Prior Authorization Criteria
Updated 11/2020

ACNE AGENTS_NVT

Products Affected

- *adapalene topical cream*
- *adapalene topical gel*
- *adapalene-benzoyl peroxide*
- *avita*
- AZELEX
- RETIN-A MICRO PUMP TOPICAL GEL WITH PUMP 0.06 %, 0.08 %
- *tretinoin*
- *tretinoin microspheres topical gel*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ADCIRCA_NVT 2017

Products Affected

- *alyq*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ADEMPAS_NVT 2016

Products Affected

- ADEMPAS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restrictions	Restricted to or in consult with Pulmonologist or Cardiologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	For diagnosis of Pulmonary Arterial Hypertension, trial of one (1) of the following: Letairis, Opsumit or Tracleer. For diagnosis of Persistent/recurrent Chronic Thromboembolic Pulmonary Hypertension (CTEPH) (WHO Group 4), trial of prior therapy is not required.
Indications	All FDA-approved Indications.
Off Label Uses	

AFINITOR_NVT 2017

Products Affected

- AFINITOR
- AFINITOR DISPERZ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

AIMOVIG

Products Affected

- AIMOVIG AUTOINJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL: THE PATIENT HAS EXPERIENCED A REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY, A REDUCTION IN MIGRAINE SEVERITY, OR MIGRAINE DURATION WITH AIMOVIG THERAPY.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE FORMULARY ALTERNATIVE FOR PREVENTIVE MIGRAINE TREATMENT SUCH AS DIVALPROEX SODIUM, TOPIRAMATE, PROPRANOLOL, OR TIMOLOL.
Indications	All FDA-approved Indications.
Off Label Uses	

ALECENSA_NVT

Products Affected

- ALECENSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by an Oncology Specialist or in consultation with an Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ALIQOPA_CCHP_2018

Products Affected

- ALIQOPA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Relapsed follicular lymphoma (FL) after at least two prior systemic therapies
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

AMPYRA_NVT 2018

Products Affected

- *dalfampridine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	WALKING DISABILITY SUCH AS MILD TO MODERATE BILATERAL LOWER EXTREMITY WEAKNESS OR UNILATERAL WEAKNESS PLUS LOWER EXTREMITY OR TRUNCAL ATAXIA.
Age Restrictions	
Prescriber Restrictions	NEUROLOGIST
Coverage Duration	INITIAL: 3 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT IN WALKING ABILITY.
Indications	All FDA-approved Indications.
Off Label Uses	

ANDROGENS_PREFERRED_NVT 2017

Products Affected

- ANDRODERM TRANSDERMAL PATCH 24 HOUR 2 MG/24 HOUR, 4 MG/24 HR
- ANDROGEL TRANSDERMAL GEL IN PACKET 1.62 % (20.25 MG/1.25 GRAM)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Two morning testoterone levels fall below the normal range for a healthy adult male. For patients on testosterone replacement therapy, documentation of at least one (1) morning testosterone level from the last 12 months is required.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

APTIOM_NVT

Products Affected

- APTIOM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ARCALYST_NVT 2014

Products Affected

- ARCALYST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, a Rheumatology Specialist, Dermatologist, or Immunologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ATYPICAL ANTIPSYCHOTIC

Products Affected

- ABILIFY MAINTENA
- ABILIFY MYCITE
- *aripiprazole oral tablet,disintegrating*
- ARISTADA
- ARISTADA INITIO
- FANAPT
- LATUDA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PATIENT HAS TRIED AND FAILED OR WAS INTOLERANT TO ANY TWO OF THE FOLLOWING FOR EACH INDICATION: BIPOLAR DISORDER: ARIPIPRAZOLE, OLANZAPINE, QUETIAPINE, PALIPERIDONE, RISPERIDONE, ZIPRASIDONE. SCHIZOPHRENIA: ARIPIPRAZOLE, OLANZAPINE, QUETIAPINE, PALIPERIDONE, RISPERIDONE, ZIPRASIDONE. IRRITABILITY WITH AUTISTIC DISORDER: ARIPIPRAZOLE, RISPERIDONE. PATIENT HAS TRIED AND FAILED OR WAS INTOLERANT TO 1 OF THE FOLLOWING FOR EACH INDICATION: BIPOLAR DEPRESSION: OLANZAPINE. MAJOR DEPRESSIVE DISORDER: ARIPIPRAZOLE. ACUTE MANIC/MIXED EPISODES WITH BIPOLAR DISORDER: ARIPIPRAZOLE.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

AUBAGIO_NVT 2018

Products Affected

- AUBAGIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

AYVAKIT

Products Affected

- AYVAKIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BALVERSA

Products Affected

- BALVERSA ORAL TABLET 3 MG, 4 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	DOCUMENTATION OF FGFR3 OR FGFR2 MUTATION
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST
Coverage Duration	12 MONTHS
Other Criteria	PREVIOUS TRIAL OF AT LEAST ONE PLATINUM-CONTAINING CHEMOTHERAPY WITHIN 12 MONTHS
Indications	All FDA-approved Indications.
Off Label Uses	

BELEODAQ_NVT 2015

Products Affected

- BELEODAQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BENLYSTA

Products Affected

- BENLYSTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	AUTOANTIBODY POSITIVE LUPUS TEST.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: MEMBER IS CURRENTLY TAKING CORTICOSTEROIDS, ANTIMALARIALS, NSAIDS, OR IMMUNOSUPPRESSIVE AGENTS. NO APPROVAL FOR DIAGNOSIS OF SEVERE ACTIVE LUPUS NEPHRITIS, SEVERE CENTRAL NERVOUS SYSTEM LUPUS OR CONCURRENT USE OF BIOLOGIC AGENTS OR INTRAVENOUS CYCLOPHOSPHAMIDE. RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Indications	All FDA-approved Indications.
Off Label Uses	

BESPONSA_CCHP_2018

Products Affected

- BESPONSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Relapsed or refractory B-cell precursor ALL
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BOSULIF_NVT 2014

