

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) Bolded medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Additional Considerations and Renewal Criteria
Abaloparatide (Tymlos)	<ol style="list-style-type: none"> Prescribed for an approved indication for use: <ul style="list-style-type: none"> Treatment of postmenopausal women with osteoporosis at high risk for fracture, or patients who have failed or are intolerant to other available osteoporosis therapy. Treatment to increase bone density in men with osteoporosis at high risk for fracture, or patients who have failed or intolerant to other available osteoporosis therapy. Patient has diagnosis of post-menopausal osteoporosis and is at high risk for bone fracture. Patient is female, age ≥ 18 years of age. Patient does not have increased baseline risk for osteosarcoma (e.g., Paget's disease of the bone, bone metastases, or skeletal malignancies). T-score ≤ -2.5 based on BMD measurements from the lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site) OR <ul style="list-style-type: none"> History of one of the following resulting from minimal trauma: vertebral compression fracture, fracture of the hip, fracture of the distal radius, fracture of the pelvis, fracture of the proximal humerus. If the criteria in #2 are not met, approval may be granted for patients with both of the following: 	<ol style="list-style-type: none"> Treatment duration has not exceeded a total of 24 months of cumulative use of parathyroid hormone analogs (e.g., Teriparatide, Forteo, Tymlos) during the patient's lifetime. Up to 12 months, not intended to last longer than the final infusion completing 24 months of therapy.

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	<ul style="list-style-type: none"> • BMD T-score between -1 and -2.5 based on BMD measurements from lumbar spine, hip, or radius; AND • ONE of the following FRAX 10-year fracture probabilities: <ul style="list-style-type: none"> ○ Major osteoporotic fracture $\geq 20\%$ ○ Hip fracture $\geq 3\%$ <ol style="list-style-type: none"> 7. Documented trial of teriparatide (Forteo). 8. Documented intolerance, ineffectiveness, contraindication, and/or treatment failure of a minimum trial of 12 weeks of an oral bisphosphonate product. 9. Treatment duration has not exceeded a total of 24 months of cumulative use of parathyroid hormone analogs (e.g., Teriparatide, Forteo, Tymlos) during the patient's lifetime. 10. Approval Duration: up to 12 months 	
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. Confirmation that requested indication continues to carry FDA-approval. 3. Patient aged 18 years or older. 4. Prescriber agrees to monthly monitoring of CBC. 5. Medication ordered by an Oncologist. 6. Maximum Approval Duration: 12 months 	<ol style="list-style-type: none"> 1. Confirmation that medication still carries FDA-approval for intended indication. 2. Prescriber has documented monthly CBC monitoring, labs submitted. 3. No documented disease progression or unacceptable toxicity.
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. 	<ol style="list-style-type: none"> 1. Confirmation that medication still carries FDA-approval for intended indication. 2. Prescriber has submitted documentation showing periodic

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	<ol style="list-style-type: none"> Test results confirming presence of <i>KRAS</i> G12C mutation in tumor or plasma specimens. Patient has had at least one prior systemic therapy. Medication ordered by an Oncologist. Approval Duration: 12 months. 	<p>monitoring of AST, ALT, alkaline phosphatase, and total bilirubin.</p> <ol style="list-style-type: none"> No documentation of disease progression or unacceptable toxicity.
Albuterol inhalers Levalbuterol inhalers	<ol style="list-style-type: none"> If patient has exceeded 6 inhalers per 365 days: Note: this applies to any combination of albuterol MDIs and levalbuterol MDIs. <ul style="list-style-type: none"> Provider must show that patient has been prescribed appropriate controller therapy for indication (asthma, COPD). Provider must provide documentation of treatment plan and patient follow-up that will occur. Patient must be referred for follow up with MFC Case Management. Approval for asthma indication is for one fill, one month only. Approval for COPD may be longer depending upon concurrent therapy and oversight by a pulmonologist. 	
alectinib (Alecensa) capsule 150mg	<ol style="list-style-type: none"> 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. Patient ≥ 18 years of age. Patient has advanced or metastatic disease. Patient has anaplastic lymphoma kinase (ALK)- positive disease as detected by an approved test. Medication ordered by an Oncologist. Maximum Approval Duration: 12 months. 	<ol style="list-style-type: none"> No documentation of disease progression or unacceptable toxicity.

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Allogeneic processed thymus tissue–agdc (Rethymic)	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
Antihemophil FVIII, B-dom del (Xyntha)	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
Avalglucosidase alfa-ngpt (Nexviazyme)	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
avapritinib (Ayvakit) tablets 100mg, 200mg, 300mg	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <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. 2. Patient age ≥ 18 years. 3. Patient has experienced treatment failure to first-line therapy. 4. Patient's platelet count is ≥ 50 x 10⁹/L; AND 5. Patient meets one of the following criteria: <ul style="list-style-type: none"> • Diagnosis of indolent systemic mastocytosis OR • Patient has one of the following subtypes of advanced systemic mastocytosis: <ul style="list-style-type: none"> ○ Aggressive systemic mastocytosis; or ○ Systemic mastocytosis with an associated hematological neoplasm; or 	<ol style="list-style-type: none"> 1. No evidence of disease progression. 2. Approval Duration: 12 months.

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	<ul style="list-style-type: none"> ○ Mast cell leukemia. 6. Approval Duration: 1 year	
avatrombopag (Doptelet) tablets 20mg	1. Ordered for an approved indication for use: <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 thrombocytopenia who have had an insufficient response to a previous treatment. 2. Patient age ≥ 18 years. 3. A recent (less than 1 month old) platelet count must be supplied with documentation submitted. 4. Medication ordered by a Hematologist. 5. Approval limited to 15 tablets per treatment course. 6. Subsequent treatment courses require a new prior authorization.	
Axicabtagene ciloleucel (Yescarta) Injection	1. 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. 2. The treatment facility that dispenses and administers Yescarta is enrolled and complies with the Risk Evaluation and Mitigation Strategy; AND 3. Patient age ≥ 18 years. 4. Patient has received prior treatment with first-line chemoimmunotherapy and has any of the following B-cell lymphoma sub-types: <ul style="list-style-type: none"> • Diffuse large B-cell lymphoma (DLBCL) • Primary mediastinal large B-cell lymphoma • High-grade B-cell lymphomas • HIV-related B-cell lymphomas • Monomorphic post-transplant lymphoproliferative B- 	

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	<p>cell type disorder</p> <p>5. Patient does not have ANY of the following:</p> <ul style="list-style-type: none"> • Primary CNS lymphoma • Previous treatment with Yescarta or other CD 19-directed chimeric antigen receptor (CAR) T-cell therapy. • ECOG performance status ≥ 3 (patient is not ambulatory, capable of self-care, or confined to bed or chair more than 50% of waking hours). • Inadequate or unstable kidney, liver, pulmonary, or cardiac function. • Active hepatitis B, active hepatitis C, or clinically active systemic infection. <p>6. Medication ordered by an Oncologist.</p> <p>7. Approval duration: 3 months.</p>	
Azacitadine (Onureg) tablets 200mg, 300mg	<p>1. Ordered for an approved indication for use:</p> <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. <p>2. Patient is not able to complete intensive curative therapy (i.e., transplant-ineligible).</p> <p>3. Medication ordered by an Oncologist.</p>	<p>1. Patient does not show evidence of progressive disease while on Onureg therapy.</p> <p>2. Approval duration: 12 months.</p>
Bedaquiline (Sirturo) tablets 20mg, 100mg #	<p>1. Ordered for an approved indication for use:</p> <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. 	

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	2. Medication ordered by infectious disease. 3. Approval duration: 24 weeks	
Belumosudil (Rezurock) tablets 200mg	1. 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. 2. Member must have tried and failed, have intolerance or medical contraindication to at least three of these medications: cyclosporine, methotrexate, mycophenolate, sirolimus, and glucocorticoids. 3. Patient age \geq 12 years. 4. Provider attestation: Drug specific baseline evaluation and monitoring completed (CBC/CMP including total bilirubin, AST, ALT). Patient is not pregnant and is using effective contraception, concurrent use of CYP3A inducers and proton pump inhibitors is contraindicated. 5. Life expectancy is > 6 months. 6. Quantity limited to 30 tablets per 30 days. 7. Approval duration: 6 months.	1. Prescriber attestation of continued clinical benefit. 2. Approval Duration: 6 months.
benralizumab (Fasenra) Pen 30mg/ml	1. Ordered for an approved indication for use: <ul style="list-style-type: none"> add-on maintenance treatment of patients \geq 12 years of age with severe asthma and with an eosinophilic phenotype. 2. Diagnosis of severe, uncontrolled asthma as defined by at least ONE of the following: <ul style="list-style-type: none"> Poor symptom control (e.g., Asthma Control Questionnaire (ACQ) score consistently greater than 1.5 or Asthma Control Test (ACT) score consistently less than 20). Two or more bursts of systemic corticosteroids for at least 	1.Documentation of positive clinical response to Fasenra therapy as demonstrated by at least one of the following: <ul style="list-style-type: none"> Reduction in frequency of exacerbations Decreased utilization of rescue medications Increase in percent predicted FEV1 from pretreatment

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	<p>3 days each in previous 12 months.</p> <ul style="list-style-type: none"> • Asthma-related emergency treatment (ER visit, hospital admission, or unscheduled OV for nebulizer or emergency treatment). • Airflow limitation (e.g., after appropriate bronchodilator withhold forced expiratory volume in 1 second (FEV1) less than 80% predicted. • Patient is currently dependent on oral corticosteroids for the treatment of asthma. <p>3. Submission of medical records documenting one of the following:</p> <ul style="list-style-type: none"> • Asthma is eosinophilic phenotype as defined by baseline (pre-benralizumab treatment) peripheral blood eosinophil level ≥ 150 cells/uL within the past 6 weeks; OR • Patient is currently dependent on maintenance therapy with oral corticosteroids for the treatment of asthma. <p>4. Fasenra will be used in combination with ONE of the following:</p> <ul style="list-style-type: none"> • One high-dose combination inhaled corticosteroid (ICS/LABA); OR • Combination therapy with BOTH one high-dose inhaled corticosteroid and one additional asthma controller medication. <p>5. Patient is not receiving treatment in combination with ANY of the following:</p> <ul style="list-style-type: none"> • Anti-interleukin-5 therapy (e.g., Cinqair (reslizumab), Nucala (mepolizumab). • Anti-IgE therapy (e.g., Xolair (omalizumab). • Anti-interleukin-4 therapy (e.g., Dupixent (dupilumab). • Thymic stromal lymphopoietin (TSLP) inhibitor (e.g., Tezpire (Tezepelumab)). 	<p>baseline.</p> <ul style="list-style-type: none"> • Reduction in severity or frequency of asthma-related symptoms • Reduction in oral corticosteroid requirements. <p>2. Used in combination with inhaled corticosteroid (ICS)-containing controller medication.</p> <p>3. Patient is not receiving treatment in combination with ANY of the following:</p> <ul style="list-style-type: none"> • Anti-interleukin-5 therapy (e.g., Cinqair (reslizumab), Nucala (mepolizumab). • Anti-IgE therapy (e.g., Xolair (omalizumab). • Anti-interleukin-4 therapy (e.g., Dupixent (dupilumab). • Thymic stromal lymphopoietin (TSLP) inhibitor (e.g., Tezpire (Tezepelumab)). <p>4. Approval Duration: 12 months.</p>

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	6. Medication ordered by a Pulmonologist, Immunologist, or Allergist. 7. Approval Duration: 12 months.	
Beremagene geperpavec (Vyjuvek)	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
berotralstat (Orladeyo) capsules	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
Betibeglogene autotemcel (Zynteglo)	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
binimetinib (Mektovi) tablets 15mg	1. 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 BRAF V600E or V600K mutation, as detected by an FDA-approved test. 2. Medication ordered by an Oncologist	
blinatumomab (Blincyto) Injection 35mcg	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
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	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
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. 	

