroviral regimen with no history of treatment failure and with no known or suspected resistance to either cabotegravir or rilpivirine. Documentation of clinical appropriateness is required and MUST include the following: <ul style="list-style-type: none"> Most recent office note (<3 months old) Lab test showing HIV-1 RNA less than 50 copies per ml (< 3 months old). 	
cabozantinib (Cabometyx) tablets 20mg, 40mg, 60mg (Cometriq) kit 60mg, 100mg, 140mg	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> Patients with advanced renal cell carcinoma (RCC) Patients with advanced renal cell carcinoma, as a first-line treatment in combination with nivolumab Patients with hepatocellular carcinoma (HCC) who have been previously treated with sorafenib Adult and pediatric patients ≥ 12 years of age with locally advanced or metastatic differentiated thyroid cancer (DTC) that has progressed following prior VEGFR-targeted therapy and who are radioactive iodine-refractory or ineligible Medication ordered by an Oncologist. 	
caplacizumab-yhdp (Cablivi) kit 11mg	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> Treatment of adult patients with acquired thrombotic 	Requires MFC Physician or Pharmacist review prior to approval.

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	thrombocytopenic purpura (aTTP), in combination with plasma exchange and immunosuppressive therapy. 2. Medication ordered by hematologist.	
Capmatinib (Tabrecta) tablets 150mg, 200mg	1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • treatment of adults with metastatic NSCLC whose tumors have a mutation that leads to mesenchymal-epithelial transition (MET) exon 14 skipping as detected by an approved test. 2. Medication ordered by an oncologist.	
casimersen (Amondys 45) injection 50mg/ml	1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • Treatment of Duchenne muscular dystrophy (DMD) in patients who have a confirmed mutation of the DMD gene that is amenable to exon 45 skipping. 2. Confirmed diagnosis of DMD with genetic confirmation of the DMD gene that is amenable to exon 45 skipping. 3. Provider attestation of baseline and subsequent evaluation and monitoring as appropriate such as hypersensitivity reactions and renal function. 4. Be on a stable dose of corticosteroid for ≥ 24 weeks. 5. Not ventilator dependent 6. Not receiving other RNA antisense therapy or gene therapy for DMD. 7. Maximum dose 30 mg/kg/dose once weekly 8. Prescribed by or in consultation with a pediatric neurologist with expertise in DMD.	<p>Requires MFC Physician or Pharmacist review prior to approval.</p> <ul style="list-style-type: none"> • This indication is approved under accelerated approval based on an increase in dystrophin production in skeletal muscle observed in patients treated with AMONDYS 45. Continued approval for this indication may be contingent upon verification of a clinical benefit in confirmatory trials. • Duration of approval is limited to 6 months. <p>Renewal Criteria:</p> <ul style="list-style-type: none"> • Not receiving other antisense therapy or gene therapy. • Not ventilator dependent. • Provider attestation of continued benefit without ADE • Max dose 30 mg/kg/dose/week • Duration: 6 months

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Cemiplimab-rwlc (Libtayo) injection 350mg/7ml	1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • treatment of patients with metastatic cutaneous squamous cell carcinoma (mCSCC) or locally advanced CSCC (laCSCC) who are not candidates for curative surgery or curative radiation. • treatment of patients with locally advanced BCC (laBCC) previously treated with a hedgehog pathway inhibitor or for whom a hedgehog pathway inhibitor is not appropriate. • treatment of patients with metastatic BCC (mBCC) previously treated with a hedgehog pathway inhibitor or for whom a hedgehog pathway inhibitor is not appropriate. • first-line treatment of patients with NSCLC whose tumors have high PD-L1 expression [Tumor Proportion Score (TPS) ≥ 50%] as determined by an FDA-approved test, with no EGFR, ALK or ROS1 aberrations, and is: <ul style="list-style-type: none"> ○ locally advanced where patients are not candidates for surgical resection or definitive chemoradiation or metastatic. 2. Medication ordered by an Oncologist	
cobimetinib (Cotellic) tablets 20mg	1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • Treatment of adult patients with unresectable or metastatic melanoma with a BRAF V600E or V600K mutation, in combination with vemurafenib. • As a single agent for the treatment of adult patients with histiocytic neoplasms. 2. Medication ordered by an Oncologist.	
Collagenase (Santyl) ointment 250units/gm	1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • Debriding chronic dermal ulcers and severely burned areas. 2. Medication ordered by a dermatologist or wound care specialist	
crisaborole (Eucrisa) ointment 2%	1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • Topical treatment of mild-to-moderate atopic dermatitis in 	

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STEP THERAPY	<p>adult and pediatric patients ≥ 3 months of age.</p> <p>2. Step Therapy: First must have tried and failed: At least one topical steroid AND topical tacrolimus OR pimecrolimus.</p>	
crizotinib (Xalkori) capsule 200mg, 250mg	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> the treatment of patients with metastatic non-small cell lung cancer (NSCLC) whose tumors are anaplastic lymphoma kinase (ALK) or ROS1-positive as detected by an FDA-approved test. pediatric patients 1 year of age and older and young adults with relapsed or refractory, systemic anaplastic large cell lymphoma (ALCL) that is ALK-positive. Medication ordered by an Oncologist 	Limitations of Use: <ul style="list-style-type: none"> The safety and efficacy of XALKORI have not been established in older adults with relapsed or refractory, systemic ALK-positive ALCL.
cysteamine bitartrate (Procysbi) capsules-25mg, 75mg granules-75mg, 300mg	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> treatment of nephropathic cystinosis in adults and pediatric patients ≥ 2 years of age. 	Requires MFC Physician or Pharmacist review prior to approval.
dabrafenib (Tafinlar) capsules 50mg, 75mg	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> treatment of patients with unresectable or metastatic melanoma with BRAF V600E or V600K mutations as detected by an FDA-approved test adjuvant treatment of patients with melanoma with BRAF V600E or V600K mutations, as detected by an FDA-approved test, and involvement of lymph node(s), following complete resection. treatment of patients with metastatic non-small cell lung cancer (NSCLC) with BRAF V600E mutation as detected by an FDA-approved test. treatment of patients with locally advanced or metastatic anaplastic thyroid cancer (ATC) with BRAF V600E mutation and with no satisfactory locoregional treatment options. 	Limitations of use: <ul style="list-style-type: none"> Tafinlar is not indicated for treatments of patients with colorectal cancer because of known intrinsic resistance to BRAF inhibition. Tafinlar is not indicated for treatment of patients with wild-type BRAF solid tumors The indication for treatment of adult and pediatric patients 6 years of age and older with unresectable or metastatic solid tumors with BRAF V600E mutation continued

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	<ul style="list-style-type: none"> • Treatment of adult and pediatric patients ≥ 6 years of age with unresectable or metastatic solid tumors with BRAF V600E mutation who have progressed following prior treatment and have no satisfactory alternative treatment options. • Treatment of pediatric patients ≥ 1 year of age with low-grade glioma (LGG) with BRAF V600E mutation who require systemic therapy. <p>2. Medication ordered by an Oncologist</p>	<p>approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trials.</p>
Dacomitinib (Vizimpro) tablets 15mg, 30mg, 45mg	<p>1. Ordered for an approved indication for use:</p> <ul style="list-style-type: none"> • first-line treatment of patients with metastatic non-small cell lung cancer (NSCLC) with epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 L858R substitution mutations as detected by an FDA-approved test. <p>2. Medication ordered by an Oncologist</p>	
dalfampridine (Ampyra) ER tablets 10mg	<p>1. Ordered for an approved indication for use:</p> <ul style="list-style-type: none"> • To Improve walking in adult patients with multiple sclerosis (MS). <p>2. Must be able to walk 25 feet within 8 to 45 seconds at baseline.</p> <p>3. Must have a baseline gait assessment by PT within 90 days of beginning Ampyra.</p> <p>4. Initial approval for 3 months only after 3 months, must show improvement in walking speed must be documented to obtain further refills.</p> <p>5. Medication ordered by a Neurologist.</p>	<p>Contraindications:</p> <ul style="list-style-type: none"> • History of seizure • Renal impairment CrCl ≤ 50 mL/min
daratumumab and hyaluronidase (Darzalex Faspro) solution	<p>1. Ordered for an approved indication for use:</p> <ul style="list-style-type: none"> • multiple myeloma in combination with bortezomib, melphalan and prednisone in newly diagnosed patients who are ineligible for autologous stem cell transplant. 	<p>Limitations of Use:</p> <ul style="list-style-type: none"> • DARZALEX FASPRO is not indicated and is not recommended for the treatment of patients with light chain (AL)

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	<ul style="list-style-type: none"> • multiple myeloma in combination with lenalidomide and dexamethasone in newly diagnosed patients who are ineligible for autologous stem cell transplant and in patients with relapsed or refractory multiple myeloma who have received at least one prior therapy. • multiple myeloma in combination with bortezomib, thalidomide, and dexamethasone in newly diagnosed patients who are eligible for autologous stem cell transplant. • multiple myeloma in combination with carfilzomib and dexamethasone in patients with relapsed or refractory multiple myeloma who have received one to three prior lines of therapy. • multiple myeloma as monotherapy, in patients who have received at least three prior lines of therapy including a proteasome inhibitor (PI) and an immunomodulatory agent or who are double refractory to a PI and an immunomodulatory agent. • light chain (AL) amyloidosis in combination with bortezomib, cyclophosphamide and dexamethasone in newly diagnosed patients. • multiple myeloma in combination with bortezomib and dexamethasone in patients who have received at least one prior therapy. • multiple myeloma in combination with pomalidomide and dexamethasone in patients who have received at least one prior line of therapy including lenalidomide and a proteasome inhibitor. <p>2. Medication ordered by an Oncologist</p>	amyloidosis who have NYHA Class IIIB or Class IV cardiac disease or Mayo Stage IIIB outside of controlled clinical trials.
darolutamide (Nubeqa) tablets 300mg	<p>1. Ordered for an approved indication for use:</p> <ul style="list-style-type: none"> • treatment of non-metastatic castration-resistant prostate 	

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	<p>cancer (mmCRPC).</p> <ul style="list-style-type: none"> Metastatic hormone-sensitive prostate cancer (mHSPC) in combination with docetaxel. <p>2. Medication ordered by an Oncologist or Urologist</p>	
<p>Dasatinib (Sprycel) tablets 20mg, 50mg, 70mg, 80mg 100mg,140mg</p>	<p>1. Ordered for an approved indication for use:</p> <ul style="list-style-type: none"> Newly diagnosed adults with Philadelphia chromosome-positive (Ph+) chronic myeloid leukemia (CML) in chronic phase. Adults with chronic, accelerated, or myeloid or lymphoid blast phase Ph+ CML with resistance or intolerance to prior therapy including imatinib. Adults with Ph+ ALL with resistance or intolerance to prior therapy. Pediatric patients ≥ 1 year of age with Ph+ CML in chronic phase. Pediatric patients ≥ 1 year of age with newly diagnosed Ph+ ALL in combination with chemotherapy. <p>2. Medication ordered by an Oncologist.</p>	
<p>Dulaglutide (Trulicity)</p>	<p>1. Ordered for an approved indication for use:</p> <ul style="list-style-type: none"> As an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus. Titration dose (0.75 mg) limited to 8 pens in 365 days without medical director review. Requires A1c within past 3 months or CGM reports that include time in range (TIR) Maximum 30-day supply per dispense. May not be concurrently taking a DPP4i (e.g. alogliptin, januvia, or tradjenta) 	<p>Cannot be approved for indication of weight management.</p> <p>Limitations of Use:</p> <ul style="list-style-type: none"> Contraindicated in patients with personal or family history of medullary thyroid carcinoma (MTC) and in patients with multiple endocrine neoplasia syndrome type 2 (MEN 2). Not for the treatment of type 1 diabetes or diabetic ketoacidosis. Not for patients with pre-existing

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		severe gastrointestinal disease <ul style="list-style-type: none"> • Not studied in patients with history of pancreatitis, consider alternate therapy.
Denosumab (Prolia; Xgeva) injection 60mg/ml (prolia)	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • treatment of postmenopausal women with osteoporosis at high risk for fracture. • treatment to increase bone mass in men with osteoporosis at high risk for fracture. • treatment of glucocorticoid-induced osteoporosis in men and women at high risk for fracture. • treatment to increase bone mass in men at high risk for fracture receiving androgen deprivation therapy for non-metastatic prostate cancer. • treatment to increase bone mass in women at high risk for fracture receiving adjuvant aromatase inhibitor therapy for breast cancer. 2. Tried and failed, had adverse reaction to, or contraindication to formulary preferred products (e.g. alendronate, calcitonin nasal spray) 	
desmopressin nasal spray products (DDAVP)	<p><u>DDAVP 0.1 mg/ml</u></p> <ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • antidiuretic replacement therapy in the management of central cranial diabetes insipidus. • Management of temporary polyuria and polydipsia following head trauma or surgery in the pituitary region. <p><u>Desmopressin acetate 1.5 mg/ml</u></p> <ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • Hemophilia A with Factor VIII coagulant activity levels greater than 5%. • Mild to moderate classic von Willebrand's disease (Type I) 	<p><u>Limitations of Use:</u></p> <ul style="list-style-type: none"> • Not indicated for treatment of: <ul style="list-style-type: none"> ○ nephrogenic diabetes insipidus ○ primary nocturnal enuresis ○ in patients with conditions that compromise the intranasal route of administration ○ patients with impaired consciousness ○ patients requiring a dose that is not a multiple of 10 mcg.

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	with Factor VIII levels greater than 5%.	Contraindications: <ul style="list-style-type: none"> in moderate to severe renal impairment, CrCl < 50 ml/min. in patients with or with a history of hyponatremia.
deutetrabenzine (Austedo) tablets 6mg, 9mg 12mg	1. Ordered for an approved indication for use: <ul style="list-style-type: none"> Chorea associated with Huntington’s disease. Tardive dyskinesia in adults. 	Contraindications: <ul style="list-style-type: none"> Suicidal, or untreated/inadequately treated depression in patients with Huntington’s disease. Hepatic impairment. Taking reserpine, MAOI’s, tetrabenazine or valbenazine.
Continuous Glucose Monitoring (CGM) systems (Dexcom G6, G7)	1. Ordered for an approved indication for use: <ul style="list-style-type: none"> The management of diabetes in persons aged 2 years and older. 2. Must report A1c with past 3 months or CGM report with 70% utilization or greater 3. Explanation of clinical need to use the requested CGM system instead of a formulary-preferred option.	Please click link below for CGM Policy: MFC Continuous Glucose Monitoring Devices Policy -MD
Dornase alfa (Pulmozyme) solution 1mg/ml	1. Ordered for an approved indication for use: <ul style="list-style-type: none"> in conjunction with standard therapies for the management of cystic fibrosis (CF) patients to improve pulmonary function. 2. Medication ordered by a Pulmonologist	
ecallantide (Kalbitor) injection 10mg/ml	1. Ordered for an approved indication for use: <ul style="list-style-type: none"> Treatment of acute attacks of hereditary angioedema (HAE) in patients ≥ 12 years of age. 2. Medication ordered by immunologist or allergist.	
Eculizumab (Soliris) injection - 10mg/ml	1. Ordered for an approved indication for use: <ul style="list-style-type: none"> Treatment of patients with paroxysmal nocturnal hemoglobinuria (PNH) to reduce hemolysis. 	Requires MFC Physician or Pharmacist review prior to approval. <ul style="list-style-type: none"> Patients should receive meningococcal vaccine at least 2

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	<ul style="list-style-type: none"> • Treatment of patients with atypical hemolytic uremic syndrome (aHUS) to inhibit complement-mediated thrombotic microangiopathy. • Treatment of generalized myasthenia gravis (gMG) in adult patients who are anti-acetylcholine receptor (AChR) antibody positive. • Treatment of neuromyelitis optica spectrum disorder (NMOSD) in adult. patients who are anti-aquaporin-4 (AQP4) antibody positive. <p>2. Prescribed by provider enrolled in REMS program.</p>	<p>weeks prior to treatment initiation; revaccination according to current guidelines.</p> <p>Limitations of Use:</p> <ul style="list-style-type: none"> • Eculizumab is not indicated for the treatment of patients with Shiga toxin E. coli related hemolytic uremic syndrome (STEC-HUS).
Efgartigimod alfa-fcab (Vyvgart) injection 400mg/20ml	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • Treatment of adult patients with anti-acetylcholine receptor antibody positive (AChR+) generalized myasthenia gravis (gMG) as monotherapy or in combination with glucocorticoids in patients with glucocorticoid-resistant or glucocorticoid-dependent disease. 2. Patient has Myasthenia Gravis Foundation of America (MGFA) Clinical Classification of Class II, III, or IV at initiation of therapy. 3. MG activities of daily living (MG-ADL) total score of ≥ 5. 4. Documentation of positive serologic test for anti-AChR antibodies. 5. Greater than 50% of baseline MG-ADL score is due to non-ocular symptoms. 6. Patient is currently receiving a stable dose of at least one gMG treatment (including cholinesterase inhibitors, corticosteroids, or non-steroidal immunosuppressants). 7. Documentation of patient's current weight for appropriate dosing. 8. Trial and failure, contraindication or documentation of intolerance to at least two of the following: <ul style="list-style-type: none"> • Rituximab or biosimilar (e.g. truxima) 	<p>Requires MFC Physician or Pharmacist review prior to approval.</p> <p>Limitations of Use:</p> <ul style="list-style-type: none"> • Not concurrently prescribed with Eculizumab (Soliris) • Dosed according to FDA labeled dosing up to a maximum of 1,200 mg/dose • Immunization with live-attenuated or live vaccines not recommended during treatment due to transient reduction in IgG levels during therapy.