Products Affected

- BOSULIF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BRANDED CLOBAZAM

Products Affected
- SYMPAZAN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BRIGATINIB

Products Affected
- ALUNBRIG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BRIVIACT_NVT

Products Affected

- BRIVIACT INTRAVENOUS
- BRIVIACT ORAL SOLUTION
- BRIVIACT ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BRUKINSA

Products Affected

- BRUKINSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

CABOMETYX_NVT

Products Affected
- CABOMETYX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

CALQUENCE_CCHP_2018

Products Affected

- CALQUENCE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGY OR HEMATOLOGY SPECIALIST.
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

CAPLYTA

Products Affected
- CAPLYTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PATIENT HAS TRIED AND FAILED OR WAS INTOLERANT TO ANY TWO OF THE FOLLOWING FOR EACH INDICATION: SCHIZOPHRENIA: ARIPIPRAZOLE, OLANZAPINE, QUETIAPINE, PALIPERIDONE, RISPERIDONE, ZIPRASIDONE.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

CAPRELSA_NVT

Products Affected

- CAPRELSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by an Oncologist or Endocrinologist or under the direct consultation of an Oncologist or Endocrinologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

CARBAGLU_NVT 2016

Products Affected

- CARBAGLU

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

CAYSTON_NVT 2017

Products Affected

- CAYSTON

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Restricted to or in consult with Infectious Disease or Pulmonology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

CESAMET_NVT 2017

Products Affected

- CESAMET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
Indications	All FDA-approved Indications.
Off Label Uses	

CHOLBAM_NVT

Products Affected

- CHOLBAM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, a hepatologist or pediatric gastroenterologist.
Coverage Duration	Initial will be 3 months, then if criteria is met approved for the rest of the plan year.
Other Criteria	Renewal requires documentation of stable or improved liver function.
Indications	All FDA-approved Indications.
Off Label Uses	

CIMZIA_NVT 2018

Products Affected

- CIMZIA
- CIMZIA POWDER FOR RECONST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS: PSORIASIS INVOLVING AT LEAST 5% OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, OR GENITAL AREA. NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS: PATIENT HAS ONE OF THE FOLLOWING OBJECTIVE SIGNS OF INFLAMMATION: 1) C-REACTIVE PROTEIN (CRP) LEVELS ABOVE THE UPPER LIMIT OF NORMAL OR 2) SACROILIITIS ON MAGNETIC RESONANCE IMMAGING (MRI). RENEWAL FOR RHEUMATOID ARTHRITIS, PSORIATIC ARTHRITIS, ANKYLOSING SPONDYLITIS, PLAQUE PSORIASIS OR NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS/ANKYLOSING SPONDYLITIS/NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS: PRESCRIBED BY, OR IN CONSULTATION WITH, A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY, OR IN CONSULTATION WITH, DERMATOLOGIST OR RHEUMATOLOGIST. CROHN'S DISEASE: PRESCRIBED BY, OR IN CONSULTATION WITH, A GASTROENTEROLOGIST. PLAQUE PSORIASIS: PRESCRIBED BY, OR GIVEN IN CONSULTATION WITH, A DERMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO (HUMIRA, ENBREL, RINVOQ). PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO (HUMIRA, ENBREL,

PA Criteria	Criteria Details
	COSENTYX). PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO (HUMIRA, COSENTYX, ENBREL, SKYRIZI). ANKYLOSING SPONDYLITIS (AS): PREVIOUS TRIAL OR CONTRAINDICATION OF ANY TWO (HUMIRA, ENBREL, COSENTYX). CROHN'S DISEASE (CD): PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA AND ONE CONVENTIONAL AGENT SUCH AS A CORTICOSTEROID (I.E., BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE. PATIENTS WHO ARE PREGNANT, BREASTFEEDING, OR TRYING TO BECOME PREGNANT ARE EXCLUDED FROM STEP CRITERIA FOR ALL INDICATIONS.
Indications	All FDA-approved Indications.
Off Label Uses	

CINRYZE_NVT 2015

Products Affected

- BERINERT INTRAVENOUS KIT
- CINRYZE
- FIRAZYR
- *icatibant*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

COMETRIQ_NVT 2014

Products Affected

- COMETRIQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

COPIKTRA

Products Affected
- COPIKTRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PRIOR TREATMENT WITH AT LEAST TWO PRIOR THERAPIES
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST OR HEMATOLOGIST
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

CORLANOR_NVT

Products Affected

- CORLANOR ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	The patient is on a maximally tolerated dose of beta blocker or has a history of a documented intolerance, contraindication, or a hypersensitivity to beta blocker.
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, a Cardiology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

COSENTYX_NVT 2018

Products Affected

- COSENTYX (2 SYRINGES)
- COSENTYX PEN (2 PENS)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PLAQUE PSORIASIS (PSO): MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING AT LEAST 5% BODY SURFACE AREA OR PSORIATIC LESIONS AFFECT THE HANDS, FEET, OR GENITAL AREA. RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	18 YEARS OR OLDER
Prescriber Restrictions	PLAQUE PSORIASIS (PSO): PRESCRIBED BY, OR IN CONSULTATION WITH, A DERMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY, OR IN CONSULTATION WITH, A RHEUMATOLOGIST OR DERMATOLOGIST. ANKYLOSING SPONDYLITIS (AS): PRESCRIBED BY, OR IN CONSULTATION WITH, A RHEUMATOLOGIST
Coverage Duration	INITIAL: 4 MONTHS. RENEWAL: 12 MONTHS FOR ALL DIAGNOSES
Other Criteria	INITIAL: PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL WITH ONE CONVENTIONAL THERAPY SUCH AS PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) AGENT SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE.
Indications	All FDA-approved Indications.
Off Label Uses	

COTELLIC_NVT

Products Affected

- COTELLIC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by an Oncology Specialist or in consultation with an Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

CYRAMZA_NVT

Products Affected

- CYRAMZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by an Oncology Specialist or in consultation with an Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