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	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 disease progression, generally a urine protein-to-creatinine ratio (UPCR) ≥ 1.5 g/g. 2. History of failure, contraindication or intolerance to a glucocorticoid. 3. 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. 4. Medication ordered by a nephrologist.	Limitations of Use: This indication is approved under accelerated approval based on a 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.
burosumab-twza (Crysvita) injection **Not on MDH list	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
c1 Inhibitor [Human] cinryze sol 500 unit haegarda injection 2000unit, 3000unit	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
cabotegravir sodium (Apretude ER); suspension 600mg/3 ml	1. 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. 2. Individuals must have a negative HIV-1 test prior to initiating APRETUDE and prior to each injection. 3. Provider confirms that the patient will be tested for HIV-1 infection with each subsequent injection; AND 4. Patient is not an appropriate candidate for oral PrEP (e.g., difficulty with adherence to prior oral PrEP, significant renal	1. Patient has previously received treatment with Apretude 2. Patient has a negative HIV-1 test 3. Provider confirms that the patient will be tested for HIV-1 with each subsequent injection; and 4. Dosing is in accordance with FDA-approved labeling. 5. Approval Duration: 2 months

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	disease); AND 5. Provider attests that patient demonstrates treatment readiness by BOTH of the following: 6. Patient understands the risks of missed doses. 7. Patient has ability to adhere to the required every 2 months injection and testing appointments. 8. Dosing is in accordance with FDA-approved labeling. 9. Approval Duration: 2 months	
cabotegravir and rilpivirine extended-release (Cabenuva) injectable suspensions 400mg-600mg, 600mg-900mg	1. 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. 2. 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). 3. Authorization Duration: 3 months	1. Patient has previously received treatment with Cabenuva 2. Laboratory documentation of maintained viral suppression (HIV-1 RNA <50 copies per ml. 3. Renewal duration: 3 months.
caplacizumab-yhdp (Cablivi) kit 11mg **Not on MDH list	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
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.	

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casimersen (Amondys 45) injection	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
Ciltacabtagene autoleucel (Carvykti) **Not on MDH list	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
Coagulation factor IX (Benefix) recombinant	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
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.	
crisaborole (Eucrisa) ointment 2% STEP THERAPY	1. Ordered for an approved indication for use: <ul style="list-style-type: none"> Topical treatment of mild-to-moderate atopic dermatitis in adult and pediatric patients ≥ 3 months of age. 2. Step Therapy: Unless patient age < 2 years of age. First must have tried and failed: <ul style="list-style-type: none"> At least one topical steroid AND topical tacrolimus OR pimecrolimus. 	
crizotinib (Xalkori) capsule 200mg, 250mg	1. 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. 2. Medication ordered by an Oncologist	Limitations of Use: The safety and efficacy of XALKORI have not been established in older adults with relapsed or refractory, systemic ALK-positive ALCL.

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cysteamine bitartrate (Procysbi) capsules/granules	USE MFC High-Cost Medication PA Criteria	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. 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. Medication ordered by an Oncologist 	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 approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trials.
dalfampridine (Ampyra) ER tablets 10mg	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> To Improve walking in adult patients with multiple sclerosis (MS). Patient age ≥ 18 years. Patient is currently receiving therapy with an agent to 	<ol style="list-style-type: none"> Improvement in walking speed as demonstrated by T25FW as compared with baseline. Approval duration: 12 months.

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	<p>reduce progression of multiple sclerosis.</p> <ol style="list-style-type: none"> Patient does not have history of seizure. Patient has appropriate renal function; CrCl > 50 ml/min. Must be able to walk 25 feet within 8 to 45 seconds at baseline. Must have a baseline gait assessment by PT within 90 days of beginning Ampyra. Limited to 2 tablets per day. Medication ordered by a Neurologist. Initial approval for 3 months only after 3 months, must show improvement in walking speed must be documented to obtain continued approval. 	
Daprodustat (Jesduvroq) tablets 1 mg, 2 mg, 4 mg, 6 mg, 8 mg	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> Treatment of anemia that is caused by chronic kidney disease (CKD) in adults who have been on dialysis for at least 4 months. Patient age ≥ 18 years. Patient on dialysis. Pre-treatment hemoglobin level is < 11 g/dL. Serum transferrin saturation (TSAT) ≥ 20% within prior 3 months. Cannot use concomitantly with other erythropoiesis stimulating agents. Maximum daily dose 24 mg per day. Initial approval duration: 6 months. 	<ol style="list-style-type: none"> Can not increase dose more frequently than once every 4 weeks. Serum transferrin saturation (TSAT) ≥ 20% within prior 3 months. May not use concomitantly with other erythropoiesis stimulating agents. After 24 weeks, if hemoglobin has not increased by ≥ 1 g/dL, then therapy should be discontinued and cannot be approved. Approval duration: 6 months.
darolutamide (Nubeqa) tablets 300mg	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> treatment of non-metastatic castration-resistant prostate cancer (mCRPC). Metastatic hormone-sensitive prostate cancer (mHSPC) in combination with docetaxel. 	

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Delandistrogene moxeparvovec (Elevidys)	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
Dextromethorphan/Quinidine (Nuedexta) tablets	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> Treatment of pseudobulbar affect (PBA) Patient age ≥ 18 years. Patient has been diagnosed with ONE of the following: <ul style="list-style-type: none"> Amyotrophic lateral sclerosis (ALS) Alzheimer's disease Multiple sclerosis (MS) Parkinson's disease Stroke Traumatic brain injury The baseline Center for Neurologic Study-Lability Scale (CNS-LS) score must be > 13. Dose must not exceed 2 capsules per day. Prescribed by or in consultation with a neurologist. <ol style="list-style-type: none"> Initial Authorization period is limited to 6 months. 	<ol style="list-style-type: none"> Documentation of positive clinical response to therapy. Authorization period is up to 12 months. <p>Limitations of Use: The following indications are considered experimental and cannot be approved:</p> <ul style="list-style-type: none"> Heroin detoxification Levodopa-induced Dyskinesia in Parkinson's Disease Neuropathic pain Psychosis-Related Aggression Treatment Resistant Depression
Dulaglutide (Trulicity)	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> As an adjunct to diet and exercise to improve glycemic control in adults or pediatric patients ≥ 10 years of age with type 2 diabetes mellitus. In adult patients with T2DM for risk reduction of major cardiovascular events (cardiovascular death, nonfatal myocardial infarction, nonfatal stroke) in adults with type 2 diabetes mellitus who have established cardiovascular disease or multiple cardiovascular risk factors. Use in patients aged ≥ 10 years to < 18 years of age with type 2 DM is limited to those who are ≥ 3 months post-diagnosis with an HbA_{1c} of $\geq 6.5\%$ while on metformin therapy (maximized). 	Cannot be approved for indication of weight management.

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	<ol style="list-style-type: none"> 3. Titration dose (0.75 mg) limited to 8 pens in 365 days without medical director review. <ul style="list-style-type: none"> • To continue at initiation dose, must show A1c < 8.0 OR TIR > 50% within the past 3 months. 4. Maximum 30-day supply per dispense. 5. A1c or TIR% report within past 3 months. 6. May not be concurrently using any other GLP1 or GLP1/GIP combination drug (e.g., Mounjaro, Trulicity, Victoza, Xultrophy or Soliqua). 7. May not be concurrently taking a DPP4i (e.g., alogliptin, Januvia (sitagliptin), Tradjenta (Linagliptin), Onglyza (saxagliptin)) 8. Maximum Approval Duration: 12 months 	
Denosumab (Prolia; Xgeva) injection 60mg/ml	<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. Patient age ≥ 18 years of age. 3. Tried and failed, had adverse reaction to, or contraindication to formulary preferred products (e.g., alendronate, calcitonin nasal spray). 	<ol style="list-style-type: none"> 1. All initial criteria met. 2. Approval Duration: 12 months.

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	4. Limited to 1 syringe every 6 months. 5. Concomitant use of calcium and vitamin D supplement required. 6. Authorization duration: 12 months.	
deutetrabenzine (Austedo) tablets XR titration kit 6mg, 9mg, 12mg	1. Ordered for an approved indication for use: <ul style="list-style-type: none"> Chorea associated with Huntington's disease. (HD) Tardive dyskinesia (TD) in adults. 2. Patient age ≥ 18 years. 3. Patient is not receiving other VMAT2 inhibitors (tetraabenazine or valbenazine), MAOI's or reserpine. 4. Patient does not have hepatic impairment. 5. Tardive dyskinesia: <ul style="list-style-type: none"> AIMS score sheet along with the progress note must be provided for initial and renewal PA requests. 6. Huntington's disease: <ul style="list-style-type: none"> Description of functional impairment, including Total Maximal Chorea (TMC) score sheet along with progress notes must be provided for both initial and renewal PA requests. 7. Patient must not be suicidal or have untreated/inadequately treated depression. 8. Approval Duration: 3 months.	1. Prescriber attestation of continued clinical benefit and subsequent evaluation and monitoring performed. 2. TD: AIMS score must show improvement over initial score. 3. HD: TMC score must show improvement over the initial score and functional impairment must show improvement from baseline. 4. All initial criteria must be met. 5. Approval duration: 12 months.
Eculizumab (Soliris) injection - 10mg/ml	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
Elacestrant (Orserdu) **Not on MDH list	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
Efgartigimod alfa-fcab (Vyvgart) injection **Not on MDH list	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.