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	<ul style="list-style-type: none"> • Cyclophosphamide • Azathioprine • Mycophenolate mofetil <p>9. Medication ordered by or in consultation with a neurologist.</p>	
elapegademase-lvlr (Revcovi) Injection 1.6mg/ml	<p>1. Ordered for an approved indication for use:</p> <ul style="list-style-type: none"> • treatment of adenosine deaminase severe combined immune deficiency (ADA-SCID) in pediatric and adult patients. 	<p>Requires MFC Physician or Pharmacist review prior to approval.</p> <p>Limitations of use:</p> <ul style="list-style-type: none"> • not studied in use of infants less than 3 months of age.
Elexacaftor, ivacaftor, and tezacaftor (Trikafta) tablets 150mg	<p>1. Ordered for an approved indication for use:</p> <ul style="list-style-type: none"> • treatment of cystic fibrosis (CF) in patients ≥ 2 years with at least one F508del mutation in the CFTR gene or a mutation in the CFTR gene that is responsive based on in vitro data. <p>2. If the patient’s genotype is unknown, an FDA-cleared CF mutation test should be used to confirm the presence of at least one F508del mutation or a mutation that is responsive based on in vitro data.</p> <p>3. Medication ordered by a Pulmonologist</p>	
Elosulfase alfa (Vimizim) injection 5mg/5ml	<p>1. Ordered for an approved indication for use:</p> <ul style="list-style-type: none"> • for patients with Mucopolysaccharidosis type IVA (MPS IVA; Morquio A syndrome). <p>2. Documented diagnosis of MPS IVA with biochemical/genetic confirmation by one of the following:</p> <ul style="list-style-type: none"> • Absence or marked reduction in N-acetylgalactosamine 6-sulfatase (GALNS) enzyme activity; OR • Sequence analysis and/or deletion/duplication analysis of the GALNS gene for biallelic mutation. <p>3. Age ≥ 5 years.</p> <p>4. Dosing and administration is 1.2 mg/kg IV over 3.5-4.5 hours once weekly.</p>	<p>Requires MFC Physician or Pharmacist review prior to approval.</p> <p>Renewal Criteria:</p> <ul style="list-style-type: none"> • 12 months with documented clinically significant improvement or stabilization in symptoms.

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emtricitabine and tenofovir alafenamide (Descovy) tablet 200mg/25mg	<p>5. Initial approval duration: 12 months</p> <p>1. Ordered for an approved indication for use:</p> <ul style="list-style-type: none"> • Combination with other antiretroviral agents for the treatment of HIV- 1 infection in adults and pediatric patients weighing at least 35 kg. • Combination with other antiretroviral agents other than protease inhibitors that require a CYP3A inhibitor for the treatment of HIV-1 infection in pediatric patients weighing at least 14 kg and less than 35 kg. 	<ul style="list-style-type: none"> • Although Descovy is FDA approved for pre-exposure prophylaxis, MFC does not cover it for this indication. Descovy is covered for HIV treatment only. [MFC covers emtricitabine tenofovir disoproxil (generic Truvada) for pre-exposure prophylaxis]. Descovy is covered only if there is a documented intolerance to or medical contraindication to emtricitabine tenofovir disoproxil (generic Truvada).
enfortumab vedotin-ejfv (Padcev) injection 20mg, 30mg	<p>1. Ordered for an approved indication for use:</p> <ul style="list-style-type: none"> • Treatment of adult patients with locally advanced or metastatic urothelial cancer who: <ul style="list-style-type: none"> ○ have previously received a programmed death receptor-1 (PD-1) or programmed death-ligand 1 (PD-L1) inhibitor and platinum containing chemotherapy, or ○ are ineligible for cisplatin-containing chemotherapy and have previously received one or more prior lines of therapy. <p>2. Medication ordered by Oncologist or Urologist</p>	
encorafenib (Braftovi) capsules 75mg	<p>1. Ordered for an approved indication for use:</p> <ul style="list-style-type: none"> • In combination with binimetinib, for the treatment of patients with unresectable or metastatic melanoma with a BRAF V600E or V600K mutation, as detected by an FDA-approved test. • In combination with cetuximab, for the treatment of adult patients with metastatic colorectal cancer (CRC) with a 	<p>Limitations of Use</p> <ul style="list-style-type: none"> • Braftovi is not indicated for treatment of patients with wild-type BRAF melanoma or wild-type BRAF CRC

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	<p>BRAF V600E mutation, as detected by an FDA-approved test, after prior therapy.</p> <p>2. Medication ordered by an Oncologist.</p>	
<p>entrectinib (Rozlytrek) Capsules 100mg, 200mg</p>	<p>1. Ordered for an approved indication for use:</p> <ul style="list-style-type: none"> • adult patients with metastatic non-small cell lung cancer (NSCLC) whose tumors are ROS1-positive. • adult and pediatric patients ≥ 12 years of age with solid tumors that have a neurotrophic tyrosine receptor kinase (NTRK) gene fusion without a known acquired resistance mutation, are metastatic or where surgical resection is likely to result in severe morbidity and have either progressed following treatment or have no satisfactory alternative therapy. <p>2. Medication ordered by an Oncologist.</p>	
<p>Enzalutamide (Xtandi) capsules 40mg</p>	<p>1. Ordered for an approved indication for use:</p> <ul style="list-style-type: none"> • castration-resistant prostate cancer for patients > 18 years of age. <p>2. Metastatic, castration-sensitive prostate cancer (mCRPC) for patients > 18 years of age.</p> <ul style="list-style-type: none"> • Medication ordered by an Oncologist or urologist 	<ul style="list-style-type: none"> • Patients receiving Xtandi should also receive a gonadotropin-releasing hormone (GnRH) analog concurrently or should have had bilateral orchiectomy. Examples of GnRH agonists include: leuprolide acetate, Lupron Depot (leuprolide acetate intramuscular injection), Trelstar (triptorelin pamoate intramuscular injection), Zoladex (goserelin acetate subcutaneous implant), Vantas (histrelin acetate subcutaneous implant).
<p>eptinezumab-jjmr (Vyepti) injection 100mg/ml</p>	<p>1. Ordered for an approved indication for use:</p> <ul style="list-style-type: none"> • preventive treatment of migraine in adults. • Trial and failure or intolerance to at least three of the following agents: beta blockers, topiramate, Aimovig, Emgality, and Ubrelvy, in medical documentation submitted. 	

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	<ul style="list-style-type: none"> • Patient must have average least 4 headache days per month. <p>2. Medication ordered by a Neurologist</p>	
erdafitinib (Balversa) tablets 3mg, 4mg, 5mg	<p>1. Ordered for an approved indication for use:</p> <ul style="list-style-type: none"> • Urothelial carcinoma in adults with locally advanced or metastatic with susceptible fibroblast growth factor receptor FGFR3 or FGFR2 genetic alterations AND • Progressed during or following at least one line of prior platinum-containing chemotherapy including within 12 months of neoadjuvant or adjuvant platinum-containing chemotherapy. <p>2. Medication ordered by an Oncologist.</p>	
estradiol and dienogest (Natazia) tablets	<p>1. Ordered for an approved indication for use:</p> <ul style="list-style-type: none"> • Treatment of non-acute heavy menstrual bleeding in women without organic pathology. • Contraception <p>2. Documentation with clinical reason that other formulary OCP cannot be used (ex: intolerance, prior side effects, failure after at least 3-month trial of formulary OCP).</p>	
evinacumab-dgnb (Evkeeza) injection 345mg/2.3ml, 1200mg/8ml	<p>1. Ordered for an approved indication for use:</p> <ul style="list-style-type: none"> • An adjunct to other low-density lipoprotein-cholesterol (LDL-C) lowering therapies for the treatment of adult and pediatric patients, ≥ 12 years of age, with homozygous familial hypercholesterolemia (HoFH). <p>2. Documented genetic test confirming homozygous familial hypercholesterolemia (HoFH).</p> <p>3. Baseline laboratory information required (full lipid panel, genetic testing, negative pregnancy test and documentation of use/counseling regarding contraception to prevent pregnancy</p>	<p>Requires MFC Physician or Pharmacist review prior to approval.</p> <p>Limitations of Use:</p> <ul style="list-style-type: none"> • The safety and effectiveness of EVKEEZA have not been established in patients with other causes of hypercholesterolemia, including those with heterozygous familial hypercholesterolemia (HeFH). • The effects of EVKEEZA on

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	<ol style="list-style-type: none"> 4. Prior trial/failure and/or documented intolerance to one high potency statin (atorvastatin, rosuvastatin) and concurrent ezetimibe. <ul style="list-style-type: none"> • Must provide laboratory data to support failure/intolerance (full lipid panel, creatinine kinase). • If failure, but no intolerance, lipid lowering therapy should be continued with aa statin and/or ezetimibe. 5. Dosing 15 mg/kg IV every 4 weeks. 6. Initial Approval Duration: 6 months. 	<p>cardiovascular morbidity and mortality have not been determined.</p> <p>Renewal Criteria:</p> <ul style="list-style-type: none"> • Meets all initial criteria • Must provide documentation of laboratory information to support continued use (full lipid panel) and continued use of concurrent therapies to lower cholesterol • Renewal Approval Duration: 12 months
<p>factor VIIa, recombinant human (NovoSeven RT) injection 1mg, 2mg, 5mg, 8mg</p>	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • treatment of bleeding episodes and perioperative management in adults and children with hemophilia A or B with inhibitors, congenital Factor VII (FVII) deficiency, and Glanzmann’s thrombasthenia with refractoriness to platelet transfusions, with or without antibodies to platelets. 2. Treatment of bleeding episodes and perioperative management in adults with acquired hemophilia 3. Medication ordered by a Hematologist 	<p>Requires MFC Physician or Pharmacist review prior to approval.</p> <ul style="list-style-type: none"> • Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial.
<p>factor VIII, recombinant human pegylated (Jivi) injection 500 unit, 1000unit, 2000unit, 3000unit</p>	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • On-demand treatment and control of bleeding episodes in adults and adolescents ≥ 12 years of age with hemophilia A. 2. Perioperative management of bleeding. 3. Routine prophylaxis to reduce the frequency of bleeding episodes. 4. Medication ordered by a Hematologist 	<p>Requires MFC Physician or Pharmacist review prior to approval.</p> <p>Limitations of use:</p> <ul style="list-style-type: none"> • Jivi is not indicated for use in previously untreated patients (PUPs). • Jivi is not indicated for the treatment of von Willebrand disease.
<p>fam-trastuzumab deuteccan-xk (Enhertu) injection 100mg</p>	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • Adult patients with unresectable or metastatic HER2-positive breast cancer who have received two or more 	

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	<p>prior anti-HER2-based regimens in</p> <ol style="list-style-type: none"> a. The metastatic setting OR b. In the neoadjuvant or adjuvant setting and have developed disease recurrence during or within six months of completing therapy <ul style="list-style-type: none"> • Adult patients with unresectable or metastatic HER2-low (IHC 1+ or IHC 2+/ISH-) breast cancer, who have received a prior chemotherapy in the metastatic setting or developed disease recurrence during or within 6 months of completing adjuvant chemotherapy. • Adult patients with unresectable or metastatic non-small cell lung cancer (NSCLC) whose tumors have activating HER2 (ERBB2) mutations and who have received a prior systemic therapy • Adult patients with locally advanced or metastatic HER2-positive gastric or gastroesophageal junction adenocarcinoma who have received a prior trastuzumab based regimen. <p>2. Medication ordered by an Oncologist.</p>	
fentanyl (Duragesic) transdermal patch 12mcg/hr, 25mcg/hr, 37.5mcg/hr, 50mcg/hr, 62.5mcg/hr, 75mcg/hr, 87.5mcg/hr, 100mcg/hr	<p>1. Ordered for an approved indication for use:</p> <ul style="list-style-type: none"> • the management of pain in opioid-tolerant patients, severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate. Patients considered opioid-tolerant are those taking, for one week or longer, at least 60 mg oral morphine per day, 25 mcg transdermal fentanyl per hour, 30 mg oral oxycodone per day, 8 mg oral hydromorphone per day, 25 mg oral oxymorphone per day, 60 mg oral hydrocodone per day, or an equianalgesic dose of another opioid. 	<ul style="list-style-type: none"> • All long-acting opioids require prior authorization (PA). The PA request form can be accessed using the following links: OPIOID PRIOR AUTH FORM-MD
finasteride/tadalafil (Entadfi) capsules-5mg/5mg	<p>1. Ordered for an approved indication for use:</p> <ul style="list-style-type: none"> • Treatment of signs and symptoms of benign prostatic 	<p>Contraindications:</p> <ul style="list-style-type: none"> • patients taking any form of organic

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	hyperplasia (BPH) in men with an enlarged prostate for up to 26 weeks.	nitrate, either regularly and/or intermittently <ul style="list-style-type: none"> concomitant use of guanylate cyclase stimulators e.g., riociguat (Adempas[®]) Discontinue alpha-blockers (e.g., alfuzosin, tamsulosin) at least 1 day prior to therapy initiation.
finerenone (Kerendia) tablets 10mg, 20mg	<ol style="list-style-type: none"> Ordered for approved indication: <ul style="list-style-type: none"> to reduce the risk of sustained eGFR decline, end stage kidney disease, cardiovascular death, non-fatal myocardial infarction, and hospitalization for heart failure in adult patients with chronic kidney disease (CKD) associated with type 2 diabetes (T2D). PA SUBMISSION REQUIREMENTS: <ul style="list-style-type: none"> Serum potassium ≤ 5.0 mEq/L eGFR ≥ 25 mL/min/1.73 m² Urine albumin-to-creatinine ratio ≥ 30 mg/g Concomitant use with maximum tolerated doses of ACE-Inhibitor or ARB unless intolerant to or contraindicated. Failed trial or contraindication to two formulary SGLT2i. 	Contraindications: <ul style="list-style-type: none"> patients with adrenal insufficiency concomitant treatment with strong CYP3A4 inhibitors (e.g adagrasib, atazanavir, ceritinib, clarithromycin, cobicistat and cobicistat-containing formulations, darunavir, idelalisib, indinavir, itraconazole, ketoconazole, levoketoconazole, lonafarnib, lopinavir, mifepristone, nefazodone, nelfinavir, Posaconazole, ritonavir and ritonavir-containing coformulations, saquinavir, telithromycin, tucatinib, voriconazole.
Fosdenopterin (Nulibry) injection 9.5mg	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> To reduce mortality risk in patients with molybdenum cofactor deficiency (MoCD) Type A. Diagnosis confirmed by genetic testing. 	Requires MFC Physician or Pharmacist review prior to approval. Limitations of use: <ul style="list-style-type: none"> Clinical studies of Nulibry did not include patients 65 years of age and older. Significant potential for drug-drug interactions.