CYSTAGON_NVT 2017

Products Affected

- CYSTAGON

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, an Endocrinologist, Geneticist, Nephrologist or Metabolic Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

CYSTARAN_NVT 2015

Products Affected

- CYSTARAN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For the treatment of corneal cystine crystal accumulation in patients with cystinosis
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an Ophthalmologist or Geneticist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

DARZALEX_NVT

Products Affected

- DARZALEX
- DARZALEX FASPRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by an Oncology Specialist or in consultation with an Oncology Specialist.
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

DAURISMO

Products Affected

- DAURISMO ORAL TABLET 100 MG, 25 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	RESTRICTED TO OR IN CONSULTATION WITH AN ONCOLOGIST OR HEMATOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

DESOXYN_NVT 2017

Products Affected

- *methamphetamine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

DRONABINOL_NVT 2016

Products Affected

- *dronabinol*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of loss of appetite due to AIDS OR chemotherapy induced nausea and vomiting
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
Indications	All FDA-approved Indications.
Off Label Uses	

DUPIXENT

Products Affected

- DUPIXENT PEN
- DUPIXENT SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	ASTHMA: 1) oral corticosteroid-dependent asthma OR eosinophilic asthma (peripheral blood eosinophil level greater than or equal to 150 cells/mcl in past 12 months) AND 2) poor asthma control or recurrent exacerbation requiring additional treatment (additional treatment may include oral corticosteroids, hospitalizations, or frequent office visits). ATOPIC DERMATITIS: diagnosis of moderate or severely uncontrolled atopic dermatitis.
Age Restrictions	
Prescriber Restrictions	ASTHMA: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST, ALLERGIST, IMMUNOLOGIST. ATOPIC DERMATITIS: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	ASTHMA: Concurrent use of a maximally tolerated dose of an ICS/LABA in patients who are not otherwise intolerant altogether, or for whom ICS/LABAs are contraindicated. ATOPIC DERMATITIS: Trial of or contraindication to two formulary topical corticosteroids
Indications	All FDA-approved Indications.
Off Label Uses	

DURVALUMAB

Products Affected
- IMFINZI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

EMPLICITI_NVT

Products Affected
- EMPLICITI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by an Oncology Specialist or Hematology Specialist, or in consultation with an Oncology Specialist or Hematology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ENBREL_NVT PA 2018

Products Affected

- ENBREL
- ENBREL MINI
- ENBREL SURECLICK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING AT LEAST 5% BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, OR GENITAL AREA. RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS, PSORIATIC ARTHRITIS: 18 YEARS OR OLDER. POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS: 2 YEARS OR OLDER. PLAQUE PSORIASIS: 4 YEARS OR OLDER
Prescriber Restrictions	RHEUMATOID ARTHRITIS, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS, ANKYLOSING SPONDYLITIS: PRESCRIBED BY, OR IN CONSULTATION WITH, A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY, OR IN CONSULTATION WITH, A DERMATOLOGIST OR RHEUMATOLOGIST. PLAQUE PSORIASIS: PRESCRIBED BY, OR IN CONSULTATION WITH, A DERMATOLOGIST.
Coverage Duration	INITIAL: RA: 6 MONTHS. PJIA: 3 MONTHS. PSA/AS/PSO: 4 MONTHS. RENEWAL: 12 MONTHS FOR ALL DIAGNOSES
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF HUMIRA OR XELJANZ/XELJANZ XR. POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PREVIOUS TRIAL OF HUMIRA. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL WITH ANY TWO PREFERRED AGENTS: HUMIRA, STELARA, XELJANZ/XELJANZ XR, COSENTYX. ANKYLOSING SPONDYLITIS (AS), PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL WITH ANY TWO PREFERRED AGENTS: HUMIRA, COSENTYX, SKYRIZI, STELARA .
Indications	All FDA-approved Indications.

2021 Chinese Community Health Plan Senior Value Program (HMO)

Prior Authorization Criteria
Updated 11/2020

PA Criteria	Criteria Details
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

ENTRESTO (CCHP)

Products Affected
- ENTRESTO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Initial Authorization: Diagnosis of heart failure (with or without hypertension). Ejection fraction is less than or equal to 40 percent. Heart failure is classified as one of the following: New York Heart Association Class II - IV. Patient does not have a history of angioedema associated with use of the following: Angiotensin converting enzyme (ACE) Inhibitor therapy, Angiotensin receptor blocker (ARB) therapy. Patient will discontinue use of any concomitant ACE Inhibitor or ARB before initiating treatment with Entresto. ACE inhibitors must be discontinued at least 36 hours prior to initiation of Entresto. Patient is not concomitantly on aliskiren therapy. Patient is not pregnant. Reauthorization: Documentation of positive clinical response to therapy.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with Cardiology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

EPANED_NVT_2017

Products Affected

- EPANED ORAL SOLUTION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Approval requires attestation of patient's inability to swallow solid dosage forms of enalapril.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

EPCLUSA_NVT_2018

Products Affected

- EPCLUSA ORAL TABLET 400-100 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HCV RNA LEVEL.
Age Restrictions	6 YEARS OF AGE AND OLDER.
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH: GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST)
Coverage Duration	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. HCV RNA LEVEL WITHIN PAST 6 MONTHS. PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS NOT RECOMMENDED BY THE MANUFACTURER: AMIODARONE, CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, RIFAMPIN, RIFABUTIN, RIFAPENTINE, HIV REGIMEN THAT CONTAINS EFAVIRENZ, ROSUVASTATIN AT DOSES ABOVE 10MG, TIPRANAVIR/RITONAVIR OR TOPOTECAN. RIBAVIRIN USE REQUIRED FOR PATIENTS WITH DECOMPENSATED CIRRHOSIS.
Indications	All FDA-approved Indications.
Off Label Uses	