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elapegademase-lvlr (Revcovi) Injection	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
Ellexacaftor, ivacaftor, and tezacaftor (Trikafta) tablets 150mg	<ol style="list-style-type: none"> Ordered for an approved indication for use: <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. 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. Patient age ≥ 2 years. Provider attestation of baseline and subsequent evaluation and monitoring as appropriate and indicated by the FDA-approved product labeling (provider must submit documentation). Provider justification of necessity of medication change if currently stable on another CF regimen and asymptomatic. Medication ordered by a Pulmonologist. Approval duration: 12 months. 	<ol style="list-style-type: none"> Provider attestation of continued benefit without adverse drug effects. Provider attestation of continued monitoring as appropriate. Approval Duration: 12 months.
Elivaldogene autotemecel (Skysona)	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
Elosulfase alfa (Vimizim) injection	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
emtricitabine and tenofovir alafenamide (Descovy) tablet 200mg/25mg	<ol style="list-style-type: none"> Ordered for an approved indication for use: <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 	<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

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	treatment of HIV-1 infection in pediatric patients weighing at least 14 kg and less than 35 kg.	(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).
encorafenib (Braftovi) capsules 75mg	<ol style="list-style-type: none"> Ordered for an approved indication for use: <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 BRAF V600E mutation, as detected by an FDA-approved test, after prior therapy. Medication ordered by an Oncologist. 	Limitations of Use <ul style="list-style-type: none"> Braftovi is not indicated for treatment of patients with wild-type BRAF melanoma or wild-type BRAF CRC
entrectinib (Rozlytrek) Capsules 100mg, 200mg	<ol style="list-style-type: none"> Ordered for an approved indication for use: <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. Medication ordered by an Oncologist. 	
Enzalutamide (Xtandi) capsules	<ol style="list-style-type: none"> Ordered for an approved indication for use: 	Patients receiving Xtandi should also

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40mg	<ul style="list-style-type: none"> castration-resistant prostate cancer for patients > 18 years of age. <ol style="list-style-type: none"> Metastatic, castration-sensitive prostate cancer (mCRPC) for patients > 18 years of age. Medication ordered by an Oncologist or urologist 	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).
erdafitinib (Balversa) tablets 3mg, 4mg, 5mg	<ol style="list-style-type: none"> Ordered for an approved indication for use: <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. Medication ordered by an Oncologist. 	
estradiol and dienogest (Natazia) tablets	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> Treatment of non-acute heavy menstrual bleeding in women without organic pathology. Contraception 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). 	
Etranacogene dezaparvocec (Hemgenix)	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
evinacumab-dgnb (Evkeeza) injection	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.

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factor VIIa, recombinant human (NovoSeven RT) injection	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
factor VIII, recombinant human pegylated (Jivi) injection **Not on MDH list	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
Factor VIII, recombinant human with VWF fusion (Altuviiio)	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
Factor VIII rec, Fc fusion prot (Eloctate)	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
Fecal microbiota capsules, oral (Vowst)	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> To prevent recurrence of <i>Clostridioides difficile</i> infection (CDI) in individuals ≥ 18 years of age following antibacterial treatment for recurrent CDI. Patient has had three or more episodes of CDI within previous 12 months (including most recent episode). Patient has recent episode of recurrent CDI with all of the following: <ul style="list-style-type: none"> At least 3 unformed stools per day for 2 consecutive days Stool test confirming the presence of <i>C. difficile</i> toxin or toxigenic <i>C. difficile</i>. An adequate clinical response (i.e., resolution of symptoms) following standard of care antibiotic therapy (e.g., vancomycin + metronidazole, fidaxomicin) Patient does not have ANY of the following: <ul style="list-style-type: none"> Known or suspected toxic megacolon and/or known small bowel ileus OR Admitted to, or expected to be admitted to an ICU for medical reasons, OR 	Limitations of Use: VOWST is not indicated for treatment of CDI.

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	<ul style="list-style-type: none"> ○ Absolute neutrophil count < 500 cells/mL³ ○ History of major GI surgery within 3 months before treatment start (not including appendectomy or cholecystectomy) OR ○ History of total colectomy or bariatric surgery that disrupted the GI lumen OR ○ History of active inflammatory bowel disease (e.g. ulcerative colitis, Crohn's disease, microscopic colitis) with diarrhea believed to be cause by active inflammatory bowel disease in the past 3 months. ○ History of fecal microbiota transplantation (FMT) within 3 months <ol style="list-style-type: none"> 5. The patient will not be using the requested agent in combination with Rebyota or Zinplava for the requested indication. 6. Provider attests that patient will follow the bowel preparation protocol outlined in the package insert. 7. Patient will not be taking a concurrent antibiotic. 8. Prescribed by or in consultation with an infectious disease specialist. 9. Approval is limited to 12 capsules per dispense; maximum of 24 capsules lifetime. 	
fentanyl (Duragesic) transdermal patch 12mcg/hr, 25mcg/hr, 37.5mcg/hr, 50mcg/hr, 62.5mcg/hr, 75mcg/hr, 87.5mcg/hr, 100mcg/hr	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • All long-acting opioids require prior authorization (PA). The PA request form can be access using the following links: OPIOID PRIOR AUTH FORM-MD

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	hydromorphone per day, 25 mg oral oxymorphone per day, 60 mg oral hydrocodone per day, or an equianalgesic dose of another opioid.	
Fezolinetant (Veoza)	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> Treatment of moderate to severe vasomotor symptoms due to menopause. Patient must be a perimenopausal or post-menopausal female Documentation of baseline bloodwork to evaluate for hepatic function and injury including ALT, AST and serum bilirubin (total and direct) before initiation of treatment. Provider attests to monitoring liver function tests at 3-months, 6-months, and 9-months after starting therapy. Patient must not have cirrhosis. Patient does not have severe renal impairment (GFR < 30 ml/min) or end-stage renal disease. The medication must not be used concomitantly with CYP1A2 inhibitors (e.g., acyclovir, allopurinol, amiodarone, cimetidine, clarithromycin, duloxetine, famotidine, fluoroquinolones, fluvoxamine, mexiletine, oral contraceptives, verapamil, zafirlukast, zileuton). Patient must have treatment failure, intolerance, or contraindication to at least one menopausal hormone therapy. Initial approval period: 9 months 	Renewal Criteria: <ol style="list-style-type: none"> All criteria listed for initial approval AND: Documented improvement of symptoms Documentation of liver function tests monitoring during first year of treatment with labs within previous 3 months. Renewal duration: 12 months
finasteride/tadalafil (Entadfi) capsules-5mg/5mg	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> Treatment of signs and symptoms of benign prostatic hyperplasia (BPH) in men with an enlarged prostate for up to 26 weeks. Patient age ≥ 18 years. Adequate trial (30 days) and inadequate response, or 	Renewal Criteria: not applicable. Treatment duration is limited to 26 weeks.

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	<p>intolerance to, at least two preferred BPH agents.</p> <ol style="list-style-type: none"> History of finasteride use in the past one year. No previous full course of therapy with Entadfi. No concomitant use of organic nitrate, either regularly or intermittently. No concomitant use of guanylate cyclase stimulators (e.g., Riociguat (Adempas®). CrCl \geq 50 ml/minute. Quantity limit: 1 capsule per day Approval Duration: 26 weeks of therapy. 	
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 \leq 5.0 mEq/L eGFR \geq 25 mL/min/1.73 m² Urine albumin-to-creatinine ratio \geq 30 mg/g Concomitant use with maximum tolerated doses of ACE-Inhibitor or ARB unless intolerant to or contraindicated. Failed trial or contraindication to one formulary SGLT2i. Approval duration: 3 months 	<ol style="list-style-type: none"> All initial criteria for approval; AND Dosing appropriate based on 4-week potassium laboratory check. <ul style="list-style-type: none"> 20 mg daily if Potassium \leq 4.8 10 mg daily if K⁺ between 4.8-5.5 Interrupt therapy if K⁺ $>$ 5.5, may restart at 10 mg daily when potassium is \geq 5.0 Approval duration: 12 months
Fosdenopterin (Nulibry) injection 9.5mg	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
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. 	<ol style="list-style-type: none"> Documentation of improved symptoms and attestation of lab parameters. Renewal approval duration: 12 months

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	<ol style="list-style-type: none"> 2. Patient age ≥ 18 years. 3. Patient is not on hemodialysis. 4. Max dose: 150 mg 2 times daily with goal platelets $\geq 50 \times 10^9/\text{mmcp/L}$. 5. Medication ordered by a Hematologist. 6. Initial Approval Duration: 3 months. 	
Furosemide subcutaneous device (Furoscix)	<ol style="list-style-type: none"> 1. Ordered for the treatment of congestion due to fluid overload in adults with NYHA Class II/III chronic heart failure. 2. Patient has CrCl > 30 ml/min OR eGFR > 20 ml/min 3. Patient has been stable and is refractory to at least one of the following loop diuretics, at up to maximally indicated doses: <ul style="list-style-type: none"> ○ Furosemide oral tablets; 40-160 mg/day ○ Torsemide oral tablets; 50-100 mg/day ○ Bumetanide oral tablets; 3-10 mg/day 4. Documentation that member is a candidate for parenteral diuresis outside of the hospital, as defined by all of the following: <ul style="list-style-type: none"> ○ Oxygen saturation $\geq 90\%$ on exertion ○ Respiratory rate < 24 breaths per minute ○ Resting heart rate < 100 beats per minute ○ Systolic blood pressure > 100 mmHg 5. Patient does not have anuria 6. Patient does not allergy to medical adhesives or furosemide. 7. Patient does not have hepatic cirrhosis or ascites. 8. Dose does not exceed 80 mg (1 cartridge) per day. 9. Prescribed by cardiologist 10. Limited to 8 kits every 30 days 11. Approval requires that patient is referred for MFC Case Management 12. Authorization Duration: 3 months 	<u>Limitations of Use:</u> <ul style="list-style-type: none"> • Furoscix is not indicated for emergency situations or in patients with acute pulmonary edema. • The On-Body Infusor will deliver only an 80-mg dose of Furoscix. • Patients must meet initial approval criteria for each request

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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. Patient age ≥ 18 years. Patient CrCl > 30 ml/min; patient is not on hemodialysis. Dose does not exceed 1800 mg per day. Approval Duration: 12 months 	<ol style="list-style-type: none"> Initial criteria continue to be met Approval duration: 12 months.
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 	
Givosiran (Givlaari)	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
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. Submission of a completed Hepatitis C Prior Authorization form and supporting documentation. Patient treatment plan aligns with MDH Clinical Criteria recommendations. Approval Duration: limited to 12 weeks. 	<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 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. <p>Concomitant use with carbamazepine, efavirenz containing regimens and St.</p>

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		John's wort may decrease concentrations of Mavyret and is not recommended.
glycerol phenylbutyrate (Ravicti) Liquid	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
glycopyrronium (Qbrexza) pad 2.4%	<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 ≥ 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.)
Golodirsen (Vyondys 53) injection	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
Goserelin (Zoladex) implant 3.6mg, 10.8mg	<ol style="list-style-type: none"> 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) 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) management of endometriosis (3.6 mg) palliative treatment of advanced breast cancer in pre- and peri-menopausal women. (3.6 mg) to cause endometrial thinning agent prior to endometrial ablation for dysfunctional uterine bleeding. (3.6 mg) management of endometriosis, including pain relief and reduction of endometriotic lesions for the duration of therapy. 	Limitations for use: <ol 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.