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Fostamatinib disodium hexahydrate (Tavalisse) tablets 100mg, 150mg	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> the treatment of thrombocytopenia in adult patients with chronic immune thrombocytopenia (ITP) when a prior treatment for ITP has not worked well enough. Medication ordered by a Hematologist. 	Limitations of use: <ul style="list-style-type: none"> Should not be used in patients on hemodialysis. Additional benefit of doses > 1800 mg/day has not been established. Unknown if safe or effective in children
gabapentin extended-release (Gralise) tablets 300mg, 600mg	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> the management of Postherpetic Neuralgia (PHN). Not interchangeable with other gabapentin products because of differing pharmacokinetic profiles that affect dosing frequency. 	Limitations of use: <ul style="list-style-type: none"> Additional benefit of doses > 1800 mg/day has not been established. Should not be used in patients on hemodialysis.
Gilteritinib (Xospata) tablets 40mg	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> the treatment of adult patients who have relapsed or refractory acute myeloid leukemia (AML) with a FLT3 mutation as detected by an FDA-approved test. Medication ordered by an Oncologist 	
glecaprevir and pibrentasvir (Mavyret) tablets 100mg-40mg	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> treatment of adult and pediatric patients 3 years and older with chronic HCV genotype (GT) 1, 2, 3, 4, 5 or 6 infections without cirrhosis or with compensated cirrhosis (Child-Pugh A). treatment of adult and pediatric patients 3 years and older, weighing at least 45 kg with HCV genotype 1 infection, previously treated with a regimen containing an HCV NS5A inhibitor or an NS3/4A protease inhibitor, but not both. 	<ul style="list-style-type: none"> For a full listing of all Prior Authorization requirements, please click the link below: HEPC CRITERIA & PRIOR AUTH FORM-MD <ul style="list-style-type: none"> Contraindicated in patients with moderate or severe hepatic impairment (Child-Pugh B or C) or those with any history of prior hepatic decompensation. Contraindicated with coadministration of atazanavir or rifampin. Concomitant use with carbamazepine, efavirenz containing regimens and St. John's

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		<p>wort may decrease concentrations of Mavyret and is not recommended.</p>
<p>glycerol phenylbutyrate (Ravicti) Liquid 1.1grams/ml</p>	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> chronic management of patients with urea cycle disorders (UCDs) who cannot be managed by dietary protein restriction and/or amino acid supplementation alone. Confirmed diagnosis of urea cycle disorders (UCD's) as evidenced by plasma ammonia concentration of 150 micromole/L or higher associated with a normal anion gap and a normal plasma glucose concentration; and molecular genetic testing or measurement of enzyme activity. Age \geq 2 years of age. Patient must have tried and failed Buphenyl[®] as evidenced by unmanaged chronic hyperammonia over a 12-month period. Patient must be on a dietary protein restriction. Prescriber is a geneticist or other experienced clinician familiar with the management of UCD's. 	<p>Requires MFC Physician or Pharmacist review prior to approval.</p> <ul style="list-style-type: none"> Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trials. Ravicti is only available via select specialty pharmacies. Additional information can be found at www.ucdsupport.com or by calling UCD Support Services 833-830-7273.
<p>glycopyrronium (Qbrexza) pad 2.4%</p>	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> topical treatment of primary axillary hyperhidrosis in adults and pediatric patients \geq 9 years of age. Must have tried and failed OTC Clinical Strength antiperspirants and at least one prescription strength antiperspirant (ex: Drysol). Documentation that symptoms are persistent despite previous treatment attempts and that the degree of symptomatology impacts quality of life must be clearly indicated in a recent (within past 6 months) clinical encounter note. 	<ul style="list-style-type: none"> Contraindicated in medical conditions that can be exacerbated by the anticholinergic effect of glycopyrronium (e.g., glaucoma, paralytic ileus, unstable cardiovascular status in acute hemorrhage, severe ulcerative colitis, toxic megacolon complicating ulcerative colitis, myasthenia gravis, Sjogren's syndrome.)
<p>Golodirsen (Vyondys 53) injection 100mg/2ml</p>	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> treatment of Duchenne muscular dystrophy (DMD) in patients who have a confirmed mutation of the DMD gene that is amenable to exon 53 skipping. 	<p>Requires MFC Physician or Pharmacist review prior to approval.</p>

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	<ol style="list-style-type: none"> 2. Genetic testing must confirm patient’s DMD gene is amenable to exon 53 skipping. 3. Patient is older than 6 years of age or older, but age ≤ 15 years at therapy initiation 4. Baseline renal function test (GFR) and Urine protein-to-creatinine ratio prior to starting treatment. 5. Documented baseline function testing using a tool to demonstrate physical functions, including, but not limited to: Brooke Upper Extremity Scale, Baseline 6-minute walk test, Pediatric Evaluation of Disability Inventory. 6. Prescribed by or in consultation with a neurologist. 	<p>Limitations of use:</p> <ul style="list-style-type: none"> • Initial authorization should be for a period of 6 months. • Reauthorization criteria includes all of the initial criteria AND • Total course of therapy has not exceeded 12 months. • Patient has experienced a benefit from therapy, is tolerating therapy, AND medical records documenting that patient is maintaining ambulatory status.
Goserelin (Zoladex) implant 3.6mg, 10.8mg	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • palliative treatment of advanced carcinoma of the prostate. (3.6 mg and 10.8 mg) 2. in combination with flutamide for the management of locally confined stage T2b-T4 (Stage B2-C) carcinoma of the prostate. (3.6 mg and 10.8 mg) 3. management of endometriosis (3.6 mg) 4. palliative treatment of advanced breast cancer in pre- and peri-menopausal women. (3.6 mg) 5. to cause endometrial thinning agent prior to endometrial ablation for dysfunctional uterine bleeding. (3.6 mg) 6. management of endometriosis, including pain relief and reduction of endometriotic lesions for the duration of therapy. 	<p>Limitations for use:</p> <ul style="list-style-type: none"> • Experience with Zoladex for the management of endometriosis has been limited to women ≥ 18 years of age, treated for six months.
Histrelin implant (Supprelin LA) Kit 50mg	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • treatment of children with central precocious puberty (CPP). • Prior to initiation of treatment, a lab-confirmed, clinical diagnosis of CPP should verified through measurement of total sex steroids, luteinizing hormone (LH), and follicle stimulating hormone (FSH) following stimulation with a GnRH analog and assessment of bone age vs. chronological 	

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	age. 2. Medication ordered by pediatric endocrinologist.	
ibrutinib (Imbruvica) capsules 140mg	1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • Chronic lymphocytic leukemia (CLL) in adult patients who have received at least one prior therapy. • CLL in Adult patients with 17p deletion. • Waldenström’s macroglobulinemia in adult patients • Adult and pediatric patients ≥ 1 year of age with chronic graft versus host disease after failure of one or more lines of systemic therapy. 2. Medication ordered by an Oncologist.	Limitations for use: <ul style="list-style-type: none"> • Indications for Mantle Cell Lymphoma and Marginal Zone Lymphoma were voluntarily withdrawn, April 2023 <u>New dose modification guidelines adopted in December 2022:</u> <ul style="list-style-type: none"> • Therapy should be withheld for any new onset or worsening Grade 2 cardiac failure or Grade 3 cardiac arrhythmia. Once symptoms have resolved to Grade 1 cardiac failure or Grade 2 or lower cardiac arrhythmia, Imbruvica can be restarted at recommended adjusted doses.
Icatibant acetate (Firazyr) injection 30mg/3ml	1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • treatment of acute attacks of hereditary angioedema (HAE) in adults ≥ 18 years of age. 2. Medication ordered by an Allergist or ENT	<ul style="list-style-type: none"> • Self-administered by the patient upon recognition of symptoms of an HAE attack after training under the guidance of a healthcare professional.
idecabtagene vicleucel (Abecma) injection	1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • To treat relapsed or refractory multiple myeloma in adults after ≥4 prior therapies, including an immunomodulatory agent, a proteasome inhibitor, and an anti-CD38 monoclonal antibody. 2. Lymphodepleting chemotherapy (with fludarabine and cyclophosphamide) is ordered for administration for 3 days followed by Abecma dose infusion 2 days after completion of lymphodepleting therapy. 3. Diagnosis of relapsed or refractory multiple myeloma (MM) 4. Age ≥ 18 years	Requires MFC Physician or Pharmacist review prior to approval. Limitations of use: <ul style="list-style-type: none"> • Will be approved for ONE treatment dose. • Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial.

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	<ol style="list-style-type: none"> 5. Must have received at least 4 prior MM therapies (induction with or without hematopoietic stem cell transplant with or without maintenance therapy is considered a single regimen) 6. Must have received an immunomodulatory drug (iMiD), proteasome inhibitor (PI), and an anti-CD38 antibody 7. ECOG performance status of 0 or 1 8. HBV, HCV, and HIV screening within previous 30 days. 9. Provider attestation: Drug specific baseline evaluation and monitoring completed according to package insert (CBC/CMP, screening for HBV, hepatitis C, HIV), patient is not pregnant and is using effective contraception, counseling/assessment of recent live vaccine use. 10. Monitor immunoglobulin levels, blood counts, and for cytokine release syndrome during and after therapy. 11. Medication ordered by Hematologist or Oncologist enrolled in ABECMA REMS and compliance with REMS program criteria. 	
Idelalisib (Zydelig) tablets 100mg, 150mg	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • treatment of patients with relapsed chronic lymphocytic leukemia (CLL), in combination with rituximab, in patients for whom rituximab alone would be considered appropriate therapy due to other co-morbidities. 2. treatment of patients with relapsed follicular B-cell non-Hodgkin lymphoma (FL) in patients who have received at least two prior systemic therapies. 3. treatment of patients with relapsed small lymphocytic lymphoma (SLL) in patients who have received at least two prior systemic therapies. 4. Medication ordered by an Oncologist 5. Ordered through a Specialty Pharmacy 	<p><u>Limitations of use:</u></p> <ul style="list-style-type: none"> • Zydelig is not indicated nor recommended for first-line treatment of any patient, including patients with CLL, small lymphocytic lymphoma (SLL), follicular lymphoma (FL), and other indolent non-Hodgkin lymphomas. • Zydelig is not indicated and is not recommended in combination with bendamustine and rituximab, or in combination with rituximab for treatment of FL, SLL, and other indolent non-Hodgkin lymphomas.

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idursulfase (Elaprase) injection 6mg/3ml	1. Ordered for an approved indication for use: <ul style="list-style-type: none"> Patients with Hunter syndrome (Mucopolysaccharidosis II, MPS II). 	Requires MFC Physician or Pharmacist review prior to approval. <u>Limitations of use:</u> <ul style="list-style-type: none"> Limited data for use in children 16 months to 5 years of age. Safety and efficacy of Elaprase has not been established in pediatric patients less than 16 months of age.
imiglucerase (Cerezyme) injection 400 unit	1. Ordered for an approved indication for use: <ul style="list-style-type: none"> Treatment of adults and pediatric patients 2 years of age and older with Type 1 Gaucher disease that results in one or more of the following conditions: anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly. Administration under the supervision of a health care provider experienced in the treatment of Gaucher disease. 2. Diagnosis of Type 1 Gaucher disease 3. Diagnosis of one of the following complications associated with Type 1 Gaucher disease: <ul style="list-style-type: none"> Anemia Thrombocytopenia Bone disease Hepatomegaly Splenomegaly 4. Patient ≥ 2 years of age. 5. Quantity limited to no more than three times weekly administration.	Requires MFC Physician or Pharmacist review prior to approval.

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immune globulin subcutaneous (human) (Cutaquig) solution 1gm, 1.65gm, 2gm, 3.3gm, 4gm, 8gm	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> Replacement therapy for primary humoral immunodeficiency (PI) in adults and pediatric patients ≥ 2 years of age. Prevention of bacterial infection in patients with hypogammaglobulinemia and/or recurrent bacterial infections with malignancy (e.g., B-cell chronic lymphocytic leukemia) or primary humoral immunodeficiency disorders. Medication ordered by an Immunologist. 	
Infigratinib (Truseltiq) capsules 50mg, 75mg, 100mg, 125mg	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> treatment of adults with previously treated unresectable, locally advanced, or metastatic cholangiocarcinoma (CCA) with a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement as detected by an FDA-approved test. Confirmed presence of FGFR2 fusion or rearrangement prior to initiation of treatment. Medication ordered by an Oncologist 	<ul style="list-style-type: none"> Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial. Avoid concomitant use of Truseltiq with strong or moderate CYP3A inducers.
interferon gamma-1b (Actimmune) injection 2 million IU/0.5ml	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> To reduce frequency and severity of serious infections associated with chronic granulomatous disease (CGD). To delay time to disease progression in patients with severe, malignant osteopetrosis (SMO). 	<p>Requires MFC Physician or Pharmacist review prior to approval.</p> <ul style="list-style-type: none"> Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial.
Ipilimumab (Yervoy) injection 50mg, 200mg	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> Melanomas: Unresectable or metastatic in adults and pediatric patients ≥ 12 years of age, as a single agent or in combination with nivolumab. Adjuvant treatment of adult patients with cutaneous melanoma with pathologic involvement of regional lymph nodes of > 1 mm 	<p>Requires MFC Physician or Pharmacist review prior to approval.</p> <ul style="list-style-type: none"> Continued approval for indications of Colorectal cancer and Hepatocellular carcinoma may be contingent upon verification and

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	<p>who have undergone complete resection, including total lymphadenectomy.</p> <ul style="list-style-type: none"> • Renal Cell Carcinoma (RCC) <ul style="list-style-type: none"> ○ Treatment of adult patients with intermediate or poor risk advanced RCC, as first-line treatment in combination with nivolumab. • Colorectal Cancer <ul style="list-style-type: none"> ○ Treatment of adult and pediatric patients 12 years and older with microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) metastatic colorectal cancer that has progressed following treatment with a fluoropyrimidine, oxaliplatin, and irinotecan, in combination with nivolumab. • Hepatocellular Carcinoma <ul style="list-style-type: none"> ○ Treatment of adult patients with hepatocellular carcinoma who have been previously treated with sorafenib, in combination with nivolumab. • Non-Small Cell Lung Cancer (NSCLC) <ul style="list-style-type: none"> ○ Treatment of adult patients with metastatic non-small cell lung cancer expressing PD-L1 (≥1%) as determined by an FDA-approved test, with no EGFR or ALK genomic tumor aberrations, as first-line treatment in combination with nivolumab. ○ Treatment of adult patients with metastatic or recurrent non-small cell lung cancer with no EGFR or ALK genomic tumor aberrations as first-line treatment, in combination with nivolumab and 2 cycles of platinum-doublet chemotherapy. • Malignant Pleural Mesothelioma <ul style="list-style-type: none"> ○ Treatment of adult patients with unresectable malignant pleural mesothelioma, as first-line 	<p>description of clinical benefit in a confirmatory trial.</p>

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	<p>treatment in combination with nivolumab.</p> <ul style="list-style-type: none"> • Esophageal Cancer <ul style="list-style-type: none"> ○ Treatment of adult patients with unresectable advanced or metastatic esophageal squamous cell carcinoma, as first line treatment in combination with nivolumab. <p>4. Medication ordered by an Oncologist.</p>	
istradefylline (Nourianz) tablet 20mg, 40mg	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • Adjunctive treatment to levodopa/carbidopa in adult patients with Parkinson’s disease (PD) experiencing “off” episodes. 2. Medication ordered by a Neurologist. 	<ul style="list-style-type: none"> • Use not recommended in severe hepatic impairment (Child-Pugh class C)
ivacaftor (Kalydeco) Packets 25mg, 50mg, 75mg Tablets 150mg	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • Treatment of cystic fibrosis (CF) in patients ≥ 4 months who have one mutation in the CFTR gene that is responsive to ivacaftor potentiation based on clinical and/or <i>in vitro</i> assay data. 2. If the patient’s genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of a CFTR mutation followed by verification with bi-directional sequencing when recommended by the mutation test instructions for use. 3. Medication ordered by Pulmonologist 	<u>Limitations of use:</u> <ul style="list-style-type: none"> • Not effective in patients with CF who are homozygous for the F508del mutation in the CFTR gene.
Ivermectin (Sklice) lotion 0.5% STEP THERAPY ; OTC product	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • the topical treatment of head lice infestations in patients ≥ 6 months of age. 	Step Therapy: First must have tried and failed: <ul style="list-style-type: none"> • Age < 6 years – OTC permethrin 1% • Age > 6 years– malathion
Ivermectin (Stromectol) tablets 3mg	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: 	<u>Limitations for use:</u> <ul style="list-style-type: none"> • At this time, outpatient use for COVID-19 treatment is prohibited.

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	<ul style="list-style-type: none"> Strongyloidiasis of the intestinal tract (i.e., nondisseminated) strongyloidiasis due to the nematode parasite <i>Strongyloides stercoralis</i>. Onchocerciasis due to the nematode parasite <i>Onchocerca volvulus</i>. 	<ul style="list-style-type: none"> Ivermectin has no activity against adult <i>Onchocerca volvulus</i> parasites. Ivermectin is not active against <i>L. loa</i> (adult worms).
Ivosidenib (Tibsovo) tablets 250mg	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> treatment of adult patients with a susceptible IDH1 mutation as detected by an FDA-approved test with: Acute Myeloid Leukemia (AML), newly diagnosed who are ≥ 75 years old or who have comorbidities that preclude use of intensive induction chemotherapy. Relapsed or refractory AML Locally Advanced or Metastatic Cholangiocarcinoma who have been previously treated. Medication ordered by an Oncologist 	
Lanadelumab-flyo (Takhzyro) injection 300mg/2ml	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> hereditary angioedema (HAE) prophylaxis in adult and pediatric patients ≥ 2 years of age. 	Requires MFC Physician or Pharmacist review prior to approval.
Lapatinib (Tykerb) tablets 250mg	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> In combination with capecitabine for the treatment of patients with advanced or metastatic breast cancer whose tumors overexpress human epidermal growth factor receptor 2 (HER2) and who have received prior therapy, including an anthracycline, a taxane, and trastuzumab. In combination with letrozole for the treatment of postmenopausal women with hormone receptor-positive metastatic breast cancer that overexpresses the HER2 receptor for whom hormonal therapy is indicated. Medication ordered by an Oncologist. 	Limitations of use: <ul style="list-style-type: none"> Lapatinib in combination with an aromatase inhibitor has not been compared to a trastuzumab-containing chemotherapy regimen for the treatment of metastatic breast cancer.