EPIDIOLEX_2019

Products Affected

- EPIDIOLEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	DIAGNOSIS OF LENNOX-GASTAUT, DRAVET SYNDROME, OR TUBEROUS SCLEROSIS COMPLEX.
Age Restrictions	1 YEAR OF AGE OR OLDER
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN EPILEPTOLOGIST OR NEUROLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	AT LEAST ONE PRIOR ANTIEPILEPTIC DRUG
Indications	All FDA-approved Indications.
Off Label Uses	

ERIVEDGE_NVT 2017

Products Affected

- ERIVEDGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or inconsultation with Oncology Specialist or Dermatologist.
Coverage Duration	Covered for duration of plan year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ERLEADA

Products Affected
- ERLEADA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	INITIAL: NON METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (NMCRPC): THE PATIENT HAS HIGH RISK PROSTATE CANCER (I.E. RAPIDLY INCREASING PROSTATE SPECIFIC ANTIGEN [PSA] LEVELS). NMCRPC OR METASTATIC CASTRATION-SENSITIVE PROSTATE CANCER (MCSPC): PATIENT MEETS ONE OF THE FOLLOWING: (1) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) AGONIST OR ANTAGONIST OR (2) PREVIOUSLY RECEIVED A BILATERAL ORCHIECTOMY. RENEWAL: A DIAGNOSIS OF NMCRPC OR MCSPC.
Indications	All FDA-approved Indications.
Off Label Uses	

ERWINAZE_NVT 2014

Products Affected
- ERWINAZE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Restricted to Oncology Specialists or in consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

EXTAVIA_MI_2018

Products Affected

- BETASERON SUBCUTANEOUS KIT
- EXTAVIA SUBCUTANEOUS KIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	TRIAL WITH TWO OF THE FOLLOWING AGENTS FOR MULTIPLE SCLEROSIS: AVONEX, PLEGRIDY, AND REBIF
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

FARYDAK_NVT 2016

Products Affected

- FARYDAK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by an Oncology or Hematology Specialist or in consultation with an Oncology or Hematology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

FERRIPROX_NVT

Products Affected

- FERRIPROX ORAL SOLUTION
- FERRIPROX ORAL TABLET 500 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Restricted to Hematology Specialists or in consult with Hematology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

FINTEPLA

Products Affected
- FINTEPLA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	TRIAL OF AT LEAST ONE PRIOR ANTIEPILEPTIC DRUG HAS BEEN NOT EFFECTIVE, NOT TOLERATED, OR ALL OTHER ANTIEPILEPTIC DRUGS ARE CONTRAINDICATED.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN EPILEPTOLOGIST OR NEUROLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	RENEWAL: PATIENT HAS SHOWN CONTINUED CLINICAL BENEFIT (E.G. REDUCTION OF SEIZURES, REDUCED LENGTH OF SEIZURES, SEIZURE CONTROL MAINTAINED)
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

FIRMAGON_NVT 2015

Products Affected

- FIRMAGON 120 MG VIAL INNER,SUV
- FIRMAGON KIT W DILUENT SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with Oncologist or Urologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Approval subject to BvD determination
Indications	All FDA-approved Indications.
Off Label Uses	

FLECTOR PATCH_NVT 2015

Products Affected

- *diclofenac epolamine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

FOLOTYN_NVT 2015

Products Affected

- FOLOTYN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or on consultation with Hematologist or Oncologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Approval subject to BvD determination.
Indications	All FDA-approved Indications.
Off Label Uses	

FORTEO_NVT 2016

Products Affected

- FORTEO
- *teriparatide*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	ONE OF THE FOLLOWING: (1) HIGH RISK FOR FRACTURES DEFINED AS ONE OF THE FOLLOWING: A) HISTORY OF OSTEOPOROTIC (I.E., FRAGILITY, LOW TRAUMA) FRACTURE(S). B) 2 OR MORE RISK FACTORS FOR FRACTURE (E.G., HISTORY OF MULTIPLE RECENT LOW TRAUMA FRACTURES, BMD T-SCORE LESS THAN OR EQUAL TO -2.5, CORTICOSTEROID USE, OR USE OF GNRH ANALOGS SUCH AS NAFARELIN, ETC.). C) NO PRIOR TREATMENT FOR OSTEOPOROSIS AND FRAX SCORE OF AT LEAST 20% FOR ANY MAJOR FRACTURE OR OF AT LEAST 3% FOR HIP FRACTURE. (2) UNABLE TO USE ORAL THERAPY (I.E., UPPER GASTROINTESTINAL PROBLEMS UNABLE TO TOLERATE ORAL MEDICATION, LOWER GASTROINTESTINAL PROBLEMS UNABLE TO ABSORB ORAL MEDICATIONS, TROUBLE REMEMBERING TO TAKE ORAL MEDICATIONS OR COORDINATING AN ORAL BISPHOSPHONATE WITH OTHER ORAL MEDICATIONS OR THEIR DAILY ROUTINE). (3) ADEQUATE TRIAL OF, INTOLERANCE TO, OR A CONTRAINDICATION TO BISPHOSPHONATES (E.G., ALENDRONATE, RISEDRONATE, IBANDRONATE).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.

2021 Chinese Community Health Plan Senior Value Program (HMO)

Prior Authorization Criteria
Updated 11/2020

PA Criteria	Criteria Details
Off Label Uses	

FYCOMPA_NVT 2014

Products Affected

- FYCOMPA ORAL SUSPENSION
- FYCOMPA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

GARDASIL_NVT 2015

Products Affected

- GARDASIL 9 (PF)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	PA not required for members age 9-45.
Prescriber Restrictions	
Coverage Duration	Approved for duration of plan year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

GATTEX_NVT 2016

Products Affected

- GATTEX 30-VIAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of short bowel syndrome. Dependent on parenteral support for at least 12 months and at least 3 days per week.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

GILENYA_NVT 2018

Products Affected

- GILENYA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

GILOTRIF_NVT

Products Affected
- GILOTRIF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an Oncology Specialist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

GLATIRAMER_MI_2018

Products Affected

- *glatiramer*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

GLEEVEC_NVT 2015

Products Affected

- *imatinib*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by Oncologist or Hematologist, or under the direct consultation with an Oncologist or Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