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Histrelin implant (Supprelin LA) Kit 50mg	<ol style="list-style-type: none"> 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 be 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 age. Medication ordered by pediatric endocrinologist. 	
Human plasma-derived plasminogen (Ryplazim)	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
ibrutinib (Imbruvica) capsules 140mg	<ol style="list-style-type: none"> 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. Medication ordered by an Oncologist. Quantity limit: 4 tablets per day. 	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> 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	<ol style="list-style-type: none"> 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. Medication ordered by an Allergist or ENT 	Self-administered by the patient upon recognition of symptoms of an HAE attack after training under the guidance of a healthcare professional.

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Icosapent ethyl (E-EPA) (Vascepa)	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> As an adjunct to maximally tolerated statin therapy to reduce the risk of myocardial infarction, stroke, coronary revascularization, and unstable angina requiring hospitalization in adult patients with elevated triglyceride (TG) levels (≥ 150 mg/dL) AND <ul style="list-style-type: none"> Established cardiovascular disease OR Diabetes mellitus and 2 or more additional risk factors for cardiovascular disease As an adjunct to diet to reduce TG levels in adult patients with severe (≥ 500 mg/dL) hypertriglyceridemia. Age ≥ 45 years Diagnosis of hypertriglyceridemia (pre-treatment TG level ≥ 150 mg/dl) AND Patient is considered high or very high risk for cardiovascular disease (CVD) as evidenced by one of the following: <ul style="list-style-type: none"> Acute coronary syndrome History of myocardial infarction Stable or Unstable angina Coronary or other arterial revascularization Stroke Transient ischemic attack Peripheral arterial disease OR, if not the criteria in #4: <ul style="list-style-type: none"> Type 2 Diabetes diagnosis AND TWO of the following: Men ≥ 55 years and women ≥ 65 years Cigarette smoker or stopped within past 3 months Hypertension diagnosis HDL-C ≥ 40 mg/dL for men or ≥ 50 mg/dL for 	Renewal Criteria: <ul style="list-style-type: none"> Used for cardiovascular risk reduction Documentation of positive clinical response to therapy Patient is receiving maximally tolerated statin therapy. Approval duration: 12 months

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	<p>women</p> <ul style="list-style-type: none"> ○ High-sensitivity C-reactive protein > 3.0 mg/L ○ Creatinine clearance > 30 and < 60 ml/min ○ Retinopathy ○ Micro- or macro-albuminuria ○ Ankle-brachial index (ABI), 0.9 without symptoms of intermittent claudication <p>6. Patient has received at least 12 consecutive weeks of high-intensity statin therapy (Atorvastatin 40-80 mg; rosuvastatin 20-40 mg) OR <u>BOTH OF THE FOLLOWING:</u></p> <ul style="list-style-type: none"> • Intolerance to high-intensity statin as evidenced by ≥ 2 weeks of myalgia and/or myositis AND • at least 12 consecutive weeks of low/moderate intensity statin therapy <p>7. Patient has been receiving at least 12 consecutive weeks of ezetimibe (Zetia) therapy as adjunct to maximally tolerated statin therapy, or contraindication or intolerance to ezetimibe OR has LDL-C less than 100 mg/dL while on maximally tolerated statin therapy.</p> <p>8. Approval duration: 12 months.</p>	
idecabtagene vicleucel (Abecma) injection **Not on MDH list	USE MFC High-Cost Medication PA Criteria	<ul style="list-style-type: none"> • Requires MFC Physician or Pharmacist review prior to approval.
Idelalisib (Zydelig) tablets 100mg, 150mg	<p>1. Ordered for an approved indication for use:</p> <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. 	<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),

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	<ol style="list-style-type: none"> treatment of patients with relapsed follicular B-cell non-Hodgkin lymphoma (FL) in patients who have received at least two prior systemic therapies. treatment of patients with relapsed small lymphocytic lymphoma (SLL) in patients who have received at least two prior systemic therapies. Medication ordered by an Oncologist Ordered through a Specialty Pharmacy 	<p>follicular lymphoma (FL), and other indolent non-Hodgkin lymphomas.</p> <ul style="list-style-type: none"> 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.
idursulfase (Elaprase) injection 6mg/3ml **Not on MDH list	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
imiglucerase (Cerezyme) injection 400 unit **Not on MDH list	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
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. 	
interferon gamma-1b (Actimmune) injection	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
Ipilimumab (Yervoy) injection 50mg, 200mg Not on MDH list	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.

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ivacaftor (Kalydeco) Packets 25mg, 50mg, 75mg Tablets 150mg	<ol style="list-style-type: none"> 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. 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. Patient is not homozygous in the CFTR gene. Patient age ≥ 4 months. Provider attestation of baseline and subsequent evaluation and monitoring as appropriate and as indicated in the FDA-approved labeling (provider must submit documentation). Provider justification of necessity of medication change if currently stable on another CF regimen and asymptomatic. Medication ordered by Pulmonologist. Approval Duration: 12 months. 	<ol style="list-style-type: none"> Provider attestation of continued benefit without adverse drug effects. Provider attestation of continued monitoring as appropriate. Approval Duration: 12 months.
Ivermectin (Sklice) lotion 0.5% STEP THERAPY ; OTC product	<ol style="list-style-type: none"> 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"> Ordered for an approved indication for use: <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</i> 	<u>Limitations for use:</u> <ul style="list-style-type: none"> Ivermectin has no activity against adult <i>Onchocerca volvulus</i> parasites.

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	volvulus. 2. Cannot be used for outpatient COVID-19 treatment.	Ivermectin is not active against <i>L. loa</i> (adult worms).
Ivosidenib (Tibsovo) tablets 250mg	1. 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. 2. Medication ordered by an Oncologist	
Lanadelumab-flyo (Takhzyro) injection 300mg/2ml	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
Larotrectinib (Vitrakvi) capsules 25mg, 100mg	<ul 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	1. 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. 2. Patient has signed informed consent on file. 3. Patient meets criteria for mild cognitive impairment (MCI) or	Renewal Criteria: <ol 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

Generic Medication (Brand Name) Bolded medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Additional Considerations and Renewal Criteria
	<p>mild AD dementia.</p> <ol style="list-style-type: none"> 4. Patient has had an MRI scan within last 12 months. 5. Amyloid PET imaging and/or CSF analysis consistent with AD. 6. Functional Assessment Staging Test Stage score of 2 to 4. 7. 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. 8. 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 siderosis, • 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. 9. Ordered by a Board-certified neurologist, geriatric psychiatrist, or geriatrician who specializes in treating dementia. 	<p>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</p> <ol style="list-style-type: none"> 4. Patient has not progressed to moderate or severe AD; AND <ul style="list-style-type: none"> • Patient has received a pre-5th, 7th, AND 14th infusion MRI for monitoring of Amyloid Related Imaging Abnormalities-edema (ARIA-E) and Amyloid Related Imaging Abnormalities hemosiderin (ARIA-H) microhemorrhages.
Lenacapavir (Sunlenca)	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use; treatment of multi-drug resistant human immunodeficiency virus (HIV) in adult patients. 2. Confirmed diagnosis of HIV-1 infection. 3. Provider attestation that patient has multi-drug resistant HIV-1 infection. 4. Provider confirms that patient has been prescribed an optimized background antiretroviral regimen, containing at 	<ol style="list-style-type: none"> 1. Patient has previously received treatment with Sunlenca. 2. Provider confirms that patient has achieved a clinically significant viral response to therapy. 3. Provider confirms that patient will continue to take an optimized background

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	<p>least one antiretroviral agent that demonstrates full viral sensitivity or susceptibility.</p> <p>5. Dosing is in accordance with FDA-approved prescribing information.</p> <p>6. Maximum Approval Duration: 12 months.</p>	<p>antiretroviral regimen in combination with Sunlenca.</p> <p>4. Maintenance dosing is in accordance with FDA-approved prescribing guidance.</p> <p>5. Authorization Duration: 12 months.</p>
Leniolisib (Joenja)	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
<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>Lupron Depot-PED:</u> <ul style="list-style-type: none"> ○ Treatment of pediatric patients with central precocious puberty (CPP). <p>2. May be approved for patients that are receiving care for gender incongruence if proper MDH-required documentation has been acquired and patient meets criteria for treatment.</p>	<p><u>Limitations of use:</u></p> <p>1. 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.</p> <ul style="list-style-type: none"> • 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.