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Lasmiditan (Reyvow)	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> the acute treatment of migraine with or without aura in adults. Member must have tried and failed NSAIDs and Triptans or have a contraindication to taking either of these medications. 	
Larotrectinib (Vitrakvi) capsules 25mg, 100mg	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> Treatment of adult and pediatric patients with solid tumors that have a neurotrophic receptor tyrosine kinase (NTRK) gene fusion without a known acquired resistance mutation, are metastatic or where surgical resection is likely to result in severe morbidity, and no satisfactory alternative treatments or that have progressed following treatment. Medication ordered by an Oncologist 	
Lecanemab-irmb (Leqembi) 200 mg/2 ml Intravenous solution	<ol style="list-style-type: none"> Ordered for an approved indication: <ul style="list-style-type: none"> Treatment of Alzheimer disease; to be initiated in patients with mild cognitive impairment or mild dementia stage of disease, with confirmed presence of amyloid beta pathology prior to initiation of treatment. Patient has signed informed consent on file. Patient meets criteria for mild cognitive impairment (MCI) or mild AD dementia. Patient has had an MRI scan within last 12 months. Amyloid PET imaging and/or CSF analysis consistent with AD. Functional Assessment Staging Test Stage score of 2 to 4. Mini-Mental State Examination score greater than 21, or St. Louis University Mental Status (SLUMS) score or Montreal Cognitive Assessment (MoCA) score of greater than 16. Patient does not have any of the following risk factors for intracerebral hemorrhage: <ul style="list-style-type: none"> prior cerebral hemorrhage greater than 1 cm in greatest diameter, more than 4 microhemorrhages, superficial 	Renewal Criteria: <ul style="list-style-type: none"> Patient continues to meet criteria for initial approval Absence of unacceptable toxicity from drug AND Patient has responded to therapy compared to pretreatment as evidenced by improvement, stability, or slowing in cognitive and/or functional impairment in one or more of the following (not all-inclusive): ADAS-Cog 13; ADCS-ADL-MCI; MMSE: CDR-SB etc, AND Patient has not progressed to moderate or severe AD; AND Patient has received a pre-5th, 7th, AND 14th infusion MRI for monitoring of Amyloid Related

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	<p>siderosis,</p> <ul style="list-style-type: none"> • evidence of vasogenic edema, • evidence of cerebral contusion, • aneurysm, • vascular malformation, • infective lesions, • multiple lacunar infarcts or stroke involving a major vascular territory, • and severe small vessel or white matter disease. <p>9. Ordered by a Board-certified neurologist, geriatric psychiatrist, or geriatrician who specializes in treating dementia.</p>	<p>Imaging Abnormalities-edema (ARIA-E) and Amyloid Related Imaging Abnormalities hemosiderin (ARIA-H) microhemorrhages.</p>
<p>Lenalidomide (Revlimid) capsules 2.5mg, 5mg, 10mg, 15mg, 20mg, 25mg</p>	<p>1. Ordered for an approved indication for use:</p> <ul style="list-style-type: none"> • Treatment of adult patients with multiple myeloma (MM) in combination with dexamethasone. • Maintenance therapy in adult patients with MM following autologous hematopoietic stem cell transplantation (auto-HSCT). • Transfusion-dependent anemia due to low- or intermediate-1-risk myelodysplastic syndromes (MDS) associated with a deletion 5q abnormality with or without additional cytogenetic abnormalities. • Adults with Mantle cell lymphoma (MCL) whose disease has relapsed or progressed after two prior therapies, one of which included bortezomib. • Previously treated adults with follicular lymphoma (FL), in combination with a rituximab product. • Previously treated marginal zone lymphoma (MZL) in combination with a rituximab product in adults. <p>2. Medication ordered by an oncologist registered in the Lenalidomide REMS program.</p>	<p>Limitations for use:</p> <ul style="list-style-type: none"> • Not indicated nor recommended for treatment of patients with chronic lymphocytic leukemia (CLL) outside of controlled trials

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<p>Leuprolide</p> <p>Eligard Injection 45mg</p> <p>Lupron Depot Injection 3.75mg, 7.5mg, 11.25mg, 22.5mg, 30mg, 45mg</p> <p>Lupron Depot-PED Injection 7.5mg, 11.25mg 15mg, 30mg, 50mg</p>	<p>1. Ordered for an approved indication for use:</p> <ul style="list-style-type: none"> • <u>Eligard or Lupron (leuprolide acetate SQ):</u> <ul style="list-style-type: none"> ○ Palliative treatment of advanced prostate cancer. • <u>Lupron Depot:</u> <ul style="list-style-type: none"> ○ Treatment of advanced prostate cancer. ○ Management of Endometriosis, including pain relief and reduction of endometriotic lesions (3.75 or 11.25 mg strengths). ○ In combination with norethindrone acetate for initial management of painful symptoms of endometriosis and recurrence of symptoms (3.75 or 11.25 mg strengths). ○ Uterine leiomyomata (fibroids) concomitantly with iron therapy for preoperative hematologic improvement of women with anemia caused by fibroids for whom three months of hormonal suppression is deemed necessary. • <u>Endometriosis</u> • <u>Lupron Depot-PED:</u> <ul style="list-style-type: none"> • Treatment of pediatric patients with central precocious puberty (CPP). 	<p><u>Limitations of use:</u></p> <ul style="list-style-type: none"> • Lupron Depot is not indicated for combination use with norethindrone acetate add-back therapy for the preoperative hematologic improvement of women with anemia caused by heavy menstrual bleeding due to fibroids. • Total duration of therapy with Lupron Depot plus add-back therapy should not exceed 12 months due to concerns about adverse impact on bone mineral density. • When indicated for endometriosis, Lupron-Depo for adults ≥ 18 years of age 3.75 mg monthly for 6 months. • When indicated for endometriosis in patients < 18 years of age, should be reserved for pain refractory to conservative surgical therapy in combinations with add-back therapy.
<p>Lifitegrast ophthalmic (Xiidra) Drop 5%</p>	<p>1. Ordered for an approved indication for use:</p> <ul style="list-style-type: none"> • the treatment of the signs and symptoms of dry eye disease (DED). <p>2. Must have tried and failed artificial tears AND cyclosporine (ophth) emulsion 0.05% (generic of Restasis)</p>	
<p>Liraglutide (Victoza)</p>	<p>1. Ordered for an approved indication for use:</p> <ul style="list-style-type: none"> • As an adjunct to diet and exercise to improve glycemic control in patients ≥ 10 years of age with type 2 diabetes mellitus. 	<p>Cannot be approved for indication of weight management.</p> <p><u>Limitations of Use:</u></p> <ul style="list-style-type: none"> • Should not be co-administered with

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	<ol style="list-style-type: none"> 2. To reduce the risk of major adverse cardiovascular events in adults with type 2 diabetes mellitus and established cardiovascular disease. 3. A1c within previous 3-months. 4. Recent CGM report if applicable. 5. Limited to 30-day supply per dispense. 6. May not be concurrently taking a DPP4i (e.g. alogliptin, januvia, or tradjenta) 	<p>other liraglutide-containing products (e.g. Xultophy)</p> <ul style="list-style-type: none"> • Contraindicated in patients with personal or family history of medullary thyroid carcinoma (MTC) and in patients with multiple endocrine neoplasia syndrome type 2 (MEN 2). • Not for the treatment of type 1 diabetes or diabetic ketoacidosis. • Not for patients with pre-existing severe gastrointestinal disease • Not studied in patients with history of pancreatitis, consider alternate therapy.
lisocabtagene maraleucel (Breyanzi) injection	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • Treatment of adult patients with large B-cell lymphoma (LBCL) including diffuse large B-cell lymphoma (DLBCL) not otherwise specified (including DLBCL arising from indolent lymphoma), high-grade B-cell lymphoma, primary mediastinal large B-cell lymphoma, and follicular lymphoma grade 3B, who have: <ol style="list-style-type: none"> a. refractory disease to first-line chemoimmunotherapy or relapse within 12 months of first-line chemoimmunotherapy; or b. refractory disease to first-line chemoimmunotherapy or relapse after first-line chemoimmunotherapy and are not eligible for hematopoietic stem cell transplantation (HSCT) due to comorbidities or age; or 	<p>Requires MFC Physician or Pharmacist review prior to approval.</p> <p><u>Limitations of Use:</u></p> <ul style="list-style-type: none"> • BREYANZI is not indicated for the treatment of patients with primary central nervous system lymphoma.

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	<p>c. relapsed or refractory disease after two or more lines of systemic therapy.</p> <ol style="list-style-type: none"> Age ≥ 18 years of age. Prescriber attestation that all baseline evaluations have been done, and no contraindications to use are present. Prescriber attests that subsequent appropriate evaluation and monitoring will be done based on the package insert. Dose: 50-110 x 10⁶ CAR positive viable T cells, one time dose. Medication ordered by an Oncologist or Hematologist. 	
lomitapide (Juxtapid) capsules 5mg, 10mg, 20mg, 30mg	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> An adjunct to a low-fat diet and other lipid-lowering treatments, including LDL apheresis where available, to reduce LDL-C, total cholesterol, apolipoprotein B, and non-HDL-C in patients with homozygous familial hypercholesterolemia. Medication ordered by a REMS registered cardiologist or endocrinologist. 	Limitations of Use: <ul style="list-style-type: none"> The safety and effectiveness of JUXTAPID have not been established in patients with hypercholesterolemia who do not have HoFH, including those with heterozygous familial hypercholesterolemia (HeFH). The effect of JUXTAPID on cardiovascular morbidity and mortality has not been determined.
Loncastuximab tesirine-lpyl (Zynlonta) solution 10mg	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> the treatment of adult patients with relapsed or refractory large B-cell lymphoma after two or more lines of systemic therapy, including diffuse large B-cell lymphoma (DLBCL) not otherwise specified, DLBCL arising from low-grade lymphoma, and high-grade B-cell lymphoma. Medication ordered by an Oncologist 	Requires MFC Physician or Pharmacist review prior to approval. <ul style="list-style-type: none"> Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trials.
lorlatinib (Lorbrena) tablets 25mg, 100mg	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> the treatment of adult patients with metastatic non-small cell lung cancer (NSCLC) whose tumors are anaplastic lymphoma kinase (ALK)-positive as detected by an FDA-approved test. 	<ul style="list-style-type: none"> Contraindicated with concomitant use of strong CYP3A inducers.

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Lumacaftor/ivacaftor (Orkambi) Granules 75mg-94mg, 100mg-125mg, 150mg-188mg Tablets 100mg-125mg, 200mg-125mg	2. Medication ordered by Oncologist 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> the treatment of cystic fibrosis (CF) in patients aged 1 year and older who are homozygous for the F508del mutation in the CFTR gene. 2. If the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to confirm the presence of the F508del mutation on both alleles of the CFTR gene. 3. Medication ordered by Pulmonologist	Limitations of use: <ul style="list-style-type: none"> The efficacy and safety of Orkambi have not been established in patients with CF other than those homozygous for the F508del mutation. Not recommended in CF patients who have undergone organ transplantation; has not been studied in this population.
lumasiran (Oxlumo) injection 94.5mg/0.5ml	1. Ordered for an approved indication for use: <ul style="list-style-type: none"> treatment of primary hyperoxaluria type 1 (PH1) to lower urinary and plasma oxalate levels in pediatric and adult patients. 	Requires MFC Physician or Pharmacist review prior to approval. <ul style="list-style-type: none"> Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial.
Lurbinectedin (Zepzelca) solution	1. Ordered for an approved indication for use: <ul style="list-style-type: none"> treatment of adult patients with metastatic small cell lung cancer (SCLC) with disease progression on or after platinum-based chemotherapy. 2. Medication ordered by an Oncologist	<ul style="list-style-type: none"> Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trials.
lusutrombopag (Mulpleta) tablets 3mg	1. Ordered for an approved indication for use: <ul style="list-style-type: none"> Treatment of thrombocytopenia in adult patients with chronic liver disease who are scheduled to undergo a procedure. 	Limitations for use: <ul style="list-style-type: none"> Mulpleta has been investigated only as a single 7-day once daily dosing regimen in clinical trials in patients with chronic liver disease. Mulpleta should not be administered to patients with chronic liver disease in an attempt to normalize platelet counts.

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Macimorelin (Macrilen) Packets 60mg	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> The diagnosis of adult growth hormone deficiency. Medication ordered by an endocrinologist 	Limitations of Use: <ul style="list-style-type: none"> The safety and diagnostic performance have not been established for subjects with BMI > 40kg/m² Potential for False Positive Test Results with use of strong CYP3A4 inducers; discontinue and washout out before testing. Potential for False Negative Test Results in recent onset hypothalamic disease: consider repeat testing if indicated.
Maribavir (Livtency) tablets 200mg	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> treatment of adults and pediatric patients (12 years of age and older and weighing at least 35 kg) with post-transplant CMV infection/disease that is refractory to treatment (with or without genotypic resistance) with ganciclovir, valganciclovir, cidofovir or foscarnet. 	<ul style="list-style-type: none"> If a patient has a paid claim in the MFC system for ganciclovir, valganciclovir, cidofovir, or foscarnet, Livtency will process at the pharmacy without PA. If there is no evidence of a paid claim for ganciclovir, valganciclovir, cidofovir, or foscarnet, a PA is required, and documentation of previous use of one of these medications should be submitted.
mavacamten (Camzyos) capsules 2.5mg, 5mg, 10mg 15mg	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> The treatment of adults with symptomatic New York Heart Association (NYHA) class II-III obstructive hypertrophic cardiomyopathy (HCM) to improve functional capacity and symptoms. Must have echocardiogram assessment of left ventricular ejection fraction before use. 	Limitations of Use: <ul style="list-style-type: none"> Initiation of mavacamten in patients with LVEF <55% is not recommended. Interrupt mavacamten if LVEF <50% at any visit or if patient experiences heart failure

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	<ol style="list-style-type: none"> 3. Must include documentation that echocardiogram assessments will be conducted during Campzyos use. 4. Prescribed by cardiologist experienced with care and treatment of people with HCM in accordance with ACC guidelines and enrolled in the CAMZYOS REMS program. 	<p>symptoms or worsening clinical status.</p> <ul style="list-style-type: none"> • Contraindicated with moderate to strong CYP2C19 inhibitors, strong CYP3A4 inhibitors, moderate-to-strong CYP2C19 inducers or moderate-to-strong CYP3A4 inducers.
<p>Mepolizumab (Nucala) Injection</p> <p>40mg/0.4ml, 100mg, 100mg/ml</p>	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • Add-on maintenance treatment for severe asthma with eosinophilic phenotype in patients aged 6 years and older. 2. Add-on treatment of adult patients with chronic rhinosinusitis with nasal polyps. 3. Treatment of eosinophilic granulomatosis with polyangiitis (EGPA) in adults. 4. Treatment of adult and pediatric patients aged ≥ 12 years of age with hypereosinophilic syndrome (HES) for ≥ 6 months without an identifiable non-hematologic secondary cause. 5. Medication ordered by an Allergist or Pulmonologist. 	
<p>Methadone (for Pain) Concentrate 10mg/ml</p> <p>Solution 5mg/5ml, 10mg/5ml,</p> <p>Tablets 5mg, 10mg</p>	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • The management of chronic pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate. 	<p>All long-acting opioids require Prior Authorization (PA). The PA form can be accessed using the following link:</p> <p>OPIOID PRIOR AUTH FORM-MD</p> <p>Limitations of Use:</p> <ul style="list-style-type: none"> • Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with long-

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		<p>acting opioids, reserve Methadone for use in patients for whom alternative treatment options are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.</p>
Methotrexate SubQ (Rasuvo) injection 7.5mg, 10mg, 12.5mg, 15mg, 17.5mg, 20mg, 22.5mg, 25mg, 30mg	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • management of patients with severe, active rheumatoid arthritis (RA) and polyarticular juvenile idiopathic arthritis (pJIA), who are intolerant of or had an inadequate response to first-line therapy. 2. Symptomatic control of severe, recalcitrant, disabling psoriasis in adults who are not adequately responsive to other forms of therapy. 3. Medication ordered by a Rheumatologist or Dermatologist 	<p>Limitations of Use:</p> <ul style="list-style-type: none"> • Rasuvo is not indicated for the treatment of neoplastic diseases. • Contraindicated for pregnant or nursing mothers, in patients with alcoholism or liver disease, in immunodeficiency syndromes, or with preexisting blood dyscrasias.
metreleptin (Myalept) injection 11.3mg	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • An adjunct to diet as replacement therapy to treat the complications of leptin deficiency in patients with congenital or acquired generalized lipodystrophy. 2. Ordering provider is registered with Myalept REMS program. 	<p>Requires MFC Physician or Pharmacist review prior to approval.</p> <p>Limitations of Use:</p> <ul style="list-style-type: none"> • The safety and effectiveness of MYALEPT for the treatment of complications of partial lipodystrophy OR liver disease, including nonalcoholic steatohepatitis (NASH), have not been established. • MYALEPT is not indicated for use in patients with HIV-related lipodystrophy.