GOCOVRI

Products Affected

- GOCOVRI ORAL
  CAPSULE,EXTENDED RELEASE
  24HR 137 MG, 68.5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

GROWTH HORMONES_NVT 2015

Products Affected

- NORDITROPIN FLEXPRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	The criteria for approval of growth hormones in adults require the diagnosis of Somatropin Deficiency Syndrome (defined by failure to stimulate Growth Hormone secretion (peak GH level of 10mcg/L or less) by one of the acceptable provocative tests). This may include adults who as children had Growth Hormone deficiency or adults with known pituitary disease.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

HARVONI_NVT PA 2018

Products Affected

- HARVONI ORAL PELLETS IN PACKET 33.75-150 MG, 45-200 MG
- HARVONI ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HCV RNA LEVEL WITHIN PAST 6 MONTHS.
Age Restrictions	Member must be 3 years of age or older.
Prescriber Restrictions	GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST).
Coverage Duration	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING: CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, ROSUVASTATIN, SOFOSBUVIR (AS A SINGLE AGENT), OR TIPRANAVIR/RITONAVIR.
Indications	All FDA-approved Indications.
Off Label Uses	

HEPATITIS B AGENTS_CCHP 2014

Products Affected

- *adefovir*
- BARACLUDE ORAL SOLUTION
- PEGASYS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	THIS SECTION APPLIES TO BARACLUDE, ADEFOVIR, AND PEGASYS (WHEN USED FOR HEP B): INITIATION OF TREATMENT (ONE OF THE FOLLOWING): HBV DNA GREATER THAN 2000IU/ML AND ALANINE AMINOTRANSFERASE (ALT) GREATER THAN UPPER LIMIT OF NORMAL (ULN)-(MALE ALT GREATER THAN 30 U/L AND FEMALE ALT TO GREATER THAN 19U/L). OR HISTOLOGIC EVIDENCE OF CIRRHOSIS AND DETECTABLE HBV DNA LEVELS. OR HISTOLOGIC EVIDENCE OF DECOMPENSATED CIRRHOSIS (THESE CASES SHOULD BE REFERRED TO GI). NONRESPONSE TO ANTIVIRAL TREATMENT - DEFINED AS HBV DNA LEVELS DECREASING LESS THAN 2 LOG DROP FROM BASELINE AFTER 6 MONTHS. SWITCHING ANTIVIRAL AGENTS SHOULD BE CONSIDERED AFTER MEDICATION COMPLIANCE HAS BEEN DETERMINED.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST OR INFECTIOUS DISEASE SPECIALIST.
Coverage Duration	INITIAL COVERAGE APPROVED FOR 6 MONTHS. CONTINUAL COVERAGE APPROVED FOR 12 MONTHS.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

HETLIOZ_NVT

Products Affected
- HETLIOZ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient is totally blind.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

HOFH_NVT 2016

Products Affected

- JUXTAPID

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Untreated LDL greater than 500 mg/dL OR treated LDL greater than or equal to 300 mg/dL. Concurrent use of maximum statin dose (atorvastatin or rosuvastatin) and one other lipid lowering agent (include dates and reasons for discontinuation). For patients with statin intolerance, concurrent use of maximum statin dose not required. Chart documentation showing the most recent full lipid panel, including Apo-B within the past 12 months.
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, a Lipidologist, Cardiologist, or an Endocrinologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

HUMIRA_NVT 2018

Products Affected

- HUMIRA
- HUMIRA PEN
- HUMIRA PEN CROHNS-UC-HS START
- HUMIRA PEN PSOR-UVEITS-ADOL HS
- HUMIRA(CF)
- HUMIRA(CF) PEDI CROHNS STARTER
- HUMIRA(CF) PEN CROHNS-UC-HS
- HUMIRA(CF) PEN PSOR-UV-ADOL HS
- HUMIRA(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS: CURRENT WEIGHT. PLAQUE PSORIASIS: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, OR GENITAL AREA. RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS, ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIS PSORIATIC ARTHRITIS: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSORIASIS: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST CROHN'S DISEASE/ULCERATIVE COLITIS: PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST. Hidradenitis Suppurativa (HS): Prescriber must be a Dermatologist.
Coverage Duration	INITIAL: RA:6 MOS.PSA/AS:4 MOS.PJIA:5 MOS.PSO/CD/UC/HS: 3 MOS.UVEITIS:6 MOS.RENEWAL: 12 MOS FOR ALL
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE.

PA Criteria	Criteria Details
	POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PREVIOUS TRIAL OF ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. ANKYLOSING SPONDYLITIS: TRIAL OF FORMULARY AGENTS NOT REQUIRED. PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF ONE OF THE FOLLOWING CONVENTIONAL THERAPIES SUCH AS PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE. CROHN'S DISEASE (CD): PREVIOUS TRIAL OF ONE CONVENTIONAL AGENT SUCH AS A CORTICOSTEROID (I.E., BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE. ULCERATIVE COLITIS (UC): PREVIOUS TRIAL OF ONE CONVENTIONAL AGENT SUCH AS A CORTICOSTEROID (I.E., BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE.
Indications	All FDA-approved Indications.
Off Label Uses	

HYDROXYPROGESTERONE_NVT

Products Affected

- *hydroxyprogesterone cap(ppres)*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

IBRANCE_NVT

Products Affected
- IBRANCE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH AN ONCOLOGY SPECIALIST
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ICLUSIG_NVT 2014

Products Affected

- ICLUSIG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

IDHIFA_CCHP_2018

Products Affected

- IDHIFA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Relapsed or refractory acute myeloid leukemia (AML) with an isocitrate dehydrogenase-2 (IDH2) mutation as detected by an FDA-approved test
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

IMBRUVICA_NVT 2014

Products Affected

- IMBRUVICA ORAL CAPSULE
- IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG, 560 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by an Oncologist, Hemotologist or Transplant specialist, or under the direct consultation of an Oncologist, Hemotologist or Transplant specialist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