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	<ol style="list-style-type: none"> Due to concerns about adverse impact on bone mineral density, total duration of therapy with Lupron Depot plus add-back therapy <u>should not exceed 12 months</u>. When indicated to endometriosis, Lupron-Depo for patients \geq 18 years of age, approval duration is for 3.75 mg monthly. Approval Duration: <u>6 months total</u>. 	
Lifitegrast ophthalmic (Xiidra) Drop 5%	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> the treatment of the signs and symptoms of dry eye disease (DED). Must have tried and failed artificial tears AND cyclosporine (ophth) emulsion 0.05% (generic of Restasis). Approval Duration: 12 months. 	
lisocabtagene maraleucel (Breyanzi) injection **Not on MDH list	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
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. Patient age \geq 18 years. Documentation of baseline LFTs (including ALT, AST, alkaline phosphatase and total bilirubin) prior to initiation of treatment. Prescriber attestation that a low-fat diet (<20% of energy from fat) has been initiated. Prior trial, failure, insufficient response, and/or documented intolerance to preferred lipid lowering treatments including statin + ezetimibe, or Praluent. 	<ol style="list-style-type: none"> Meets all initial approval criteria. Attestation of continued benefit without significant adverse drug effects. Laboratory data (full lipid panel) submitted to support continued use. Renewal Duration: 12 months

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	6. Medication ordered by a REMS registered cardiologist or endocrinologist. 7. Approval Duration: 12 months.	
Loncastuximab tesirine-lpyl (Zynlonta) solution **Not on MDH list	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
lorlatinib (Lorbrena) tablets 25mg, 100mg	1. 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. 2. Medication ordered by Oncologist	Contraindicated with concomitant use of strong CYP3A inducers.
Lotilaner 0.25% solution (Xdemvy)	1. Ordered for an approved indication for use: <ul style="list-style-type: none"> Treatment of Demodex blepharitis in adults 2. Patient aged ≥ 18 years of age. 3. Diagnosis of Demodex blepharitis based on presence of clinical signs such as collarettes, lid erythema, madarosis and/or misdirected lashes. 4. Documentation indicating that the patient has symptoms attributable to Demodex blepharitis in at least one eye (e.g., itching, foreign body sensation, burning, etc.); and 5. Patient has not undergone more than 1 6-week treatment in the previous 12 months. 6. Written by or in consultation with an ophthalmologist or optometrist. 7. Approval limited to 1 bottle (10 ml) per 12 months.	At this time, there is no clinical evidence to show benefit beyond 6 weeks of treatment.
Lumacaftor/ivacaftor (Orkambi) Granules	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. 	1. Provider attestation of continued benefit without adverse drug effects. 2. Provider attestation of continued monitoring as appropriate.

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75mg-94mg, 100mg-125mg, 150mg-188mg Tablets 100mg-125mg, 200mg-125mg	<ol style="list-style-type: none"> 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. Patient age \geq 2 years. Provider justification of necessity of medication change if currently stable on another CF regimen and asymptomatic. Patient has not undergone an organ transplant. Medication ordered by Pulmonologist. Approval Duration: 12 months 	<ol style="list-style-type: none"> Renewal Duration: 12 months.
lumasiran (Oxlumo) injection 94.5mg/0.5ml	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
lusutrombopag (Mulpleta) tablets 3mg	<ol style="list-style-type: none"> 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. Patient age \geq 18 years. Not being ordered for patient with chronic liver disease in an attempt to normalize platelet counts. Dose: 3 mg (1 tablet) daily for 7 days. Approval Duration: one treatment course. 	Each treatment course requires a separate PA request. Initial criteria applies to all requests.
Maralixibat (Livmarli)	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
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. Medication is not prescribed in conjunction with ganciclovir or valganciclovir. 	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

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	3. Medication is prescribed by or in consultation with a hematologist, infectious disease specialist, oncologist or physician affiliated with a transplant center. 4. Approval Duration: not to exceed 8 weeks.	documentation of previous use of one of these medications should be submitted.
Mepolizumab (Nucala) Injection 40mg/0.4ml, 100mg, 100mg/ml	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. Add-on treatment of adult patients with chronic rhinosinusitis with nasal polyps. Treatment of eosinophilic granulomatosis with polyangiitis (EGPA) in adults. 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. 2. Medication ordered by an Allergist or Pulmonologist.	
Methadone (for Pain) Concentrate 10mg/ml Solution 5mg/5ml, 10mg/5ml, Tablets 5mg, 10mg	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. 	All long-acting opioids require Prior Authorization (PA). The PA form can be accessed using the following link: OPIOID PRIOR AUTH FORM-MD Limitations of Use: <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- acting opioids, reserve Methadone for use in patients for whom

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		alternative treatment options are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.
Metreleptin (Myalept) injection	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
Mifepristone (Korlym) tablets Korlym-300mg ONLY **Not on MDH list	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
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) Approval Duration: 12 months. 	Limitations for use: 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.
Mirvetuximab (Elahere) **Not on MDH list	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
Mitapivat (Pyrukynd) tablets 5mg, 20mg, 50mg	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> The treatment of hemolytic anemia in adults with pyruvate kinase (PK) deficiency 	<ol style="list-style-type: none"> Documentation of positive clinical response to Pyrukynd therapy based on ONE of the following:

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	<ol style="list-style-type: none"> 2. Confirmatory genetic testing of PKLR gene showing ≥ 2 variant alleles with at least one- missense mutation in the liver and red blood cell (PKLR) gene. 3. Patient is not homozygous for the c.1436G>A (p.R479H) variant. 4. Patient does not have two non-missense variants (without the presence of another missense variant) in the PKLR gene. 5. Baseline hemoglobin less than or equal to 10 g/dL. 6. Prescribed by or in consultation with a Hematologist. 7. Initial Approval Duration limited to 6 months. 	<ul style="list-style-type: none"> • Patient has been on Pyrukynd for > 52 weeks and has maintained positive clinical response to therapy; OR • Reduction in transfusions of $\geq 33\%$ in the number of red blood cell units transfused during the initial 24-week period compared with the patient's historical transfusion burden; OR • A ≥ 1.5 g/dL increase in hemoglobin from baseline sustained at 2 or more scheduled assessments 4 weeks apart during the initial 24-week period without any transfusions. <ol style="list-style-type: none"> 2. Authorization duration: 12 months <ul style="list-style-type: none"> • If documentation does not provide evidence of positive clinical response to Pyrukynd therapy, allow for dose titration with discontinuation of therapy. In this case, authorization duration is for 4 weeks.
Mobocertinib (Exkivity) capsules **Not on MDH list	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
Mogamulizumab-kpkc (Poteligeo) injection **Not on MDH list	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.

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Morphine sulfate extended-release (MS Contin) tablets 15mg, 30mg, 60mg 100mg, 200mg	1. 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. 	All long-acting opioids require Prior Authorization (PA). The PA form can be accessed using the following link: OPIOID PRIOR AUTH FORM-MD
Mosunetuzumab-axgb (Lunsumio)	1. Ordered for an approved indication for use: <ul style="list-style-type: none"> Treatment of adult patients with relapsed or refractory follicular lymphoma after two or more lines of systemic therapy. 2. Documentation of at least two lines of systemic therapy including an anti-CD20 monoclonal antibody (e.g. rituximab) and an alkylating agent (e.g. bendamustine). 3. Patient age ≥ 18 years. 4. Patient does not have central nervous system (CNS) lymphoma; AND 5. Used for histologically confirmed grades 1-3a disease; AND 6. Patient has an Eastern Cooperative Oncology Group (ECOG) performance status of 0-1. 7. Confirmation that drug continues to carry FDA-approval for indication. 8. Coverage for eight, 21-day cycles.	1. Patient continues to meet the requirements for initial approval. 2. Patient has absence of unacceptable toxicity from the drug. 3. Patient achieved a partial response or has stable disease as evidenced by metabolic and radiologic response criteria. 4. Confirmation that drug continues to carry FDA-approval for indication. 5. Patient has not exceeded a maximum total of 17 cycles. 6. Approval for up to eight, 21-day cycles.
Nanoparticle albumin bound sirolimus (Fyarro) **Not on MDH list	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
Naxitamab (Danyelza)	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
Nintedanib (Ofev) capsule 100mg, 150mg	1. 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. 	1. All initial criteria are met. 2. Documentation of positive clinical response to Ofev therapy. 3. Approval Duration: 12 months

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	<ul style="list-style-type: none"> To slow the rate of decline in pulmonary function in patients with systemic sclerosis associated interstitial lung disease (SSc-ILD). <ol style="list-style-type: none"> Documentation that patient does not smoke. Medication ordered by a pulmonologist. Authorization Duration: 12 months. 	
Niraparib (Zejula) tablets 100mg, 200 mg, 300 mg	<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 cancer who are in a complete or partial response to first-line platinum-based chemotherapy. 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. <ol style="list-style-type: none"> Medication ordered by an Oncologist. 	Select patients for therapy based on an FDA-approved companion diagnostic for ZEJULA.
Nitisinone (Orfadin) capsules Orfadin brand preferred for 20 mg dose. **Not on MDH list	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval. ORFADIN PRIOR AUTH FORM
norethindrone ace-ethinyl estradiol-fe cap 1 mg-20 mcg (Minastrin 24 FE) Finzala Chew FE 1/20 Meldotta Chew 24 FE Milbelas 24 chew FE norethindrone ace-ethinyl estradiol-fe cap 1 mg-20 mcg	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]	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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(Taytulla) norethindrone ace-ethinyl estradiol-fe cap 1 mg-20 mcg (24)		
Nusinersen (Spinraza)	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
Ocrelizumab (Ocrevus) injection 300mg/10ml	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> Primary progressive multiple sclerosis (MS); Relapsing forms of MS, to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease. Age is ≥18 years and <55 years of age. Patient has one of the following: <ul style="list-style-type: none"> Ineffective treatment response due to continued clinical relapse, intolerance, or contraindication to two or more MS drugs; Patient is not a candidate for any other preferred first-line treatments due to MS severity; Patient is at higher risk of poor long-term outcome (spinal cord involvement, highly active disease, poor relapse recovery), as determined by their neurologist. Not being used in combination with other immune-modulating or immunosuppressive therapies, including immunosuppressant doses of corticosteroids. Not being used in combination with another MS disease modifying agent [Avonex, Betaseron, dalfampridine, dimethyl fumarate, Extavia, fingolimod, glatiramer, glatopa, Kesimpta, Mayzent, Rebif, teriflunomide, Vumerity]. Medication ordered by a neurologist. 	<ol style="list-style-type: none"> All initial criteria continue to be met. Documentation of positive clinical response to Ocrevus therapy. Approval duration: 12 months.