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		<ul style="list-style-type: none"> • MYALEPT is not indicated for use in patients with metabolic disease, without concurrent evidence of generalized lipodystrophy.
mifepristone (Korlym) tablets Korlym-300mg ONLY	1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • Control of hyperglycemia secondary to hypercortisolism in adult patients with endogenous Cushing’s syndrome who have type 2 diabetes mellitus or glucose intolerance and have failed surgery or are not candidates for surgery. 	<p>Requires MFC Physician or Pharmacist review prior to approval.</p> <p>**No other indications approved, can redirect requests for Mifeprex brand to appropriate formulary alternatives.</p> <p><u>Limitations of Use:</u></p> <ul style="list-style-type: none"> • Do not use for the treatment of type 2 diabetes mellitus unrelated to endogenous Cushing’s syndrome. • Obtain a negative pregnancy test in females of reproductive potential prior to initiating treatment with KORLYM or if treatment is interrupted for more than 14 days • maximum of 1200 mg daily. Do not exceed 20 mg/kg per day • Renal impairment: do not exceed 600 mg once daily • Mild-to-moderate hepatic impairment: do not exceed 600 mg once daily. • Do not use in severe hepatic impairment

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		<ul style="list-style-type: none"> Concomitant administration with strong CYP3A inhibitors: Do not exceed 900 mg once
mirabegron (Myrbetriq) tablets 25mg, 50mg	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> Overactive bladder (OAB) in adult patients with symptoms of urge urinary incontinence, urgency, and urinary frequency, either alone or in combination with the muscarinic antagonist solifenacin succinate. Pediatric neurogenic detrusor overactivity (NDO) in patients weighing ≥ 35 kg. OAB: adequate trial (30 days), or intolerance to at least 2 preferred bladder agents. NDO: Adequate trial (30 days), or intolerance to oxybutynin IR or ER OR the patient is ≥ 5 years of age No concurrent diagnosis of severe hepatic impairment (Child-Pugh Class C) 	<ul style="list-style-type: none"> MYRBETRIQ Granules is a beta-3 adrenergic agonist indicated for the treatment of NDO in pediatric patients aged 3 years and older. Indication: Neurogenic detrusor overactivity (NDO) in pediatric patients aged 3 years and older and weighing 35 kg or more. <p>Limitations for use:</p> <ul style="list-style-type: none"> Extended-release tablets and granules are not bioequivalent and cannot be substituted on a mg:mg basis. Do not combine dosage forms to achieve a specific dose.
mobocertinib (Exkivity) capsules 40mg	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> Treatment of adult patients with locally advanced or metastatic non-small cell lung cancer (NSCLC) with epidermal growth factor receptor (EGFR) exon 20 insertion mutations, as detected by an FDA-approved test, whose disease has progressed on or after platinum-based chemotherapy. Medication ordered by an oncologist. 	<ul style="list-style-type: none"> Black box warning for Qtc-prolongation. Avoid concomitant use of drugs that prolong QTc and use of strong/moderate CYP3A inhibitors. This indication is approved under accelerated approval based on overall response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit.
Mogamulizumab-kpkc (Poteligeo) injection	<ol style="list-style-type: none"> Ordered for an approved indication for use: 	Requires MFC Physician or Pharmacist review prior to approval.

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20mg/5ml	<ul style="list-style-type: none"> the treatment of adult patients with relapsed or refractory mycosis fungoides or Sézary syndrome after at least one prior systemic therapy. 	
morphine sulfate extended-release (MS Contin) tablets 15mg, 30mg, 60mg 100mg, 200mg	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> The management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate. 	<ul style="list-style-type: none"> All long-acting opioids require Prior Authorization (PA). The PA form can be accessed using the following link: OPIOID PRIOR AUTH FORM-MD
Nilotinib (Tasigna) capsules 50mg, 150mg, 200mg	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> adult and pediatric patients ≥ 1 year of age with newly diagnosed Philadelphia chromosome positive chronic myeloid leukemia (Ph+ CML) in chronic phase. adult patients with chronic phase (CP) and accelerated phase (AP) Ph+ CML resistant to or intolerant to prior therapy that included imatinib. pediatric patients ≥ 1 year of age with Ph+ CML-CP resistant or intolerant to prior tyrosine-kinase inhibitor (TKI) therapy. Medication ordered by an Oncologist. 	
Nintedanib (Ofev) capsule 100mg, 150mg	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> Treatment of adults for idiopathic pulmonary fibrosis. Treatment of adults for chronic fibrosing interstitial lung diseases (ILDs) with a progressive phenotype. To slow the rate of decline in pulmonary function in patients with systemic sclerosis associated interstitial lung disease (SSc-ILD). Medication ordered by a pulmonologist 	Limitations to Use: <ul style="list-style-type: none"> Smoking may decrease exposure to nintedanib; patients should stop smoking prior to treatment and avoid smoking during therapy.
Niraparib (Zejula) capsules 100mg	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> maintenance treatment of adult patients with advanced epithelial ovarian, fallopian tube, or primary peritoneal 	<ul style="list-style-type: none"> Select patients for therapy based on an FDA-approved companion diagnostic for ZEJULA.

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	<p>cancer who are in a complete or partial response to first-line platinum-based chemotherapy.</p> <ol style="list-style-type: none"> Maintenance treatment of adult patients with deleterious or suspected deleterious germline BRCA-mutated recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in complete or partial response to platinum-based chemotherapy. Medication ordered by an Oncologist. 	
<p>Nitisinone (Orfadin) capsules</p> <p>Nitisinone is preferred for 2mg, 5mg 10mg</p> <p>Orfadin 20mg</p>	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> treatment of adult and pediatric patients with hereditary tyrosinemia type 1 (HT-1) in combination with dietary restriction of tyrosine and phenylalanine. Diagnosis of type 1 tyrosinemia. Patient adherent to dietary restrictions of tyrosine and phenylalanine. Patient is under the care of a nutritionist. Dose not to exceed 2 mg/kg/day. 	<p>Requires MFC Physician or Pharmacist review prior to approval.</p> <p>ORFADIN PRIOR AUTH FORM</p>
<p>norethindrone ace-ethinyl estradiol-fe cap 1 mg-20 mcg</p> <p>(Minastrin 24 FE)</p> <p>Finzala Chew FE 1/20</p> <p>Meldotta Chew 24 FE</p> <p>Milbelas 24 chew FE</p> <p>norethindrone ace-ethinyl estradiol-fe cap 1 mg-20 mcg (Taytulla)</p> <p>norethindrone ace-ethinyl estradiol-fe cap 1 mg-20 mcg (24)</p>	<ol style="list-style-type: none"> ANY OCP on prior authorization requires documentation demonstrating a compelling reason why formulary OCPs cannot be used [ex: intolerance, prior side effects, failures, etc. documented after a 3-month trial of formulary OCPs] 	<ul style="list-style-type: none"> While some oral contraceptives have additional indications (ex: Beyaz for acne, PMDD, folate replacement; Estrostep Fe for acne; Safyral for folate replacement; Natazia for heavy periods), most are simply indicated for the prevention of pregnancy.

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Nusinersen (Spinraza)	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • Diagnosis of SMA Type I, II, or III. 2. Genetic testing confirming both: <ul style="list-style-type: none"> • 5q SMA homozygous gene deletion, homozygous gene mutation, or compound heterozygous mutation: AND • At least 2 copies of SMN2 3. AND <ul style="list-style-type: none"> • Patient is not dependent on invasive ventilation or tracheostomy • Patient is not dependent on non-invasive ventilation beyond use for naps and nighttime sleep; • Patients with Type II and III SMA must have some functional upper extremity use: 4. A) Initial therapy <ul style="list-style-type: none"> • Medical records must be submitted documenting all of the above criteria: • Medical records must be submitted documenting a baseline motor examination utilizing at least one of the following exams (based on patient age and motor ability) to establish baseline motor ability; <ul style="list-style-type: none"> • Hammersmith infant neurological exam (HINE); • Hammersmith Functional Motor Scale Expanded (HFMSSE); • Upper Limb Module Test (non-ambulatory; or • Childrens Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP-INTEND) <p>**Spinraza will initially preauthorized for 4 loading doses when criteria are met</p> <ol style="list-style-type: none"> 4. B) Continuation Criteria: <ul style="list-style-type: none"> • Each Spinraza maintenance dose must be preauthorized; • All the criteria for initial therapy must be met: 	<p>Requires MFC Physician or Pharmacist review prior to approval.</p> <p>Limitations of use:</p> <ul style="list-style-type: none"> • Cannot be used in combination with Zolgensma (onasemnogene abeparvovec).

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	<ul style="list-style-type: none"> ○ Medical records must be submitted that document repeat motor testing since the most recent Spinraza® dose using the same motor test done to establish baseline motor ability, unless it is determined that the original test is no longer appropriate; ○ Repeat motor testing must document a response to treatment as defined by the following: <p>HINE:</p> <ul style="list-style-type: none"> ● Improvement or maintenance of previous improvement of at least 2 points (or max score of 4) in ability to kick (improvement in at least 2 milestones); OR ● Improvement or maintenance of previous improvement of at least 1 point increase in motor milestones of head control, rolling, sitting, crawling, standing or walking (consistent with improvement by at least 1 milestone); AND ● Improvement or maintenance of previous improvement in more HINE motor milestones than worsening; <p>HFMSE:</p> <ul style="list-style-type: none"> ● Improvement or maintenance of improvement of at least a 3 point increase in score; <p>ULM:</p> <ul style="list-style-type: none"> ● Improvement or maintenance of previous improvement of at least 2 point increase in score; <p>CHOP-INTEND:</p> <ul style="list-style-type: none"> ● Improvement or maintenance of previous improvement of at least 4 point increase in score. <p>5. Prescribed by a neurologist</p>	
Ocrelizumab (Ocrevus) injection 300mg/10ml	1. Ordered for an approved indication for use: <ul style="list-style-type: none"> ● Primary progressive MS 	Limitations to Use: <ul style="list-style-type: none"> ● Effectiveness not studied in adults ≥ 55 years of age.

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	<ul style="list-style-type: none"> Relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease <p>2. Medication ordered by a neurologist</p>	<ul style="list-style-type: none"> Contraindicated in patient with active hepatitis B infection.
Omaliuzumab (Xolair) Injection 75mg/0.5ml, 150mg/ml Solution for injection 150mg	<p>1. Ordered for an approved indication for use:</p> <ul style="list-style-type: none"> moderate to severe persistent asthma in patients ≥ 6 years of age with a positive skin test or in vitro reactivity to a perennial aeroallergen and symptoms that are inadequately controlled with inhaled corticosteroids. chronic spontaneous urticaria (CSU) in adults and adolescents ≥ 12 years of age who remain symptomatic despite H1 antihistamine treatment. Chronic rhinosinusitis with nasal polyps (CRSwNP) in adult patients ≥ 18 years of age with inadequate response to nasal corticosteroids, as add-on maintenance treatment. <p>2. Medication ordered by allergist or Pulmonologist</p>	<ul style="list-style-type: none"> Regarding ASTHMA indication only: moderate to severe persistent ALLERGIC asthma (confirmed by a positive skin test or RAST for ≥ 1 perennial aeroallergen). IgE level obtained prior to initiation of therapy. currently using an inhaled corticosteroid at maximum dose; compliance must be confirmed in the patient's Caremark profile. currently using a long-acting inhaled beta2-agonist OR a leukotriene modifier; compliance must be confirmed in the patient's Caremark profile. <p>NOT approved for monotherapy.</p>
omega-3-acid ethyl esters (Lovaza) capsules 1 Gram	<p>1. Ordered for an approved indication for use:</p> <ul style="list-style-type: none"> as an adjunct to diet to reduce triglyceride levels in adult patients with severe (≥ 500 mg/dL) hypertriglyceridemia <p>2. Member must have tried and failed OTC fish oil.</p>	
Omnipod insulin pump management system	<p>1. Ordered for an approved indication for use:</p> <ul style="list-style-type: none"> Subcutaneous delivery of insulin at set and variable rates to manage diabetes mellitus in persons requiring insulin and for the quantitative measurement of glucose in fresh whole capillary blood (in vitro) from the finger. <p>2. Medication ordered by an Endocrinologist.</p>	Please click link below for EIM Policy: MFC External Insulin Pumps Policy-MD

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onabotulinumtoxinA (Botox) injection 100 Unit, 200 Unit	<p>3. Patient must also be ordered for a pump-compatible insulin.</p> <p>1. Ordered for an approved indication for use:</p> <ul style="list-style-type: none"> Overactive bladder (OAB) with symptoms of urge urinary incontinence, urgency, and frequency, in adults who have an inadequate response to or are intolerant of an anticholinergic medication. Urinary incontinence due to detrusor overactivity associated with a neurologic condition [e.g., spinal cord injury, multiple sclerosis] in adults who have an inadequate response to or are intolerant of an anticholinergic medication. Neurogenic detrusor overactivity (NDO) in pediatric patients ≥ 5 years of age who have an inadequate response to or are intolerant of anticholinergic medication. Prophylaxis of headaches in adult patients with chronic migraine (≥ 15 days per month with headache lasting ≥ 4 hours a day). Spasticity in adult patients. Cervical dystonia in adult patients to reduce the severity of abnormal head position and neck pain. Severe axillary hyperhidrosis of adults inadequately managed by topical agents. Treatment of blepharospasm associated with dystonia in patients 12 years of age and older. Treatment of strabismus in patients 12 years of age and older. <p>2. Medication ordered by a Neurologist, Urologist, Ophthalmologist, or applicable specialist.</p>	<p>Limitations for Use:</p> <ul style="list-style-type: none"> Botox will NOT be approved for cosmetic purposes Safety and effectiveness have <u>not</u> been established for: Prophylaxis of episodic migraine (≤ 14 headache days/month). treatment of upper or lower limb spasticity in pediatric patients. treatment of hyperhidrosis in body areas other than axillary.
Onasemnogene abeparvovec-xioi (Zolgensma) injection	<p>1. Ordered for an approved indication for use:</p> <ul style="list-style-type: none"> treatment of pediatric patients < 2 years of age with spinal muscular atrophy (SMA) with bi-allelic mutations in the survival motor neuron 1 (SMN1) gene. 	<p>Requires MFC Physician or Pharmacist review prior to approval.</p> <p>Limitations for Use:</p> <ul style="list-style-type: none"> Safety and effectiveness

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	<ol style="list-style-type: none"> 2. Genetic testing confirming bi-allelic mutations in the SMN1 gene on chromosome 5q 3. Patient age less than 2 years 4. Prescriber attests that baseline evaluation has been done and there are no contraindications to use. 5. Prescriber attests that subsequent appropriate evaluation and monitoring will be done based on package insert. 6. Patient is not receiving concomitant SMA disease modifying therapy (e.g. Spinraza) 7. Prescribed by a neurologist 8. One time approval only 	<p>of repeat administration has not been evaluated</p> <ul style="list-style-type: none"> • Use of Zolgensma in patients with advanced SMA (e.g. complete limb paralysis, permanent ventilator dependence) has not been evaluated. • Continued approval for this medication may be contingent upon verification of clinical benefit in confirmatory trials.
Oral Contraceptives	<ol style="list-style-type: none"> 1. ANY OCP on prior authorization requires documentation demonstrating a compelling reason why formulary OCPs cannot be used (ex: intolerance, prior side effects, failures, etc. documented after a 3-month trial of formulary OCPs) 	<ul style="list-style-type: none"> • While some oral contraceptives have additional indications (ex: Beyaz for acne, PMDD, folate replacement; Estrostep Fe for acne; Safyral for folate replacement; Natazia for heavy periods), most are simply indicated for the prevention of pregnancy.
Opioids IR: ER:	FOR IMPORTANT INFORMATION ABOUT PRESCRIBING OPIOIDS FOR MEDSTAR FAMILY CHOICE MEMBERS, PLEASE CLICK THE LINK BELOW:	The Opioid PA form can be accessed using the following link: OPIOID PRIOR AUTH FORM-MD
Osimertinib (Tagrisso) tablets 40mg, 80mg	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • as adjuvant therapy after tumor resection in adult patients with non-small cell lung cancer (NSCLC) whose tumors have 	