INCRELEX_NVT 2015

Products Affected
- INCRELEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For the long-term treatment of growth failure in children with severe primary insulin-like growth factor-1 (IGF-1) deficiency (primary IGFD) or with growth hormone (GH) gene deletion who have developed neutralizing antibodies to GH.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

INLYTA_NAVITUS

Products Affected

- INLYTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	RESTRICTED TO OR IN CONSULT WITH ONCOLOGY SPECIALIST.
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

INQOVI

Products Affected

- INQOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, A HEMATOLOGIST OR ONCOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

INREBIC

Products Affected
- INREBIC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST OR HEMATOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

INTERFERON_MI_2018

Products Affected

- AVONEX INTRAMUSCULAR PEN INJECTOR KIT
- AVONEX INTRAMUSCULAR SYRINGE KIT
- PLEGRIDY SUBCUTANEOUS PEN INJECTOR
- PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML
- REBIF (WITH ALBUMIN)
- REBIF REBIDOSE
- REBIF TITRATION PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

IPF_NVT 2016

Products Affected

- ESBRIET ORAL CAPSULE
- OFEV

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	FOR OFEV AND ESBRIET: INITIAL FOR IDIOPATHIC PULMONARY FIBROSIS (IPF): DEFINITIVE DIAGNOSIS OF IDIOPATHIC PULMONARY FIBROSIS DEFINED BY THE FOLLOWING: NO KNOW CAUSE OF LUNG FIBROSIS AND ONE OF THE FOLLOWING: A. SURGICAL LUNG BIOPSY REVEALING HISTOPATHOLOGICAL PATTERN OF UNSPECIFIED INTERSTITIAL PNEUMONIA (UIP) B. HIGH-RESOLUTION COMPUTED TOMOGRAPHY INDICATES DEFINITE UIP PATTERN C. HIGH-RESOLUTION COMPUTED TOMOGRAPHY INDICATES POSSIBLE UIP PATTERN AND SURGICAL LUNG BIOPSY REVEALS A HISTOPATHOLOGICAL PATTERN OF PROBABLE UIP. FOR OFEV: INITIAL FOR CHRONIC FIBROSING INTERSTITIAL LUNG DISEASE: DEFINITIVE DIAGNOSIS OF PROGRESSIVE PHENOTYPE DEFINED BY BOTH OF THE FOLLOWING: A. AT LEAST 10% FIBROSIS ON A CHEST HRCT B. BASELINE FVC AT LEAST 45% OF PREDICTED VALUE. FOR OFEV: INITIAL FOR SYSTEMIC SCLEROSIS-ASSOCIATED INTERSTITIAL LUNG DISEASE: DEFINITIVE DIAGNOSIS DEFINED BY BOTH OF THE FOLLOWING: A. DIAGNOSIS OF SYSTEMIC SCLEROSIS ACCORDING TO AMERICAN COLLEGE OF RHEUMATOLOGY AND EUROPEAN LEAGUE AGAINST RHEUMATISM B. AT LEAST 10 PERCENT FIBROSIS ON HRCT. RENEWAL FOR ALL DIAGNOSES: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	Prescribed by a Pulmonology Specialist or in consultation with a Pulmonology Specialist.

2021 Chinese Community Health Plan Senior Value Program (HMO)

Prior Authorization Criteria
Updated 11/2020

PA Criteria	Criteria Details
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Will not be used in combination with other medications used to treat IPF.
Indications	All FDA-approved Indications.
Off Label Uses	

IRESSA_NVT

Products Affected
- IRESSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by an Oncology Specialist or in consultation with an Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ISTODAX_NVT 2015

Products Affected

- *romidepsin*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or consultation with Hematologist or Oncologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Approval subject to BvD determination.
Indications	All FDA-approved Indications.
Off Label Uses	

ITRACONAZOLE_NVT 2015

Products Affected

- *itraconazole*
- SPORANOX ORAL SOLUTION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For onychomycosis or diffuse dermatologic fungal infections: 1. fungal infection is confirmed by a positive KOH test, fungal culture or nail biopsy. 2. For onychomycosis, must fail terbinafine. For dermatologic infections, must fail one topical antifungal medication.
Age Restrictions	
Prescriber Restrictions	Infectious Disease Specialists, Pulmonologist or Dermatologist, Podiatrist or have consulted with an Infectious Disease Specialist, Pulmonologist or Dermatologist or Podiatrist concerning the patient.
Coverage Duration	Approved for 6 months.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

IVIG_NVT 2017

Products Affected

- FLEBOGAMMA DIF INTRAVENOUS SOLUTION 10 %
- GAMASTAN
- GAMMAGARD LIQUID
- GAMMAGARD S-D (IGA < 1 MCG/ML)
- GAMMAKED INJECTION SOLUTION 10 GRAM/100 ML (10 %)
- GAMMAPLEX (WITH SORBITOL)
- GAMUNEX-C INJECTION SOLUTION 20 GRAM/200 ML (10 %)
- OCTAGAM
- PRIVIGEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

JAKAFI_NVT 2014

Products Affected

- JAKAFI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	RESTRICTED TO OR IN CONSULT WITH ONCOLOGY OR HEMATOLOGY SPECIALIST.
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

KADCYLA_NVT

Products Affected
- KADCYLA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

KALYDECO_NAVITUS

Products Affected
- KALYDECO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PATIENT IS NOT ON CONCURRENT THERAPY WITH OTHER IVACAFTOR-CONTAINING PRODUCTS. RENEWAL: THERE IS CLINICAL DOCUMENTATION OF MAINTAINED OR IMPROVEMENT IN FEV1, BMI, OR REDUCTION IN NUMBER OF EXACERBATIONS
Age Restrictions	
Prescriber Restrictions	RESTRICTED TO OR IN CONSULT WITH PULMONOLOGIST OR CYSTIC FIBROSIS SPECIALIST.
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

KEYTRUDA_NVT 2015

Products Affected

- KEYTRUDA INTRAVENOUS SOLUTION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