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	7. Approval duration: 12 months.	
Odevixibat (Bylvay)	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
Olipudase alfa- (Xenpozyme)	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
omega-3-acid ethyl esters (Lovaza) capsules 1 Gram	1. Ordered for an approved indication for use: <ul style="list-style-type: none"> as an adjunct to diet to reduce triglyceride levels in adult patients with severe (≥ 500 mg/dL) hypertriglyceridemia 2. Member must have tried and failed OTC fish oil.	
Omnipod insulin pump management system	1. Ordered for an approved indication for use: <ul style="list-style-type: none"> Diabetes mellitus in persons requiring insulin. 2. Medication ordered by an Endocrinologist or practitioner who specializes in diabetes. 3. Office visit notes from last two encounters with prescribing provider to support Medical Necessity. 4. Evidence of face-to-face visit within past 3 months. 5. Documentation of uncontrolled diabetes on multiple daily injections. 6. Documentation that patient has been educated on device. 7. Documentation of self blood-glucose monitoring (30-day blood glucose log or CGM report). 8. May not be used if patient needs to make insulin adjustments of less than 2-unit increments due to risk of hypoglycemia. 9. Approval Duration: 12 months.	1. Office visit notes from last two encounters with prescribing provider support of Medical Necessity. 2. Prescribed by Endocrinologist or practitioner who specializes in diabetes with evidence of face-to-face visit within the past 3 months. 3. Documentation of self-blood glucose monitoring (30-day blood glucose log or CGM report). 4. Approval duration: 12 months.
onabotulinumtoxinA (Botox) injection 100 Unit, 200 Unit	1. Ordered for an approved indication for use: <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 	Limitations for Use: <ul style="list-style-type: none"> Botox will NOT be approved for cosmetic purposes Safety and effectiveness have <u>not</u> been established for:

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	<p>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.</p> <ul style="list-style-type: none"> • 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>	<ul style="list-style-type: none"> • 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	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
Oral Contraceptives	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

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		indicated for the prevention of pregnancy.
Opioids IR: ER:	FOR IMPORTANT INFORMATION ABOUT PRESCRIBING OPIOIDS FOR MEDSTAR FAMILY CHOICE MEMBERS, PLEASE CLICK THE LINK	The Opioid PA form can be accessed using the following link: OPIOID PRIOR AUTH FORM-MD
oxycodone ER and IR tablets	1. 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. 	OPIOID PRIOR AUTH FORM-MD
oxycodone/APAP 5-325mg/5ml Solution (Roxicodone)	1. 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. 	OPIOID PRIOR AUTH FORM-MD
oxymorphone extended release 12-hour (Opana) tablets 5mg, 7.5mg, 10mg, 15mg, 20mg, 30mg, 40mg, SEE SPECIAL NOTE REGARDING PA REQUIREMENTS & FORM *****	1. 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. 	All long-acting opioids require Prior Authorization (PA). The PA form can be accessed using the following link: OPIOID PRIOR AUTH FORM-MD
Ozanimod (Zeposia) capsules 7-day starting pack 0.92 mg capsules, Capsule starting kit	1. Ordered for an approved indication for use: <ul style="list-style-type: none"> Treatment of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults. Treatment of moderately to severely active ulcerative colitis (UC) in adults. 2. Patient has not received a manufacturer supplied sample or any form of assistance from the manufacturer coupon or	<u>Renewal Criteria:</u> <ul style="list-style-type: none"> Initial approval criteria continue to be met. Patient is not receiving in combination a biologic DMARD or janus kinase inhibitor <u>Multiple Sclerosis:</u>

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	<p>sample card as a means to establish as a current user of Zeposia.</p> <ol style="list-style-type: none"> Baseline evaluation of the following labs before starting treatment: CBC, ECG, LFT's No history (within previous 6 months) of myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure. No severe untreated sleep apnea Zeposia will not be used in combination with either a biologic DMARD (e.g. adalimumab, Simponi (golimumab), Stelara (ustekinumab) OR a Janus kinase inhibitor (e.g. Xeljanz (tofacitinib), Rinvoq (upadacitinib) (Note: Ampyra and Nuedexta are not disease modifying). <u>7. Additional Criteria for Multiple Sclerosis</u> <ul style="list-style-type: none"> Prescribed by or within consultation with a neurologist. <u>8. Additional Criteria for Ulcerative Colitis</u> <ul style="list-style-type: none"> Diagnosis of moderately to severely active UC Patient has failed, contraindicated or intolerance to a course of oral corticosteroids and/or immunosuppressants (e.g. azathioprine, or 6-mercaptopurine) OR Patient has been previously treated with a biologic or targeted synthetic DMARD FDA-approved for the treatment of UC as documented by claims history or submission of medical records. (e.g., adalimumab, Simponi (golimumab), Stelara (ustekinumab), Xeljanz (tofacitinib), Rinvoq (upadacitinib)). Prescribed by or in consultation with a gastroenterologist. Approval duration: 12 months 	<ul style="list-style-type: none"> Patient experiencing disease stability or improvement while receiving Zeposia. Maximum approval Duration: 12 months <p><u>Ulcerative Colitis:</u></p> <ul style="list-style-type: none"> Patient has achieved or maintained remission. Patient shows positive clinical response as evidenced by low disease activity or improvement in signs/symptoms of the condition when there is improvement in any ONE of the following from baseline: <ul style="list-style-type: none"> Stool frequency Rectal bleeding Urgency of defecation C-reactive protein (CRP) Fecal calprotectin (FC) Endoscopic appearance of the mucosa Improvement on a disease activity scoring tool (e.g. Ulcerative Colitis Endoscopic Index of Severity (UCEIS, Mayo score) Approval Duration: 12 months

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Palbociclib (Ibrance) capsules 75mg, 100mg, 125mg	<ol style="list-style-type: none"> Ordered for an approved indication for use: <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: <ol style="list-style-type: none"> An aromatase inhibitor as initial endocrine based therapy. Fulvestrant in patients with disease progression following endocrine therapy. Medication ordered by an Oncologist 	
Palivizumab (Synagis)	<ol style="list-style-type: none"> Indicated for prevention of serious lower respiratory tract disease caused by RSV in pediatric Patients: <ul style="list-style-type: none"> with a history of premature birth (≤ 35 weeks gestational age) and who are 6 months of age or younger at the beginning of RSV season. with bronchopulmonary dysplasia (BPD) that required medical treatment within the previous 6 months and who are 24 months of age or younger at the beginning of RSV season. with hemodynamically significant congenital heart disease (CHD) and who are 24 months of age or younger at the beginning of RSV season. MedStar Family Choice uses the newest recommendations of the American Academy of Pediatrics (AAP). Recommendations were last updated in the journal Pediatrics (7/28/2014 issue): Updated Guidance for Palivizumab Prophylaxis Among Infants and Young Children at Increased Risk of Hospitalization for Respiratory Syncytial Virus Infection. Note: when available, Beyfortus (Nirsevimab) is preferred. 	Please submit: A COMPLETED PRIOR AUTHORIZATION FORM (see link below) SYNAGIS PRIOR AUTHORIZATION AND PRESCRIPTION FORM To view the most up to date AAP Synagis Guidelines, follow the link below: <ul style="list-style-type: none"> AAP SYNAGIS GUIDELINES

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Patisiran (Onpattro) Solution 10mg/5ml **Not on MDH list	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
Pegcetacoplan (Empaveli) injection 1080mg **Not on MDH list	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
pegloticase (Krystexxa) injection 8mg/ml	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
Pegunigalsidase alfa (Elfabrio) **Not on MDH list	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
Pirtobrutinib (Jaypirca) 50 mg	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. 1. Medication ordered by an oncologist.	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.
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). Treatment of oropharyngeal candidiasis (OPC), including OPC refractory (rOPC) to itraconazole and/or fluconazole in adults or pediatric patients ≥ 13 years of age. 1. Medication ordered by Infectious Disease specialist.	<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 PowderMix oral suspension due to differences in dosing of each formulation. Coadministration is Contraindicated with sirolimus,

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		ergot alkaloids, HMG-CoA reductase inhibitors. <ul style="list-style-type: none"> Significant risk for drug-drug interactions.
pralsetinib (Gavreto) capsule 100mg	<ol style="list-style-type: none"> 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). Medication ordered by an Oncologist 	
Pretomanid tablets 200mg	<ol style="list-style-type: none"> 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). Medication ordered by a Pulmonologist. 	<u>Limitations of Use:</u> <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. Safety and effectiveness has not been established for its use in combination with drugs other than bedaq

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		<ul style="list-style-type: none"> • uilinel and linezolid. • Risk for significant drug-drug interactions.
Ravulizumab-cwvz (Ultomiris) injection **Not on MDH list	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
ripretinib (Qinlock) tablet 50mg	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	
Rucaparib (Rubraca) tablets 200mg, 250mg, 300mg	1. Ordered for an approved indication for use: <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 	

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	therapy based on an FDA-approved companion diagnostic for RUBRACA. 2. Medication ordered by an Oncologist	
Ruxolitinib (Jakafi) tablets 5mg, 10mg, 15mg, 20mg, 25mg	1. Ordered for an approved indication for use: <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. 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. 2. Medication ordered by Hematologist or Oncologist.	Limitations of Use: <ul style="list-style-type: none"> Avoid concomitant use with fluconazole doses greater than 200 mg. Reduce Jakafi dosage with fluconazole doses ≤ 200 mg. Strong CYP3A4 Inhibitors: Reduce, interrupt, or discontinue Jakafi doses as recommended except in patients with acute or chronic graft-versus-host-disease.
Ruxolitinib (Opzelura) For systemic Ruxolitinib (Jakafi) see above	1. Ordered for an approved indication for use: <ul style="list-style-type: none"> The topical short-term and non-continuous chronic treatment of mild to moderate atopic dermatitis in Non-immunocompromised patients ≥ 12 years of age whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable. The topical treatment of nonsegmental vitiligo in patients ≥ 12 years of age. 2. Patient is ≥ 12 years of age. 3. Atopic Dermatitis: <ul style="list-style-type: none"> Patient has inadequate treatment response, intolerance, or contraindication to at least two classes of formulary drugs (medium/high potency corticosteroid and a topical calcineurin inhibitor (e.g., 	1. Documented positive clinical response to therapy. 2. Patient is not receiving Opzelura in combination with another biologic medication (e.g. Dupixent (dupilumab), Xolair (omalizumab), Rituxan (rituximab), Enbrel (etanercept), Avsola/Inflectra (infliximab)) OR JAK inhibitor (e.g. Jakafi (ruxolitinib, Xeljanz (tolacitinib), Rinvoq (upadacitinib)). 3. Patient is not receiving Opzelura in combination with a potent immunosuppressant medication

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	<p>tacrolimus or pimecrolimus) Adequate trial is considered 2 months AND</p> <ul style="list-style-type: none"> • Treatment failure, intolerance, or contraindication to Eucrisa. • The drug will not be applied to affected areas greater than 20% of body surface area (BSA). <p><u>Nonsegmental Vitiligo:</u></p> <ul style="list-style-type: none"> • The drug will not be applied to affected areas greater than 10% of body surface area (BSA). • Patient has inadequate treatment response, intolerance, or contraindication to at least two classes of formulary drugs (medium/high potency corticosteroid and a topical calcineurin inhibitor (e.g., tacrolimus or pimecrolimus). An adequate trial is considered 6 months. <p>4. Patient is not receiving Opzelura in combination with another biologic medication (e.g. Dupixent (dupilumab), Xolair (omalizumab), Rituxan (rituximab), Enbrel (etanercept), Avsola/Inflectra (infliximab)) OR JAK inhibitor (e.g. Jakafi (ruxolitinib), Xeljanz (tolacitinib), Rinvoq (upadacitinib)).</p> <p>5. Patient is not receiving Opzelura in combination with a potent immunosuppressant medication (e.g., azathioprine, cyclosporine).</p> <p>6. Prescribed by a Dermatologist</p> <p>7. Patient has not received a sample or coupon trial supply to establish themselves as a current user for authorization under continuity-of-care.</p> <p>8. <u>Initial authorization duration:</u></p> <ul style="list-style-type: none"> • Atopic dermatitis: 2 months • Nonsegmental vitiligo: 6 months 	<p>(e.g., azathioprine, cyclosporine).</p> <p>4. Approval Duration: 12 months</p>

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Safinamide (Xadago) tablets 50mg, 100mg	<p>9. Quantity limits: 60 gm per week or 180 gm per 28-days</p> <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, cyclobenzaprine, methylphenidate, amphetamine or their derivatives, St John’s wort, dextromethorphan. Severe hepatic impairment (Child-Pugh C) <p>Hypersensitivity to safinamide.</p>
Sastralizumab-mwge (Enspryng) injection **Not on MDH list	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
Selinexor (Xpovio) Pak 40mg, 50mg, 60mg, 80mg 100mg	<p>1. Ordered for an approved indication for use:</p> <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. 	Continued approval for treatment of DLBCL may be contingent upon verification and description of clinical benefit in confirmatory trials.