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	<p>epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R mutations.</p> <ul style="list-style-type: none"> • first-line treatment of adult patients with metastatic NSCLC whose tumors have EGFR exon 19 deletions or exon 21 L858R mutations. • treatment of adult patients with metastatic EGFR T790M mutation-positive NSCLC, whose disease has progressed on or after EGFR TKI therapy. <p>2. Medication ordered by an Oncologist</p>	
<p>Oxcarbazepine extended release 24-hour (Oxtellar XR) tablets 150mg, 300mg, 600mg</p>	<p>1. Ordered for an approved indication for use:</p> <ul style="list-style-type: none"> • Treatment of partial-onset seizures in adults and in children ≥ 6 years of age. <p>2. Treatment failure, adverse effects, or contraindication to formulary preferred agents.</p> <p>3. Medication ordered by a Neurologist.</p>	<ul style="list-style-type: none"> • Immediate-release and extended-release preparations are not bioequivalent and not interchangeable on a mg per mg basis.
<p>Oxymorphone extended release 12-hour (Opana) tablets 5mg, 7.5mg, 10mg, 15mg, 20mg, 30mg, 40mg, SEE SPECIAL NOTE REGARDING PA REQUIREMENTS & FORM *****</p>	<p>1. Ordered for an approved indication for use:</p> <ul style="list-style-type: none"> • The management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate. 	<ul style="list-style-type: none"> • All long-acting opioids require Prior Authorization (PA). The PA form can be accessed using the following link: OPIOID PRIOR AUTH FORM-MD
<p>Palbociclib (Ibrance) capsules 75mg, 100mg, 125mg</p>	<p>1. Ordered for an approved indication for use:</p> <ul style="list-style-type: none"> • Treatment of adult patients with hormone receptor positive (HR+), human epidermal growth factor receptor 2-negative (HER2-) advanced or metastatic breast cancer in combination with: 	

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	<ol style="list-style-type: none"> a. An aromatase inhibitor as initial endocrine based therapy. b. Fulvestrant in patients with disease progression following endocrine therapy. <ol style="list-style-type: none"> 2. Medication ordered by an Oncologist 	
Palivizumab (Synagis) injection 50mg, 50mg/0.5ml, 100mg/ml	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • with a history of premature birth (≤ 35 weeks gestational age) and who are ≤ 6 months of age at the beginning of RSV season • with bronchopulmonary dysplasia (BPD) that required medical treatment within the previous 6 months and ≤ 24 months of age or younger at the beginning of RSV season • with hemodynamically significant congenital heart disease (CHD) and ≤ 24 months of age at the beginning of RSV season. 	Please submit: A COMPLETED PRIOR AUTHORIZATION FORM (see link below) SYNAGIS PRIOR AUTHORIZATION AND PRESCRIPTION FORM-MD Limitations of Use: <ul style="list-style-type: none"> • Safety and efficacy of Synagis have not been established for treatment of RSV.
Pasireotide (Signifor LAR) Injection 10mg, 20mg, 30mg, 40mg, 60mg	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • treatment of patients with acromegaly who have had an inadequate response to surgery and/or for whom surgery is not an option. • Patients with Cushing’s disease for whom pituitary surgery is not an option or has not been curative. 2. Medication ordered by an Endocrinologist 	
Patisiran (Onpattro) Solution 10mg/5ml	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • Treatment of polyneuropathy in adults with hereditary transthyretin-mediated amyloidosis. 2. Medication ordered by a Rheumatologist or Neurologist. 	Requires MFC Physician or Pharmacist review prior to approval.
Peanut allergen (Palforzia) Capsules Level 1 through level 11	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • mitigation of allergic reactions, including anaphylaxis, that may occur with accidental exposure to peanut. • in children aged 4 through 17 years of age for initial dose escalation; 	Limitations of Use: <ul style="list-style-type: none"> • Not indicated for the emergency treatment of allergic reactions, including anaphylaxis.

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	<ul style="list-style-type: none"> • Up-dosing and maintenance may be continued in patients \geq 4 years of age. <ol style="list-style-type: none"> 2. Medication ordered by allergist or immunologist registered with Palforzia REMS program. 	<ul style="list-style-type: none"> • Not to be prescribed for use by patients with uncontrolled asthma.
Pegcetacoplan (Empaveli) injection 1080mg	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • Treatment of adult patients with paroxysmal nocturnal hemoglobinuria (PNH). 2. Prescribed by provider registered with Empaveli REMS program. 	<p>Requires MFC Physician or Pharmacist review prior to approval.</p> <p>Limitations for Use:</p> <ul style="list-style-type: none"> • Follow Advisory Committee on Immunization Practices (ACIP) recommendations for vaccinations against encapsulated bacteria. • Recommended vaccinations at least 2 weeks prior to administration of first dose of Empaveli.
pegloticase (Krystexxa) injection 8mg/ml	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • Treatment of chronic gout in adults refractory to conventional therapy. 2. Screening for G6PD deficiency of at-risk patients prior to therapy initiation. 3. Medication ordered by Rheumatologist, Nephrologist or Podiatrist. 	<p>Requires MFC Physician or Pharmacist review prior to approval.</p> <p>Limitations of use:</p> <ul style="list-style-type: none"> • KRYSTEXXA is not recommended for treatment of asymptomatic hyperuricemia. • Discontinue use of oral antihyperuricemic agents prior to and during use.
pemigatinib (Pemazyre) tablets 4.5mg, 9mg, 13.5mg	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • treatment of adults with previously treated, unresectable locally advanced or metastatic cholangiocarcinoma with a fibroblast growth factor receptor 2 fusion (FGFR2) or other rearrangement as detected by an FDA-approved test. 	<ul style="list-style-type: none"> • This indication is approved under accelerated approval based on overall response rate and duration of response. Continued approval for this indication may be

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	<ul style="list-style-type: none"> • Treatment of adults with relapsed or refractory myeloid/lymphoid neoplasms (MLNs) with FGFR1 rearrangement. <ol style="list-style-type: none"> 2. Medication ordered by an Oncologist. 	contingent upon verification and description of clinical benefit.
Pexidartinib (Turalio) capsules 125mg, 200mg	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • treatment of adult patients with symptomatic tenosynovial giant cell tumor (TGCT) associated with severe morbidity or functional limitations and not amenable to improvement with surgery. 2. Medication ordered by an Oncologist registered with the Turalio REMS program. 	Limitations of Use: <ul style="list-style-type: none"> • Avoid concomitant use with proton pump inhibitors. • Significant potential for drug-drug interactions.
pirfenidone (Esbriet) capsules 267mg	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • The treatment of idiopathic pulmonary fibrosis (IPF). 2. Medication ordered by a Pulmonologist or Cardiologist. 	<ul style="list-style-type: none"> • Significant potential for drug-drug interactions.
Pirtobrutinib (Jaypirca) 50 mg	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • Treatment of adult patients with relapsed or refractory mantle cell lymphoma (MCL) after at least two lines of systemic therapy, including a BTK inhibitor. 2. Medication ordered by an oncologist. 	<ul style="list-style-type: none"> • This indication is approved under accelerated approval based on response rate. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial.
polatuzumab vedotin (Polivy) injection 140mg	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • In combination with a rituximab product, cyclophosphamide, doxorubicin, and prednisone (R-CHP) for treatment of adult patients who have previously untreated diffuse large B-cell lymphoma (DLBCL), not otherwise specified (NOS) or high-grade B-cell lymphoma (HGBL) and who have an International Prognostic Index score ≥ 2. • in combination with bendamustine and a rituximab product for the treatment of adult patients with relapsed or refractory DLBCL, NOS, after at least 2 prior therapies. 	

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pomalidomide (Pomalyst) capsules 1mg, 2mg, 3mg, 4mg	2. Medication ordered by an Oncologist 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> in combination with dexamethasone, for patients with multiple myeloma (MM) who have received at least two prior therapies including lenalidomide and a proteasome inhibitor and have demonstrated disease progression on or within 60 days of completion of last therapy. with AIDS-related Kaposi sarcoma (KS) after failure of highly active antiretroviral therapy (HAART) or in patients with KS who are HIV-negative. 2. Medication ordered by an Oncologist registered with Pomalyst REMS program.	<ul style="list-style-type: none"> Antithrombotic prophylaxis is recommended due to risk of deep venous thrombosis (DVT), pulmonary embolism (PE), myocardial infarction and stroke. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial.
ponatinib (Iclusig) tablets 10mg, 15mg, 30mg, 45mg	1. Ordered for an approved indication for use: <ul style="list-style-type: none"> Chronic phase (CP) chronic myeloid leukemia (CML) with resistance or intolerance to at least 2 prior kinase inhibitors. Accelerated phase (AP) or blast phase (BP) CML or Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL) for whom no other kinase inhibitors are indicated. 2. T315I-positive CML (chronic-, accelerated-, or blast phase) or T315I-positive Ph+ ALL. 3. Medication ordered by an Oncologist	Limitations of Use: <ul style="list-style-type: none"> Iclusig is not indicated and is not recommended for the treatment of patients with newly diagnosed CP-CML. Risk for significant drug-drug interactions.
posaconazole (Noxafil) 40mg/ml suspension 100mg tablets	1. Ordered for an approved indication for use: <ul style="list-style-type: none"> Treatment of invasive aspergillosis in adults and pediatric patients ≥ 13 years of age. (Injection and tablets). Prophylaxis of invasive Aspergillus and Candida infections in patients at high risk of infection development (ages vary by dose formulation). 	<ul style="list-style-type: none"> Patient at high infection risk: severely immunocompromised, such as HSCT recipients with GVHD or those with hematologic malignancies with prolonged neutropenia from chemotherapy. Oral suspension is not substitutable with tablets or

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	<ul style="list-style-type: none"> • Treatment of oropharyngeal candidiasis (OPC), including OPC refractory (rOPC) to itraconazole and/or fluconazole in adults or pediatric patients ≥ 13 years of age. <ol style="list-style-type: none"> 2. Medication ordered by Infectious Disease specialist. 	<p>PowderMix oral suspension due to differences in dosing of each formulation.</p> <ul style="list-style-type: none"> • Coadministration is Contraindicated with sirolimus, ergot alkaloids, HMG-CoA reductase inhibitors. • Significant risk for drug-drug interactions.
pralsetinib (Gavreto) capsule 100mg	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • treatment of adult patients with metastatic rearranged during transfection (RET) fusion- positive non-small cell lung cancer (NSCLC). • Adult and pediatric patients ≥ 12 years of age with advanced or metastatic RET-mutant medullary thyroid cancer (MTC) who require systemic therapy. • Adult and pediatric patients ≥ 12 years of age with advanced or metastatic RET fusion-positive thyroid cancer who require systemic therapy and who are radioactive iodine-refractory (if radioactive iodine is appropriate). 2. Medication ordered by an Oncologist 	
Pretomanid tablets 200mg	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • as part of a combination regimen with bedaquiline and linezolid for the treatment of adults with pulmonary extensively drug resistant (XDR), treatment-intolerant or nonresponsive multidrug-resistant (MDR) tuberculosis (TB). 2. Medication ordered by a Pulmonologist. 	<p>Limitations of Use:</p> <ul style="list-style-type: none"> • Pretomanid is not indicated in patients with drug-sensitive TB. • Not indicated Latent infection due to Mycobacterium tuberculosis or extra-pulmonary infection due to Mycobacterium tuberculosis. • TB with known resistance to any component of the combination therapy.

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		<ul style="list-style-type: none"> • Safety and effectiveness has not been established for its use in combination with drugs other than bedaquiline and linezolid. • Risk for significant drug-drug interactions.
Ravulizumab-cwvz (Ultomiris) injection 100mg/ml 300mg/30ml	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • treatment of adult and pediatric patients ≥ 1 month of age with paroxysmal nocturnal hemoglobinuria (PNH). • treatment of adult and pediatric patients ≥ 1 month of age with atypical hemolytic uremic syndrome (aHUS) to inhibit complement-mediated thrombotic microangiopathy (TMA). • treatment of adult patients with generalized myasthenia gravis (gMG) who are anti-acetylcholine receptor (AChR+) antibody positive. 2. Medication ordered by Oncologist registered with Ultomiris REMS program. 	<p>Requires MFC Physician or Pharmacist review prior to approval.</p> <p>Limitations for Use:</p> <ul style="list-style-type: none"> • Ultomiris is not indicated for the treatment of patients with Shiga toxin E. coli related hemolytic uremic syndrome (STEC-HUS). • Follow Advisory Committee on Immunization Practices (ACIP) recommendations for vaccinations against encapsulated bacteria. • Recommended vaccinations at least 2 weeks prior to administration of first dose Ultomiris.
Regorafenib (Stivarga) tablet 40mg	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • treatment of metastatic colorectal cancer previously treated with: fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy, an anti-vascular endothelial growth factor (VEGF) therapy, and, if RAS wild-type, an anti-EGFR therapy. • Treatment of locally advanced, unresectable, or metastatic gastrointestinal stromal tumor (GIST), previously treated with imatinib mesylate and sunitinib malate. 	<p>Limitations of Use:</p> <ul style="list-style-type: none"> • According to guidelines from the American Society of Clinical Oncology for systemic therapy for advanced HCC, regorafenib is a potential second-line therapy option in patients who received atezolizumab and bevacizumab as first-line therapy, although

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	<ul style="list-style-type: none"> • hepatocellular carcinoma (HCC) who have been previously treated with sorafenib. <ol style="list-style-type: none"> 2. Medication ordered by Oncologist. 	<p>sorafenib or lenvatinib are preferred in this setting. Regorafenib is also a second-line therapy option in patients who received first-line therapy with sorafenib or lenvatinib.</p> <ul style="list-style-type: none"> • Interrupt therapy in patients who develop new or acute onset ischemia or infarction; resume only if the benefit of therapy outweighs the cardiovascular risk.
<p>ribociclib (Kisqali) tablets 200 mg dose, 400 mg dose, 600 mg dose</p>	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • Treatment of adult patients with hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer in combination with: <ol style="list-style-type: none"> a. An aromatase inhibitor as initial endocrine-based therapy; or b. Fulvestrant as initial endocrine-based therapy or following disease progression on endocrine therapy in postmenopausal women or in men. 2. Medication ordered by Oncologist 	
<p>Rimegepant (Nurtec) tablet 75mg ODT</p>	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • Acute treatment of moderate to severe migraines. <ul style="list-style-type: none"> ○ Member must have tried and failed NSAIDs and Triptans or have a contraindication to taking either of these medications. • Migraine prevention. <ul style="list-style-type: none"> ○ Member must have documented evidence of failure/intolerance of beta blockers, Aimovig, and Emgality in the medical notes sent for MFC review. 	<ul style="list-style-type: none"> • Triptan contraindications may include: cardiovascular risk factors), ineffective, or poorly tolerated. • Avoid use in patients with recent cardiovascular or cerebrovascular ischemic events.

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	<ul style="list-style-type: none"> ○ Patient must average ≥ 4 headache days per month. <ol style="list-style-type: none"> 2. Limit use to patients with significant disability from frequent migraines who are unable to tolerate or do not respond to adequate trials of other preventive therapies 	<ul style="list-style-type: none"> • An adequate trial for assessment of effect is considered at least 8 weeks at a therapeutic dose
ripiretinib (Qinlock) tablet 50mg	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • the treatment of adult patients with advanced gastrointestinal stromal tumor (GIST) who have received prior treatment with 3 or more kinase inhibitors, including imatinib. 2. Medication ordered by Oncologist 	
Rituximab (Rituxan) injection 100mg, 500mg	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • Pediatric patients aged 6 months and older with mature B-cell NHL and mature B-cell acute leukemia (B-AL) 2. Previously untreated, advanced stage, CD20-positive, diffuse large B-cell lymphoma (DLBCL), Burkitt lymphoma (BL), Burkitt-like lymphoma (BLL) or mature B-cell acute leukemia (B-AL) in combination with chemotherapy. <ul style="list-style-type: none"> • Moderate to severe Pemphigus Vulgaris (PV) in adult patients • Demonstrated failure or intolerance to Truxima for the following indications: <ul style="list-style-type: none"> • Adult patients with Non-Hodgkin's Lymphoma (NHL) 3. Relapsed or refractory, low grade or follicular, CD20-positive B-cell NHL as a single agent. 4. Previously untreated follicular, CD20-positive, B-cell NHL in combination with first line chemotherapy and, in patients achieving a complete or partial response to a rituximab product in combination with chemotherapy, as single-agent maintenance therapy. 5. Non-progressing (including stable disease), low-grade, CD20-positive, Bcell NHL as a single agent after first-line 	<ul style="list-style-type: none"> • Note: Prior authorization requirements apply for patients new to starting therapy. Documentation showing history of prior use of Rituxan within the past 90 days will be considered and PA Criteria will not apply.