KINERET_NVT 2018

Products Affected
- KINERET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL: RA: 6 MONTHS. NOMID/CAPS: 12 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF ANY TWO PREFERRED AGENTS (HUMIRA, ENBREL, XELJANZ/XELJANZ XR) AND ONE DMARD (DISEASE MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE.
Indications	All FDA-approved Indications.
Off Label Uses	

KORLYM_NVT

Products Affected

- KORLYM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

KOSELUGO

Products Affected
- KOSELUGO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

KUVAN_NVT 2017

Products Affected

- KUVAN
- *sapropterin*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For continuing therapy the patient must have shown a 20% drop in Phenylalanine levels after 2 months of Kuvan treatment.
Age Restrictions	
Prescriber Restrictions	Prescribed by a Medical Geneticist or Metabolic Specialist.
Coverage Duration	Initial = 3 months, then if critieria is met approved for the rest of the plan year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

KYPROLIS_NVT_2017

Products Affected
- KYPROLIS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with an Oncologist or Hematologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

LENVIMA_NVT 2016

Products Affected
- LENVIMA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by an Oncology Specialist or in consultation with an Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

LETAIRIS_NVT 2015

Products Affected

- *ambrisentan*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restrictions	Restricted to or in consult with Pulmonologist or Cardiologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

LIDOCAINE PATCH_NVT 2015

Products Affected

- *lidocaine topical adhesive patch,medicated 5 %*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

LINZESS

Products Affected
- LINZESS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PATIENT HAS TRIED AND FAILED POLYETHYLENE GLYCOL (MIRALAX).
Age Restrictions	AGE 18 YEARS AND OLDER
Prescriber Restrictions	
Coverage Duration	3 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

LOBRENA

Products Affected
- LORBRENA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

LONSURF_NVT

Products Affected

- LONSURF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY AN ONCOLOGY SPECIALIST OR IN CONSULTATION WITH AN ONCOLOGY SPECIALIST.
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

LYNPARZA_NVT 2015

Products Affected

- LYNPARZA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Restricted to Oncology Specialist or in consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

MAVYRET_CCHP_2018

Products Affected

- MAVYRET

PA Criteria	Criteria Details
Exclusion Criteria	Moderate or severe hepatic impairment (Child Pugh B Or C)
Required Medical Information	HCV RNA level within past 6 months
Age Restrictions	
Prescriber Restrictions	Prescribed by or given in consultation with: gastroenterologist, infectious disease specialist, physician specializing in the treatment of hepatitis (hepatologist), or a specially trained group such as ECHO (extension for community healthcare outcomes) model.
Coverage Duration	Criteria will be applied consistent with current AASLD/IDSA guidance.
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance. Trial of a preferred formulary alternative including Harvoni or Epclusa when these agents are considered acceptable for treatment of the specific genotype per AASLD/IDSA guidance. Patient is not concurrently taking any of the following medications not recommended or contraindicated by the manufacturer: carbamazepine, rifampin, ethinyl estradiol-containing medication, atazanavir,darunavir, lopinavir, ritonavir, efavirenz, atorvastatin, lovastatin, simvastatin, rosuvastatin at doses greater than 10mg, or cyclosporine at doses greater than 100mg per day. Patient must not have prior failure of a DAA regimen with NS5A inhibitor and HCV protease inhibitor.
Indications	All FDA-approved Indications.
Off Label Uses	

MEGESTROL SUSP_NVT 2017

Products Affected

- *megestrol oral suspension 400 mg/10 ml (40 mg/ml), 625 mg/5 ml (125 mg/ml)*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

MEGESTROL TABS_NVT 2017

Products Affected

- *megestrol oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

MEKINIST_NVT 2016

Products Affected

- MEKINIST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consult with an Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

MEKTOVI BRAFTOVI 2018

Products Affected

- BRAFTOVI
- MEKTOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	(1) BRAF V600E or V600K mutations as detected by an FDA-approved test (2) Not used as a single agent
Age Restrictions	
Prescriber Restrictions	prescribed by or given in consultation with an oncology specialist
Coverage Duration	APPROVED FOR DURATION OF CONTRACT YEAR SUBJECT TO FORMULARY CHANGE AND MEMBER ELIGIBILITY.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

MEPERIDINE_NVT 2017

Products Affected

- *meperidine (pf) injection solution 100 mg/ml, 25 mg/ml, 50 mg/ml*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

METHITEST

Products Affected

- METHITEST
- *methyltestosterone oral capsule*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: Two morning testosterone levels fall below the normal range for a healthy adult male, AND patient must have tried and failed BOTH ANDRODERM AND ANDROGEL. For Methitest only: if prescribed to treat delayed male sexual development, metastatic (skeletal) mammary cancer in women 1 to 5 years postmenopause, or hormone-responsive breast cancer in premenopausal women, testosterone levels and previous trial of ANDRODERM and ANDROGEL are not required. RENEWAL: Documentation of at least one (1) morning testosterone level from the last 12 months is required.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

MIDOSTAURIN

Products Affected
- RYDAPT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

MOVANTIK_NVT 2016

Products Affected
- MOVANTIK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Initial Therapy: Member must meet all criteria. 1. Opioid-induced constipation. 2. Failed two laxative/bowel therapies -- polyethylene glycol and lactulose.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	4 Months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

MYLOTARG_CCHP_2018

Products Affected
- MYLOTARG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Adults: newly diagnosed CD33+ AML. Children over the age of 2: refractory CD33+ AML
Age Restrictions	Patients age 2 and greater
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

NATPARA (CCHP2017)

Products Affected
- NATPARA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PTH below reference range within the last 12 months (2 readings)
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consult with Endocrinologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