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	<ul style="list-style-type: none"> 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 inhibitors, at least two immunomodulatory agents, and an anti-CD38 monoclonal antibody. 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. 2. Medication ordered by an Oncologist	
Selpercatinib (Retevmo) capsules 40mg, 80mg	1. Ordered for an approved indication for use: <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. 2. Medication ordered by an Oncologist	
Semaglutide (Ozempic, Rybelsus)	1. Ordered for an approved indication for use: <ul style="list-style-type: none"> As adjunct to diet and exercise to improve glycemic control 	Cannot be approved for indication of weight management.

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Ozempic 2mg/1.5ml, 2mg/3ml, 4mg/3ml, 8mg/3ml Rybelus 3mg, 7mg, 14mg	<p>in adults with type 2 diabetes mellitus.</p> <ul style="list-style-type: none"> To reduce the risk of major adverse cardiovascular events in adults with type 2 diabetes mellitus and established cardiovascular disease. NOTE: Semaglutide is only approved in adolescents for weight loss and is not a covered benefit for patients aged < 18 years. <ol style="list-style-type: none"> Patient age ≥ 18 years. Not indicated for Type 1 Diabetes. Within past 3 months: A1c OR CGM report with TIR%. May not be concurrently using any other GLP1 or GLP1/GIP combination drug (e.g., Mounjaro, Trulicity, Victoza, Xultrophy or Soliqua). May not be concurrently taking a DPP4i (e.g., alogliptin, Januvia (sitagliptin), Tradjenta (Linagliptin), Onglyza (saxagliptin). Rybelsus 3 mg is limited to 60-days supply, then may be approved only for 7 mg or 14 mg doses. Limited to 30-day supply per dispense. Maximum approval duration: 12 months. 	<p>Titration doses will be approved for a maximum of 60-days supply per year.</p> <ol style="list-style-type: none"> A1c or CGM report with TIR% within previous 3 months. All initial approval criteria met. Approval Duration: 12 months.
Seracycline (Seysara) tablet 60mg, 100mg, 150mg	<ol style="list-style-type: none"> 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. Failure of at least one other oral tetracycline antibiotic. Medication ordered by a Dermatologist. Approval duration: 3 months only. 	<p>Not eligible for renewal because efficacy beyond 12 weeks has not been proven effective.</p>
sildenafil (Revatio) 20 mg tablets 10 mg/ml solution	<ol style="list-style-type: none"> 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 	<p><u>Limitations of Use:</u></p>

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	<p>clinical worsening.</p> <p>2. Medication ordered by a cardiologist or pulmonologist.</p>	<ul style="list-style-type: none"> Medication will not be covered for use to treat erectile dysfunction (ED). <p>Viagra and generic product strengths (25 mg, 50 mg, 100 mg) are not covered.</p>
Sodium oxybate (Xyrem) solution 500mg/ml	<ol style="list-style-type: none"> 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. Patient must have no history of succinic semialdehyde dehydrogenase deficiency. Patient must have no history of a substance use disorder. No concurrent use or therapy with a sedative hypnotic, CNS depressant or alcohol. When prescribed for cataplexy, must have failed tricyclics or SSRIs. When prescribed for excessive daytime sleepiness, must have failed at least one formulary stimulant treatment (ex: methylphenidate or dextroamphetamine) Medication ordered by a Neurologist. Initial approval for maximum of 1-month supply. 	<ol style="list-style-type: none"> Approval Duration: 12 months.
Sodium phenylbutyrate (Olpruva) Suspension	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
Sofosbuvir and Velpatasvir (Epclusa)	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> Treatment of patient with chronic HCV genotype (GT) 1, 2, 3, 4, 5, or 6 infections without cirrhosis and with compensated cirrhosis (Child-Pugh A) and with decompensated cirrhosis for use in combination with ribavirin (Child-Pugh B or C). Treatment of adult and pediatric patients aged 6 years or 	Hepatitis C Medication Prior Authorization Form

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	<p>older, weighing at least 17 kg, with HCV GT 1, 2, 3, 4, 5, or 6 infections, who previously were treated with a regimen containing an HCV NS5A inhibitor or an NS5B protease inhibitor, but not both.</p> <ol style="list-style-type: none"> 2. A fully completed Hepatitis C Prior-Authorization Form with supporting clinical documents. 3. Patient treatment plan aligns with MDH Clinical Criteria recommendations. 4. Authorization is for a maximum of 24 weeks. 	
somatrogen (Ngenla) solution pen-injector 24mg/1.2ml; 60mg/1.2ml	<ol style="list-style-type: none"> 1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • Treatment of growth failure in children due to inadequate secretion of endogenous growth hormone (GH) 2. Age 3 < 18 years 3. Medication ordered by or in consultation with an Endocrinologist 4. <u>Initial approval</u>: <ul style="list-style-type: none"> • Confirmation of open epiphysial growth plates • Patient meets at least one of the following: <ul style="list-style-type: none"> ○ Height is at least TWO standard deviations (SD) below the mean height for normal children of same age and gender; ○ Height velocity less than 25th percentile for age. 5. Approval duration: 12 months 	<ol style="list-style-type: none"> 1. Confirmation of open epiphysial growth plates as above, OR the patient has not completed prepubertal growth 2. Patient meets at least one of the following: <ul style="list-style-type: none"> • Has an annual growth velocity of at least 2 cm during most recent approval year; • Is near the terminal phase of puberty and has an annual growth velocity of at least 1 cm during the most recent approval year. 3. Approval duration: 12 months <p><u>Limitations of Use:</u></p> <ul style="list-style-type: none"> • Ngenla will not be approved for idiopathic short stature (ISS), athletic enhancement, central precocious puberty, congenital adrenal hyperplasia, constitutional delay of growth and puberty, or

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		angi-aging purposes.
Somatropin [recombinant human growth hormone] (Norditropin FlexPro; Nutropin AQ; Serostim) injection Norditropin 5/1.5ml, 10/1.5ml, 15/1.5ml, 30mg/3ml Serostim 4mg, 5mg, 6mg	1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • Growth failure in pediatric patients: <ul style="list-style-type: none"> ○ Due to inadequate endogenous growth hormone secretion; short stature associated with Turner Syndrome [Norditropin FlexPro; Nutropin AQ] ○ Idiopathic Short Stature (ISS); short stature born small for gestational age (SGA) with no catch-up growth by age 2 to 4 years; Prader-Willi syndrome; short stature associated with Noonan syndrome[Norditropin ONLY] ○ Growth failure associated with chronic kidney disease until time of renal transplant [Nutropin ONLY]. • Growth hormone deficiency in adults: replacement of endogenous growth hormone in adults with growth hormone deficiency [Norditropin FlexPro, Nutropin AQ] • Treatment of HIV patients with wasting or cachexia to increase lean body mass and body weight and improve physical endurance [Serostim ONLY] <ol style="list-style-type: none"> 1. Medication ordered by an Endocrinologist or Infectious disease specialist (Serostim ONLY). 2. For pediatric patients with growth failure: Confirmation of open epiphysial growth plates. 3. Approval duration: 12 months. 	<u>Growth failure in pediatric patients:</u> <ol style="list-style-type: none"> 1. Confirmation of open epiphysial growth plates as above, OR the patient has not completed prepubertal growth 2. Patient meets at least one of the following: <ul style="list-style-type: none"> ○ Has an annual growth velocity of at least 2 cm during most recent approval year; ○ Is near the terminal phase of puberty and has an annual growth velocity of at least 1 cm during the most recent approval year. 3. Approval duration: 12 months. <u>Adult indications for use:</u> <ol style="list-style-type: none"> 1. Clinical documentation indicating positive clinical response during previous 12 months. 2. Approval duration: 12 months
Sotorasib (Lumakras) tablet 120mg	1. Ordered for an approved indication for use: <ul style="list-style-type: none"> • treatment of adult patients with KRAS G12C-mutated 	This indication is approved under accelerated approval based on overall

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	<p>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.</p> <p>2. Medication ordered by Oncologist</p>	<p>response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trials.</p>
<p>tacrolimus extended-release (Envarsus XR) tablets 0.75mg, 1mg, 4mg</p>	<p>1. Ordered for an approved indication for use:</p> <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. <p>2. Evidence that the patient had at least three-month trial and failure or intolerance to immediate-release tacrolimus.</p> <p>3. 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.</p> <p>4. Prescribed by a Nephrologist and Transplant Specialist.</p>	<p><u>Limitations of use:</u></p> <p>Not interchangeable or substitutable with other tacrolimus products.</p>
<p>tadalafil (Adcirca; Alyq) tablets 20mg PAH:20 mg</p>	<p>1. Ordered for an approved indication for use:</p> <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. <p>2. Confirmation the patient is not currently taking any forms of nitrate-containing medication (e.g. NitroDur, NitroStat).</p> <p>3. BPH-specific requirements:</p> <ul style="list-style-type: none"> Ordered for generic Cialis (tadalafil) 5 mg tablets Ordered by a urologist. <p>4. PAH-specific requirements:</p> <ul style="list-style-type: none"> Ordered for generic Adcirca (tadalafil PAH) 20 mg tablets. <p>5. Medication ordered by a Pulmonologist, Cardiologist, or Rheumatologist.</p> <p>6. Approval Duration: 12 months.</p>	<ul style="list-style-type: none"> BPH: <ul 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: <ul style="list-style-type: none"> Tadalafil is contraindicated in patients taking guanylate

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		cycase stimulators (e.g. riociguat) due to potentially severe hypotension. <ul style="list-style-type: none"> Erectile dysfunction is not a covered indication for use.
Talazoparib (Talzenna) capsules 0.5mg, 0.25mg, 0.75mg, 1mg	1. 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. 2. Medication ordered by an Oncologist	
Tazemetostat (Tazverik) tablets 200mg	1. 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. 1. Medication ordered by an Oncologist	
Tebentafusp (Kimmtrak)	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
Teclistamab (Tecvayli) **Not on MDH list	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
Teduglutide (Gattex)	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.