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	<p>cyclophosphamide, vincristine, and prednisone (CVP) chemotherapy.</p> <p>6. Previously untreated diffuse large B-cell, CD20-positive NHL in combination with (cyclophosphamide, doxorubicin, vincristine, and prednisone) (CHOP) or other anthracycline-based chemotherapy regimens.</p> <ul style="list-style-type: none"> • Adult patients with Chronic Lymphocytic Leukemia (CLL) <p>7. Previously untreated and previously treated CD20-positive CLL in combination with fludarabine and cyclophosphamide (FC).</p> <ul style="list-style-type: none"> • Rheumatoid Arthritis (RA) in combination with methotrexate in adult patients with moderately-to severely-active RA who have inadequate response to one or more TNF antagonist therapies • Granulomatosis with Polyangiitis (GPA) (Wegener’s Granulomatosis) and Microscopic Polyangiitis (MPA) in adult and pediatric patients ≥ 2 years of age in combination with glucocorticoids <p>8. Prescribed by oncologist or rheumatologist.</p>	
Rituximab and hyaluronidase human (Rituxan Hycela) injection	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • Follicular Lymphoma (FL): 2. Relapsed or refractory, follicular lymphoma as a single agent. 3. Previously untreated follicular lymphoma in combination with first line chemotherapy and, in patients achieving a complete or partial response to rituximab in combination with chemotherapy, as single agent maintenance therapy. 4. Non-progressing (including stable disease), follicular lymphoma as a single agent after first-line cyclophosphamide, vincristine, and prednisone (CVP) chemotherapy. 6. Diffuse Large B-cell Lymphoma (DLBCL) previously untreated diffuse large B-cell lymphoma in combination with 	<p><u>Limitations of use:</u></p> <ul style="list-style-type: none"> • Initiate treatment with Rituxan Hycela only after patients have received at least one full dose of a rituximab product by intravenous infusion. • Not indicated for the treatment of non-malignant conditions.

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	<p>cyclophosphamide, doxorubicin, vincristine, prednisone (CHOP) or other anthracycline-based chemotherapy regimens.</p> <p>7. Chronic Lymphocytic Leukemia (CLL) previously untreated and previously treated CLL in combination with fludarabine and cyclophosphamide (FC).</p> <p>8. Medication ordered by Oncologist</p>	
<p>Rucaparib (Rubraca) tablets 200mg, 250mg, 300mg</p>	<p>1. Ordered for an approved indication for use:</p> <ul style="list-style-type: none"> • <u>Ovarian Cancer</u> <ul style="list-style-type: none"> ○ for the maintenance treatment of adult patients with recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in a complete or partial response to platinum-based chemotherapy. ○ for the treatment of adult patients with a deleterious BRCA mutation (germline and/or somatic)-associated epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in a complete or partial response to platinum-based chemotherapy. • <u>Prostate Cancer</u> <ul style="list-style-type: none"> ○ for the treatment of adult patients with a deleterious BRCA mutation (germline and/or somatic)-associated metastatic castration-resistant prostate cancer (mCRPC) who have been treated with androgen receptor-directed therapy and a taxane-based chemotherapy. Select patients for therapy based on an FDA-approved companion diagnostic for RUBRACA. <p>2. Medication ordered by an Oncologist</p>	
<p>Ruxulitinib (Jakafi) tablets 5mg, 10mg, 15mg, 20mg, 25mg</p>	<p>1. Ordered for an approved indication for use:</p> <ul style="list-style-type: none"> • Intermediate or high-risk myelofibrosis, including primary myelofibrosis, post-polycythemia vera myelofibrosis and post-essential thrombocythemia myelofibrosis in adults. 	<p>Limitations of Use:</p> <ul style="list-style-type: none"> • Avoid concomitant use with fluconazole doses greater than 200

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	<ul style="list-style-type: none"> • Polycythemia vera in adults who have had an inadequate response to or are intolerant of hydroxyurea. • Steroid-refractory acute graft-versus-host disease in adult and pediatric patients 12 years and older. • Chronic graft-versus-host disease after failure of one or two lines of systemic therapy in adult and pediatric patients 12 years and older. <p>2. Medication ordered by Hematologist or Oncologist.</p>	<p>mg. Reduce Jakafi dosage with fluconazole doses ≤ 200 mg.</p> <ul style="list-style-type: none"> • Strong CYP3A4 Inhibitors: Reduce, interrupt, or discontinue Jakafi doses as recommended except in patients with acute or chronic graft-versus-host-disease.
Sacituzumab govitecan-hziy (Trodelvy) solution 180mg	<p>1. Ordered for an approved indication for use:</p> <ul style="list-style-type: none"> • metastatic triple-negative breast cancer who have received at least two prior therapies for metastatic disease. • Locally advanced or metastatic urothelial cancer (mUC) who have previously received a platinum-containing chemotherapy and either programmed death receptor-1 (PD-1) or programmed death-ligand 1 (PDL1) inhibitor. <p>2. Medication ordered by an Oncologist</p>	<p>Limitations of Use:</p> <ul style="list-style-type: none"> • Withhold Trodelvy for absolute neutrophil count below 1500/mm³ or neutropenic fever. Monitor blood counts periodically during treatment Consider G-CSF for secondary prophylaxis. Initiate anti-infective treatment in patients with febrile neutropenia without delay.
Safinamide (Xadago) tablets 50mg, 100mg	<p>1. Ordered for an approved indication for use:</p> <ul style="list-style-type: none"> • as adjunctive treatment to levodopa/carbidopa in patients with Parkinson’s disease (PD) experiencing “off” episodes. <p>2. Medication ordered by a neurologist</p>	<p>Limitations of Use:</p> <ul style="list-style-type: none"> • Contraindicated with concomitant use of the following drugs: <ul style="list-style-type: none"> ○ Other monoamine oxidase inhibitors or drugs that are potent inhibitors of monoamine oxidase (e.g. linezolid). ○ Opioid drugs; serotonin-norepinephrine reuptake inhibitors, tri-or tetra-cyclic or triazolopyridine antidepressants,

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		<p>cyclobenzaprine, methylphenidate, amphetamine or their derivatives, St John's wort, dextromethorphan.</p> <ul style="list-style-type: none"> • Severe hepatic impairment (Child-Pugh C) • Hypersensitivity to safinamide.
Sastralizumab-mwge (Enspryng) injection	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • Treatment of neuromyelitis optica spectrum disorder (NMOSD) in adult patients who are anti-aquaporin-4 (AQP4) antibody positive. 2. Age ≥ 18 years. 3. Prescriber attests that baseline evaluation has been done and there are no contraindications to use (e.g. Hep B, TB, LFT's, live or live-attenuated vaccines 4 weeks prior or 2 weeks for non-live vaccines. 4. Prescriber attests that subsequent appropriate evaluation and monitoring will be done based on the package insert (e.g. infections, LFT's, CBCs – neutrophils) 5. Medication ordered by neurologist, immunologist, or ophthalmologist. 	<p>Requires MFC Physician or Pharmacist review prior to approval.</p> <ul style="list-style-type: none"> • Contraindicated in patients with active hepatitis B infection or active or untreated latent tuberculosis. • Use in caution if ALT/AST > 1.5 x ULN.c • Approval duration is 12 months <p>Renewal Criteria:</p> <ul style="list-style-type: none"> • Meets all initial criteria, AND • Provider attestation of continued benefit • 12 months authorization period
Selinexor (Xpovio) Pak 40mg, 50mg, 60mg, 80mg 100mg	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • In combination with bortezomib and dexamethasone for the treatment of adult patients with multiple myeloma who have received at least one prior therapy. • in combination with dexamethasone for the treatment of adult patients with relapsed or refractory multiple myeloma (RRMM) who have received at least four prior therapies and whose disease is refractory to at least two proteasome 	<ul style="list-style-type: none"> • Continued approval for treatment of DLBCL may be contingent upon verification and description of clinical benefit in confirmatory trials.

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	<p>inhibitors, at least two immunomodulatory agents, and an anti-CD38 monoclonal antibody.</p> <ul style="list-style-type: none"> Treatment of adult patients with relapsed or refractory diffuse large B-cell lymphoma (DLBCL), not otherwise specified, including DLBCL arising from follicular lymphoma, after a least 2 lines of systemic therapy. <p>2. Medication ordered by an Oncologist</p>	
<p>Selpercatinib (Retevmo) capsules 40mg, 80mg</p>	<p>1. Ordered for an approved indication for use:</p> <ul style="list-style-type: none"> Adult patients with locally advanced or metastatic non-small cell lung cancer (NSCLC) with a rearranged during tranfection (RET) gene fusion, as detected by an FDA-approved test. Adult and pediatric patients ≥ 12 years of age with advanced or metastatic medullary thyroid cancer (MTC) with a RET mutation, who require systemic therapy. adult and pediatric patients ≥ 12 years of age with advanced or metastatic RET fusion-positive thyroid cancer who require systemic therapy and who are radioactive iodine-refractory (if radioactive iodine is appropriate). Adult patients with locally advanced or metastatic solid tumors with a RET gene fusion that have progressed on or following prior systemic treatment or who have no satisfactory alternative treatment options. <p>2. Medication ordered by an Oncologist</p>	
<p>Semaglutide (Ozempic, Rybelsus) injection</p> <p>Ozempic 2mg/1.5ml, 2mg/3ml, 4mg/3ml, 8mg/3ml</p>	<p>1. Ordered for an approved indication for use:</p> <ul style="list-style-type: none"> As adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus. To reduce the risk of major adverse cardiovascular events in adults with type 2 diabetes mellitus and established cardiovascular disease. <p>2. A1C lab within past 3 months OR Recent CGM report if</p>	<p>Cannot be approved for indication of weight management.</p> <p>Titration doses will be approved for a maximum of 60-days supply per year</p> <p><u>Limitations of Use:</u></p>

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Rybelus 3mg, 7mg, 14mg	applicable with 70% utilization 3. Dispense quantity limited to 30-day supply per dispense. 4. May not be taking a DPP4i (e.g. alogliptin, januvia, tradjenta)	<ul style="list-style-type: none"> • Contraindicated in patients with personal or family history of medullary thyroid carcinoma (MTC) and in patients with multiple endocrine neoplasia syndrome type 2 (MEN 2). • Not for the treatment of type 1 diabetes or diabetic ketoacidosis. • Not for patients with pre-existing severe gastrointestinal disease • Not studied in patients with history of pancreatitis, consider alternate therapy.
Seracycline (Seysara) tablet 60mg, 100mg, 150mg	1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • treatment of inflammatory lesions of non-nodular moderate to severe acne vulgaris in patients ≥ 9 years of age. 2. Failure of at least one other oral tetracycline antibiotic. Medication ordered by a Dermatologist.	Limitations of Use: <ul style="list-style-type: none"> • Efficacy of Seysara beyond 12 weeks and safety beyond 12 months have not been established. • Seysara has not been evaluated in the treatment of infections and should only be used as indicated.
sildenafil (Revatio) tablet 20mg	1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • treatment of pulmonary arterial hypertension (PAH) (WHO Group I) in adults to improve exercise ability and delay clinical worsening. 2. Medication ordered by a cardiologist or pulmonologist.	Limitations of Use: <ul style="list-style-type: none"> • Medication will not be covered for use to treat erectile dysfunction (ED). • Viagra and generic product strengths (25 mg, 50 mg, 100 mg) are not covered.
Sodium oxybate (Xyrem) solution 500mg/ml	1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • treatment of cataplexy or excessive daytime sleepiness (EDS) in patients ≥ 7 years of age with narcolepsy. • alternative diagnoses must have been excluded 	Limitations of Use: <ul style="list-style-type: none"> • Xyrem is available only through a restricted program called the Xyrem REMS or Xyway REMS.

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	<ol style="list-style-type: none"> 2. for cataplexy, must have failed tricyclic or SSRIs 3. for excessive daytime sleepiness, must have failed at least one formulary stimulant treatment (ex: methylphenidate or dextroamphetamine) 4. initial approval for maximum of 1-month supply with subsequent renewals for maximum approval period of 3 months at a time (Patients are to be re-evaluated by physician no less frequently than every 3 months) 5. Medication ordered by a Neurologist 	<ul style="list-style-type: none"> • Contraindicated in combination with sedative hypnotics or alcohol • Contraindicated in patients with succinic semialdehyde dehydrogenase deficiency.
<p>Somatropin [recombinant human growth hormone] (Norditropin FlexPro; Serostim) injection</p> <p>Norditropin 5/1.5ml, 10/1.5ml, 15/1.5ml, 30mg/3ml</p> <p>Serostim 4mg, 5mg, 6mg</p>	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • Norditropin -- Pediatric: growth failure due to inadequate secretion of endogenous growth hormone (GH), short stature associated with Noonan syndrome, short stature associated with Turner syndrome, short stature born small for gestational age (SGA) with no catch-up growth by age 2 to 4 years, Idiopathic Short Stature (ISS), and growth failure due to Prader-Willi Syndrome. • Norditropin -- Adult: Replacement of endogenous GH in growth hormone deficiency. • Serostim – treatment of HIV patients with wasting or cachexia to increase lean body mass and body weight and improve physical endurance. 2. Medication ordered by an Endocrinologist or Infectious disease specialist. 	<p>Contraindications:</p> <ul style="list-style-type: none"> • Acute critical illness • Pediatric patients with Prader-Willi syndrome who are severely obese, have history of severe upper airway obstruction, or have severe respiratory impairment due to risk of sudden death. • Active malignancy • Active proliferative or severe non-proliferative diabetic retinopathy • Pediatric patients with closed epiphyses.
<p>Sotorasib (Lumakras) tablet 120mg</p>	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • treatment of adult patients with KRAS G12C-mutated locally advanced or metastatic non-small cell lung cancer (NSCLC), as determined by an FDA-approved test, who have received at least one prior systemic therapy 2. Medication ordered by Oncologist 	<ul style="list-style-type: none"> • This indication is approved under accelerated approval based on overall response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trials.

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tacrolimus extended-release (Envarsus XR) tablets 0.75mg, 1mg, 4mg	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> prophylaxis of organ rejection in kidney transplant in adult patients converted from tacrolimus immediate-release formulations in combination with other immunosuppressants. Evidence that the patient had at least three-month trial and failure or intolerance to immediate-release tacrolimus. Documented evidence that the patient is unable to achieve or maintain an appropriate therapeutic drug level with immediate-release tacrolimus---Lab values must be submitted. Prescribed by a Nephrologist and Transplant Specialist. 	Limitations of use: <ul style="list-style-type: none"> Not interchangeable or substitutable with other tacrolimus products.
tadalafil (Adcirca; Alyq) tablets 20mg BPH:5mg (Cialis) PAH:20 mg	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> To treat signs and symptoms of benign prostatic hyperplasia (BPH). To treat pulmonary arterial hypertension (World Health Organization group 1) to improve exercise ability. Confirmation the patient is not currently taking any forms of nitrate-containing medication (e.g. NitroDur, NitroStat). BPH-specific requirements: <ul style="list-style-type: none"> Ordered for generic Cialis (tadalafil) 5 mg tablets Ordered by a urologist. PAH-specific requirements: <ul style="list-style-type: none"> Ordered for generic Adcirca (tadalafil PAH) 20 mg tablets Medication ordered by a Pulmonologist, Cardiologist, or Rheumatologist 	<ul style="list-style-type: none"> BPH: <ol style="list-style-type: none"> Tadalafil should not be used concurrently with an alpha-1 blocker (e.g. tamsulosin) due to minimal added benefit and higher adverse effect likelihood. If using tadalafil and finasteride, max recommended duration of tadalafil is ≤26 weeks (manufacturer’s labeling). PAH: <ol style="list-style-type: none"> Tadalafil is contraindicated in patients taking guanylate cyclase stimulators (e.g. riociguat) due to potentially severe hypotension. Erectile dysfunction is not a covered indication for use.