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Tenofovir (Vemlidy) tablets 25mg	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> Treatment of chronic hepatitis B virus infection in adults and pediatric patients ≥ 12 years of age with compensated liver disease. Baseline test results prior to treatment start. <ul style="list-style-type: none"> Confirmed negative HIV test result prior to starting medication. Hepatitis Be antigen (HBeAg) status. Liver function tests. Not recommended for Child-Pugh class B or C hepatic impairment. Patient has a history of adverse event, intolerance to or contraindication to treatment with entecavir OR meets one of the following criteria: <ul style="list-style-type: none"> Patient age < 20 years. Documentation of osteopenia or osteoporosis as defined by a T-score ≤ 1 and supported by clinical documentation of DEXA scan results. Submission of medical records documenting a prior low-trauma or non-traumatic fracture. Medication ordered or in consultation with an Infectious Disease specialist, Gastroenterologist, or Hepatologist. Initial authorization period: 12 months. 	<ol style="list-style-type: none"> Documentation of a positive clinical response to Vemlidy therapy. Patient is not a suitable candidate for entecavir. Approval duration: 12 months.
Teplizumab (Tzield)	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist prior to approval.
Teprotumumab-trbw (Tepezza) injection **Not on MDH list	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist prior to approval.
Teriparatide (Forteo) 630 mcg/2.4 ml Pen-injector	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> Treatment of postmenopausal women with osteoporosis at high risk for fracture. 	<u>Osteoporosis</u> <ol style="list-style-type: none"> Patient previously met initial approval criteria.

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	<ul style="list-style-type: none"> To increase bone mass in men with primary or hypogonadal osteoporosis at high risk of fracture. Treatment of men and women with osteoporosis associated with sustained systemic glucocorticoid therapy (daily dose equivalent to ≥ 5 mg of prednisone) at high risk for fracture. <ol style="list-style-type: none"> Age ≥ 18 years or documentation of closed epiphyses on X-ray. Patient is at very high fracture risk as evidenced by one of the following: <ul style="list-style-type: none"> Recent osteoporotic fracture within the past 12 months. Bone mineral density (BMD) T-score at hip or spine ≤ -3.0 BMD T-score at hip or spine ≤ -2.5 AND major osteoporotic fracture (i.e., hip, spine, forearm, wrist, humerus). Patient has completed a 3-year trial of bisphosphonate therapy at up to maximally indicated doses, UNLESS one of the following: <ul style="list-style-type: none"> All bisphosphonates are contraindicated. Clinically adverse effects are experienced to both IV and PO formulations. Patient has experienced a loss of- or a lack of increase in- BMD while receiving bisphosphonate therapy. Patient experienced an osteoporotic fracture or fragility fracture while receiving bisphosphonate therapy. If request is for continuation of cumulative PTH analog therapy beyond 2 years, provider attestation that member remains at or has returned to having a high risk for fracture (e.g., history of osteoporotic fracture or multiple risk factors for fracture) and that the risk versus benefit of continued therapy has been reviewed with the member. Dose does not exceed 20 mcg per day (1 pen every 28 days) Approval Duration: 6 months. 	<ol style="list-style-type: none"> Documentation supports positive response to therapy. If request is for continuation of cumulative PTH analog therapy beyond 2 years, provider attestation that member remains at or has returned to having a high risk for fracture (e.g., history of osteoporotic fracture or multiple risk factors for fracture) and that the risk versus benefit of continued therapy has been reviewed with the member. If request is for a dose increase, the new dose does not exceed 20 mcg per day (1 per per 28 days). Approval duration: 12 months <p><u>Glucocorticoid-induced osteoporosis:</u></p> <ol style="list-style-type: none"> Documentation supports positive response to therapy. If request is for continuation of cumulative PTH analog therapy beyond 2 years, provider attestation that member remains at or has returned to having a high risk for fracture (e.g., history of osteoporotic fracture or multiple risk factors for fracture) and that the risk versus benefit of continued therapy has been reviewed with the member. Approval duration: not to exceed 6 months.

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Tesamorelin (Egrifta SV) injection 2mg	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. 	<u>Limitations of use:</u> <ul style="list-style-type: none"> Long-term cardiovascular safety of EGRIFTA SV has not been established. 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	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 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	1. Ordered for an approved indication for use: <ul style="list-style-type: none"> Treatment of adult patients with Type 2 Diabetes mellitus. 2. Patient age ≥ 18 years. 3. A1c or TIR% report within past 3 months. 4. May not be concurrently taking a DPP4i (e.g., alogliptin, Januvia (sitagliptin), Onglyza, or Tradjenta (linagliptin)). 5. May not be concurrently using any other GLP1 or GLP1/GIP combination drug (e.g., Ozempic, Rybelsus, Trulicity, Victoza, Xultrophy or Soliqua).	Cannot be approved for indication of weight management. <ol style="list-style-type: none"> A1c or CGM report with TIR% within previous 3 months. All initial approval criteria met. Approval Duration: 12 months.

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	6. Not approved for use in Type 1 Diabetes mellitus. 7. Titration dose 2.5 mg limited to 8 pens per year. 8. Maximum Approval Duration: 12 months	
Tisotumab vedotin-tftv (Tivdak) injection **Not on MDH list	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
tivozanib (Fotivda) capsules 0.89mg, 1.34mg	1. Ordered for an approved indication for use: <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. 2. Medication order by Hematology/oncology	
topotecan (Hycamtin) capsules 0.25mg, 1mg	1. Ordered for an approved indication for use: <ul style="list-style-type: none"> Treatment of patients with relapsed small cell lung cancer (SCLC). 2. Medication ordered by an Oncologist	
tramadol hydrochloride extended release (Ultram) capsules (biphasic release) 100mg, 150mg, 200mg, 300mg Tablets 100mg, 200mg, 300mg Tablets (biphasic release) 100mg, 200mg, 300mg	1. 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. 	All long-acting opioids require Prior Authorization (PA). The PA form can be accessed using the following link: OPIOID PRIOR AUTH FORM-MD Limitations of Use: Not indicated as an as-needed (prn) analgesic.
trientine (Syprine) capsules 250mg	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. 	Limitations of Use: <ul style="list-style-type: none"> Syprine and penicillamine cannot be considered interchangeable. Syprine is not recommended in cystinuria or rheumatoid arthritis.

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Trofinetide (Daybue)	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
tucatinib (Tukysa) tablets 50mg, 150mg	<ol style="list-style-type: none"> 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 one or more prior anti-HER2-based regimens in the metastatic setting. Medication ordered by an Oncologist. 	
ubrogepant (Ubrelvy) tablets 50mg, 100mg	<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. Patient age ≥ 18 years. Member must have tried and failed NSAIDs and at least two formulary triptans or have a contraindication to taking both classes of medications. Quantity limited to 16 doses per 30 days, 200 mg max daily dose. Approval Duration: 12 months. 	<ol style="list-style-type: none"> Meets all initial clinical criteria. Documentation of positive clinical response to treatment. Quantity limited to 16 doses per 30 days, 200 mg max daily dose. Approval Duration: 12 months.
V-go wearable insulin delivery system 20, 30, 40	<ol style="list-style-type: none"> Ordered for an approved indication for use: <ul style="list-style-type: none"> Diabetes mellitus in persons requiring insulin. Medication ordered by an Endocrinologist or practitioner who specializes in diabetes. Office visit notes from last two encounters with prescribing provider to support Medical Necessity. Evidence of face-to-face visit within past 3 months. Documentation of uncontrolled diabetes on multiple daily injections. Documentation that patient has been educated on device. 	<ol style="list-style-type: none"> Office visit notes from last two encounters with prescribing provider support of Medical Necessity. Prescribed by Endocrinologist or practitioner who specializes in diabetes with evidence of face-to-face visit within the past 3 months. Documentation of self-blood glucose monitoring (30-day blood glucose log or CGM report).

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	11. Documentation of self blood-glucose monitoring (30-day blood glucose log or CGM report). 12. May not be used if patient needs to make insulin adjustments of less than 2-unit increments due to risk of hypoglycemia. 13. Approval Duration: 12 months.	4. May not be used if patient needs to make insulin adjustments of less than 2-unit increments should not use V-GO as it may result in hypoglycemia. 5. Approval duration: 12 months.
Valoctocogene roxaparvovec (Roctavian)	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
Velmanase alfa (Lamzed)	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
vemurafenib (Zelboraf) tablet 240mg	1. Ordered for an approved indication for use: <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. treatment of patients with Erdheim Chester Disease with BRAF V600 mutation. 2. Medication ordered by an Oncologist or dermatologist	Limitations of Use: <ul style="list-style-type: none"> Zelboraf is not indicated for use in patients with wild-type BRAF melanoma. The safety and efficacy of Zelboraf in combination with ipilimumab have not been established.
viltolarsen (Viltepso) 50 mg/ml solution	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.
voclosporin (Lupkynis) capsule 7.9mg	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 active lupus nephritis. (mycophenolate mofetil and corticosteroids). 2. Patient age \geq 18 years. 3. Not taking concurrently with cyclophosphamide. 4. Prescriber specialty: immunologist, nephrologist, rheumatologist, or provider experienced in treatment of lupus nephritis.	1. All initial criteria continue to be met. 2. Documentation provided or attestation of therapeutic benefit. 3. Approval Duration: 6 months.

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	5. Prescriber attestation that all baseline evaluations have been done, and not contraindications to use are present (strong 3A4 inhibitor contraindicated, live vaccines, pregnancy/breastfeeding negative, assessment of renal function). 6. Quantity Limit: 6 tablets per day (23.7 mg twice daily). 7. Approval Duration: 6 months	
vorapaxar (Zontivity) tablet 2.08mg	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	Contraindicated in patients with history of stroke, TIA, or ICH and/or active pathologic bleeding.
Vutrisiran (Ambuttra) **Not on MDH list	USE MFC High-Cost Medication PA Criteria	Requires MFC Physician or Pharmacist review prior to approval.