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tagraxofusp-erzs (Elzonris) sol 1000mcg	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> The treatment of blastic plasmacytoid dendritic cell neoplasm (BPDCN) in adults and in pediatric patients ≥ 2 years of age. Medication ordered by an Oncologist 	
Talazoparib (Talzenna) capsules 0.5mg, 0.25mg, 0.75mg, 1mg	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> treatment of adult patients with deleterious or suspected deleterious germline BRCA-mutated (gBRCAm) HER2-negative locally advanced or metastatic breast cancer. Medication ordered by an Oncologist 	
Tazemetostat (Tazverik) tablets 200mg	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> adults and pediatric patients aged ≥ 16 years with metastatic or locally advanced epithelioid sarcoma not eligible for complete resection. adult patients with relapsed or refractory follicular lymphoma whose tumors are positive for an EZH2 mutation as detected by an FDA- approved test and who have received at least 2 prior systemic therapies. adult patients with relapsed or refractory follicular lymphoma who have no satisfactory alternative treatment options. Medication ordered by an Oncologist 	
teduglutide (Gattex)	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> the treatment of adults and pediatric patients ≥ 1 year of age with Short Bowel Syndrome (SBS) who are dependent on parenteral support. 200 cm or less of remaining small intestine Chart notes documenting the use of parenteral nutrition, including recent PN orders specifying frequency of Phosphatidylserine (PS), caloric requirements, fluid and electrolyte needs, current volume of PS per week and duration 	<p>Requires MFC Physician or Pharmacist review prior to approval.</p> <p>Renewal Criteria:</p> <ul style="list-style-type: none"> Chart notes documenting at least a 20% reduction in parental nutrition use from baseline Submission of recent PN orders required

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	<p>of use of PS.</p> <ol style="list-style-type: none"> 4. Patient weight over 22 pounds (10 kg) 5. Adult patients must have colonoscopy with polyp removal within past 6 months. 6. Pediatric patients must have fecal occult blood testing, with follow up colonoscopy/sigmoidoscopy if unexplained blood in stool. 7. Must have recommended lab values checked every 6 months: bilirubin, alkaline phosphatase, and amylase levels 8. Approval Duration: 6 months 	<ul style="list-style-type: none"> • Attestation of continued benefit • Free from intestinal obstruction • Repeat colonoscopy after initial 1 year of treatment shows no signs of intestinal malignancy • No significant changes in bilirubin, alkaline phosphatase, or amylase levels • Approval duration: 12 months.
Teprotumumab-trbw (Tepezza) injection 500mg	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • treatment of Thyroid Eye Disease (TED). 2. Requested dose and frequency in accordance with FDA-approved labeling. 3. Is age-appropriate according to FDA-approved labeling. 4. Adult patient > 18 years of age. 5. Patient has clinical diagnosis of Grave’s disease. 6. Must be euthyroid or have thyroxine and free triiodothyronine levels less than 50% above or below normal limits. 7. Must have a Clinical Activity Score ≥ 4. 8. Onset of TED symptoms within past 9 months. 9. Must provide documentation that member has tried and failed and/or has intolerance or contraindication to at least one of the following: <ul style="list-style-type: none"> • Intravenous Corticosteroids • Rituximab or any of its biosimilars 10. Surgical management 	<p>Requires MFC Physician or Pharmacist review prior to approval.</p> <p>Limitations of Use:</p> <ul style="list-style-type: none"> • Duration of Approval is limited to 8 infusions.
tesamorelin (Egrifta SV) injection 2mg	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • Reduction of excess abdominal fat in HIV-infected adult patients with lipodystrophy. 	<p>Limitations of use:</p> <ul style="list-style-type: none"> • Long-term cardiovascular safety of EGRIFTA SV has not been established.

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		<ul style="list-style-type: none"> • Not indicated for weight loss management. • There are no data to support improved compliance with anti-retroviral therapies in HIV-positive patients taking EGRIFTA SV.
Tezepelumab-ekko (Tezspire) sol 210mg	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • the add-on maintenance treatment of adult and pediatric patients aged ≥ 12 years with severe asthma. 2. Patient has refractory Type 2 airway inflammation (i.e., allergic asthma) AND has tried and failed at least one of the following: Nucala, Fasenra, Dupixent, or Xolair OR Patient has refractory non-Type 2 airway inflammation (i.e., non-allergic asthma). 3. Medication ordered by an Allergist, Immunologist or Pulmonologist 	
tirzepatide (Mounjaro) injection 2.5mg/0.5ml, 5mg/0.5ml, 7.5mg/0.5ml, 10mg/0.5ml, 12.5mg/0.5ml, 15mg/0.5ml	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • Treatment of Type 2 Diabetes mellitus. 2. Documented ≥ 4-week trial of other formulary GLP-1 receptor agonist medication. 3. Must have tried and failed or have a contraindication to a formulary GLP-1 agonist (e.g., Ozempic, Rybelsus, Trulicity, or Victoza). 4. Include recent CGM report if applicable. 5. Limited to 30-day supply 6. May not be concurrently taking a DPP4i (e.g. alogliptin, januvia, or tradjenta) 	<p>Cannot be approved for indication of weight management.</p> <p>Titration dose 2.5 mg limited to 8 pens per year</p> <p>Limitations of Use:</p> <ul style="list-style-type: none"> • Mounjaro is not indicated for use in patients with type 1 diabetes mellitus <p>The ASCVD benefit of Mounjaro is under investigation; other GLP-1 medications are preferred in patients with DM2 and high ASCVD risk.</p>
tisagenlecleucel (Kymriah) Sus	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • Patients up to 25 years of age with B-cell precursor acute 	<p>Limitations of Use:</p>

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	<p>lymphoblastic leukemia (ALL) that is refractory or in second or later relapse.</p> <ul style="list-style-type: none"> • Adult patients with relapsed or refractory (r/r) large B-cell lymphoma after two or more lines of systemic therapy including diffuse large B-cell lymphoma (DLBCL) not otherwise specified, high grade B-cell lymphoma and DLBCL arising from follicular lymphoma. <p>2. The treatment facility that dispenses and administers Kymriah is enrolled and complies with the Risk Evaluation and Mitigation Strategy.</p> <p>3. Medication ordered by Oncologist</p> <p>In accordance with criteria developed by the Maryland Medicaid Program, MedStar Family Choice considers Kymriah medically necessary when all of the following conditions are met:</p> <ul style="list-style-type: none"> • Recipient has relapsed or refractory B-cell ALL, defined as Second or greater bone marrow relapse, OR • Any bone marrow relapse after allogeneic stem cell transplantation; OR • Primary refractory as defined by not achieving a complete remission after 2 cycles of a standard chemotherapy regimen or chemorefractory as defined by not achieving a complete remission after 1 cycle of standard chemotherapy for relapsed leukemia, OR • Patients with Philadelphia chromosome positive (Ph+) ALL are eligible if they are intolerant to or have failed 2 lines of tyrosine kinase inhibitor therapy (TKI), or if TKI therapy is contraindicated; AND • Documentation of CD19 tumor expression; AND • Performance score on Karnofsky or Lansky Scale is greater than or equal to 50%; AND • Life expectancy > 12 weeks; AND 	<ul style="list-style-type: none"> • Not indicated for treatment of patients with primary CNS lymphoma • Kymriah is considered investigational and not medically necessary for all other indications not listed in the approval criteria.

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	<ul style="list-style-type: none"> • Adequate cardiac, pulmonary, and other organ function (as determined by protocol from treatment facility); AND <p>4. One-time, single administration with dosing in accordance with the FDA label.</p>	
Tisotumab vedotin-tftv (Tivdak) injection 40mg	<p>1. Ordered for an approved indication for use:</p> <ul style="list-style-type: none"> • the treatment of adult patients with recurrent or metastatic cervical cancer with disease progression on or after chemotherapy. <ul style="list-style-type: none"> ○ Medication ordered by an oncologist ○ Member does not have active ocular surface disease or history of cicatricial conjunctivitis AND ○ Member has not had prior Steven-Johnson syndrome AND ○ Member does not have Grade ≥ 2 peripheral neuropathy AND ○ Member does not have known coagulation defects leading to increased risk of bleeding AND ○ Member has had an ophthalmic exam at baseline, prior to each dose, and as clinically indicated AND • Tivdak is used as a single agent therapy 	<p>Requires MFC Physician or Pharmacist review prior to approval.</p> <p>Limitations of Use:</p> <ul style="list-style-type: none"> • Initial approval for 6 months only • Continuation criteria requires that patient meets the initial criteria and also: <ul style="list-style-type: none"> ○ Disease response with treatment as defined by stabilization of disease or decrease in tumor size or tumor spread • Absence of unacceptable toxicity from the drug (e.g. peripheral neuropathy, hemorrhage, recurrent or persistent grade 2 or higher pneumonitis, keratitis, conjunctival ulceration, etc) • Max units per dose and over time: 200 mg every 21 days.
tivozanib (Fotivda) capsules 0.89mg, 1.34mg	<p>1. Ordered for an approved indication for use:</p> <ul style="list-style-type: none"> • the treatment of adult patients with relapsed or refractory advanced renal cell carcinoma (RCC) following two or more prior systemic therapies. • Medication order by Hematology/oncology 	

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tolvaptan (Jynarque) pak 15mg, 30-15mg, 45-15mg, 60-30mg, 90-30mg, Tab 15mg, 30mg,	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> Slow kidney function decline in adults at risk of rapidly progressing autosomal dominant polycystic kidney disease. Medication ordered by provider registered in Jynarque REMS program. Medication ordered by nephrologist 	Contraindicated in history of signs or symptoms of significant liver impairment or injury.
topotecan (Hycamtin) capsules 0.25mg, 1mg	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> Treatment of patients with relapsed small cell lung cancer (SCLC). Medication ordered by an Oncologist 	
<tramadol <b="" hydrochloride="">extended release (Ultram) capsules (biphasic release) 100mg, 150mg, 200mg, 300mg Tablets 100mg, 200mg, 300mg Tablets (biphasic release) 100mg, 200mg, 300mg </tramadol>	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> in adults for the management of pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate. 	<ul style="list-style-type: none"> All long-acting opioids require Prior Authorization (PA). The PA form can be accessed using the following link: OPIOID PRIOR AUTH FORM-MD <p>Limitations of Use: Not indicated as an as-needed (prn) analgesic.</p>
trametinib (Mekinist) tablets 0.5mg, 2mg	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> Monotherapy for BRAF-inhibitor treatment-naïve patients with unresectable or metastatic melanoma with BRAF V600E or V600K mutations as detected by an FDA approved test. In combination with dabrafenib, for: Treatment of patients with unresectable or metastatic melanoma with BRAF V600E or V600K mutations. Adjuvant treatment of patients with melanoma with BRAF 	<p>Limitations of Use:</p> <ul style="list-style-type: none"> MEKINIST is not indicated for treatment of patients with colorectal cancer because of known intrinsic resistance to BRAF inhibition. The indication for patients ≥ 6 years of age with unresectable or metastatic solid tumors with

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	<p>V600E or V600K mutations and involvement of lymph node(s), following complete resection.</p> <ol style="list-style-type: none"> 4. Treatment of patients with metastatic non-small cell lung cancer (NSCLC) with BRAF V600E mutation. 5. Treatment of patients with locally advanced or metastatic anaplastic thyroid cancer (ATC) with BRAF V600E mutation and no satisfactory locoregional treatment options. 6. Treatment of adult and pediatric patients ≥ 6 years of age with unresectable or metastatic solid tumors with BRAF V600E mutation who have progressed following prior treatment and have no satisfactory alternative treatment options. <ul style="list-style-type: none"> • Treatment of pediatric patients ≥ 1 year of age with low-grade glioma (LGG) with a BRAF V600E mutation who require systemic therapy. 	<p>BRAF V600E mutation without satisfactory treatment options is approved under accelerated approval based on overall response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial.</p> <ul style="list-style-type: none"> •
trientine (Syprine) capsules 250mg	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • the treatment of patients with Wilson’s disease who are intolerant of penicillamine. 	<p>Limitations of Use:</p> <ul style="list-style-type: none"> • Syprine and penicillamine can not be considered interchangeable. • Syprine is not recommended in cystinuria or rheumatoid arthritis.
trilaciclib (Cosela) injection 300mg	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • Decrease the incidence of chemotherapy-induced myelosuppression in adult patients when administered prior to a platinum/etoposide-containing regimen or topotecan-containing regimen for extensive-stage small cell lung cancer. 2. Medication ordered by an Oncologist. 	
tucatinib (Tukysa) tablets 50mg, 150mg	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • in combination with trastuzumab and capecitabine for treatment of adult patients with locally advanced unresectable or metastatic HER2-positive breast cancer, including patients with brain metastases, who have received 	

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	<p>one or more prior anti-HER2-based regimens in the metastatic setting.</p> <p>2. Medication ordered by an Oncologist.</p>	
ubrogepant (Ubrelvy) tablets 50mg, 100mg	<p>1. Ordered for an approved indication for use:</p> <ul style="list-style-type: none"> the acute treatment of migraine with or without aura in adults. <p>2. Member must have tried and failed NSAIDs and Triptans or have a contraindication to taking either of these medications.</p>	
V-go wearable insulin delivery system 20, 30, 40	<p>1. Ordered for an approved indication for use:</p> <ul style="list-style-type: none"> Wearable insulin device indicated for use in adult patients requiring insulin. <p>2. Medication ordered by an Endocrinologist.</p> <p>3. Patient meets all Policy #1413 criteria.</p>	Please click link below for External Insulin Pump Policy: MFC External Insulin Pumps Policy-MD
vemurafenib (Zelboraf) tablet 240mg	<p>1. Ordered for an approved indication for use:</p> <ul style="list-style-type: none"> the treatment of patients with unresectable or metastatic melanoma with BRAF V600E mutation as detected by an FDA-approved test. <p>2. the treatment of patients with Erdheim Chester Disease with BRAF V600 mutation.</p> <p>3. Medication ordered by an Oncologist or dermatologist</p>	<p>Limitations of Use:</p> <ul style="list-style-type: none"> Zelboraf is not indicated for use in patients with wild-type BRAF melanoma. <p>The safety and efficacy of Zelboraf in combination with ipilimumab have not been established.</p>
venetoclax (Venclexta) tablet 10mg, 50mg, 100mg	<p>1. Ordered for an approved indication for use:</p> <ul style="list-style-type: none"> for the treatment of adult patients with chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL). <p>2. in combination with azacitidine, or decitabine, or low dose cytarabine for the treatment of newly diagnosed acute myeloid leukemia (AML) in adults 75 years or older, or who have comorbidities that preclude use of intensive induction chemotherapy.</p> <p>3. Medication ordered by an Oncologist</p>	
viltolarsen (Viltepso) 50 mg/ml solution	<p>1. Ordered for an approved indication for use:</p>	<p>Requires MFC Physician or Pharmacist review prior to approval.</p>

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	<ul style="list-style-type: none"> • treatment of Duchenne muscular dystrophy (DMD) in patients who have a confirmed mutation of the DMD gene that is amenable to exon 53 skipping. <ol style="list-style-type: none"> 2. Genetic testing must confirm patient’s DMD gene is amenable to exon 53 skipping. 3. Current patient weight, including date weight was obtained and within 30 days of requested date. 4. Baseline renal function test (GFR) and Urine protein-to-creatinine ratio prior to starting treatment. 5. Documented baseline function testing using a tool to demonstrate physical functions, including, but not limited to: Brooke Upper Extremity Scale, Baseline 6-minute walk test, Pediatric Evaluation of Disability Inventory. 6. Stable dose of glucocorticoid for at least 3 months. 7. Prescribed by a neurologist. 8. Approval duration: 6 months 	<ul style="list-style-type: none"> • Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial. <p>Limitations of Use:</p> <ul style="list-style-type: none"> • Can not be used concomitantly with other exon-skipping therapies for DMD. • Studied only in males from ages 4-10, Vyondy’s 53 has been studied in children aged 6-13 years of age. • Should not be continued as treatment for individuals who experience decreasing physical function while on medication. <p>Renewal Criteria:</p> <ul style="list-style-type: none"> • Documentation and provider attestation of continued benefit, including respiratory status assessment, without adverse effects • Not receiving another antisense therapy or gene therapy <p>Approval duration: 12 months</p>
voclosporin (Lupkynis) capsule 7.9mg	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • in combination with a background immunosuppressive therapy regimen for the treatment of adult patients with 	<p>Limitations of Use:</p> <ul style="list-style-type: none"> • Safety and efficacy of Lupkynis have not been established in

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	active lupus nephritis.	combination with cyclophosphamide and is not recommended.
vorapaxar (Zontivity) tablet 2.08mg	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • reduction of thrombotic cardiovascular events in patients with a history of myocardial infarction (MI) or with peripheral arterial disease (PAD) 2. Medication ordered by Cardiology, Neurology or Vascular Surgery 	<ul style="list-style-type: none"> • Contraindicated in patients with history of stroke, TIA, or ICH and/or active pathologic bleeding.