NERLYNX_CCHP_2018

Products Affected

- NERLYNX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	EARLY STAGE (I-II) HER2+ BREAST CANCER AFTER ADJUVANT TRASTUZUMAB-BASED THERAPY AND NERLYNX USED AS MONOTHERAPY. LATE STAGE (III-IV) HER2+ BREAST CANCER: AFTER TWO OR MORE PRIOR ANTI-HER2 BASED REGIMENS IN THE METASTATIC SETTING AND NERLYNX USED IN COMBINATION WITH CAPECITABINE.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	EARLY STAGE HER2+ BREAST CANCER: DURATION OF TREATMENT TO NOT EXCEED ONE YEAR.
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

NEXAVAR_NVT 2015

Products Affected
- NEXAVAR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Require patient to be at least 18 years old.
Prescriber Restrictions	Prescribed by a Oncologist or under the direct consultation of an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

NINLARO_NVT

Products Affected
- NINLARO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by an Oncology Specialist or Hematology Specialist, or in consultation with an Oncology Specialist or Hematology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

NIRAPARIB TOSYLATE

Products Affected
- ZEJULA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

NORTHERA_NVT 2016

Products Affected
- NORTHERA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, a Neurology Specialist or Cardiologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

NOXAFIL_NVT 2015

Products Affected

- NOXAFIL ORAL
- *posaconazole oral tablet,delayed release (dr/ec)*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

NUBEQA

Products Affected

- NUBEQA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, A UROLOGIST OR ONCOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	CONCURRENTLY RECEIVING GONADOTROPIN-RELEASING HORMONE ANALOG OR HAD BILATERAL ORCHIECTOMY
Indications	All FDA-approved Indications.
Off Label Uses	

NUCALA_NVT PA 2017

Products Affected

- NUCALA

PA Criteria	Criteria Details
Exclusion Criteria	SEVERE ASTHMA: CONCURRENT USE OF XOLAIR
Required Medical Information	SEVERE ASTHMA: PERIPHERAL BLOOD EOSINOPHIL COUNT OF GREATER THAN OR EQUAL TO 150 CELLS/MCL WITHIN THE LAST 6 WEEKS OR GREATER THAN OR EQUAL TO 300 CELLS/MCL WITHIN THE LAST 12 MONTHS.
Age Restrictions	SEVERE ASTHMA: MEMBER MUST BE AT LEAST 6 YEARS OLD. EGPA: MEMBER MUST BE AT LEAST 18 YEARS OLD.
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ALLERGY SPECIALIST, IMMUNOLOGIST, RHEUMATOLOGIST, OR PULMONARY SPECIALIST.
Coverage Duration	INITIAL: SEVERE ASTHMA: 24 WEEKS. EGPA: 12 MONTHS. RENEWAL FOR ALL INDICATIONS: 12 MONTHS.
Other Criteria	INITIAL THERAPY: SEVERE ASTHMA: HISTORY OF 2 OR MORE EXACERBATIONS IN THE PREVIOUS YEAR DESPITE REGULAR USE OF HIGH-DOSE INHALED CORTICOSTEROIDS PLUS AN ADDITIONAL CONTROLLER(S). AN EXCEPTION IS MADE FOR PATIENTS WITH INTOLERANCE OR CONTRAINDICATION TO HIGH-DOSE INHALED CORTICOSTEROIDS AND ADDITIONAL CONTROLLER(S). RENEWAL: SEVERE ASTHMA: REQUIRES DOCUMENTATION THAT THE PATIENT HAS EXPERIENCED IMPROVEMENT IN ASTHMA EXACERBATIONS FROM BASELINE (PHYSICIAN ATTESTATION) AND A REDUCTION IN ORAL CORTICOSTEROID DOSE (IF THE PATIENT WAS ON A MAINTENANCE REGIMEN OF ORAL CORTICOSTEROIDS AT THE INITIATION OF TREATMENT).
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

NUPLAZID_NVT

Products Affected

- NUPLAZID ORAL CAPSULE
- NUPLAZID ORAL TABLET 10 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

NUVIGIL_NVT 2015

Products Affected

- *armodafinil*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of narcolepsy, OR obstructive sleep apnea/hypopnea syndrome, OR shift work sleep disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ODOMZO_NVT 2017

Products Affected
- ODOMZO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or inconsultation with Oncology Specialist or Dermatologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ONUREG

Products Affected

- ONUREG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST OR HEMATOLOGIST.
Coverage Duration	12 MONTHS.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

OPDIVO_NVT 2015

Products Affected

- OPDIVO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Restricted to Oncology Specialist or in consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

OPSUMIT_NVT

Products Affected

- OPSUMIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restrictions	Restricted to or in consult with Pulmonologist or Cardiologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ORAL FENTANYL_NVT 2017

Products Affected

- *fentanyl citrate*
- FENTORA
- LAZANDA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Breakthrough cancer pain and opioid tolerence. Documented tolerance to opioids defined as patients taking around the clock medicine consisting of at least 60mg of oral morphine daily, at least 25mcg of transdermal fentanyl per hour, at least 30mg of oxycodone daily, at least 8mg of oral hydromorphone daily, or an equianalgesic dose of another opioid daily for a week or longer.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Trial of fentanyl lozenge before another branded fentanyl product.
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

ORENCIA_NVT 2018

Products Affected

- ORENCIA
- ORENCIA (WITH MALTOSE)
- ORENCIA CLICKJECT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS, JUVENILE IDIOPATHIC ARTHRITIS, PSORIATIC ARTHRITIS: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL: RA/PSA: 6 MONTHS. JIA: 4 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA) OR JUVENILE IDIOPATHIC ARTHRITIS (JIA): PREVIOUS TRIAL OF ANY TWO PREFERRED AGENTS (HUMIRA, ENBREL, XELJANZ/XELJANZ XR) AND ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. PSORIATIC ARTHRITIS: PREVIOUS TRIAL OF ANY TWO PREFERRED AGENTS (HUMIRA, ENBREL, COSENTYX, XELJANZ/XELJANZ XR, STELARA)
Indications	All FDA-approved Indications.
Off Label Uses	

ORFADIN_NVT 2015

Products Affected

- *nitisinone*
- ORFADIN ORAL CAPSULE 10 MG, 2 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

ORKAMBI_NVT

Products Affected
- ORKAMBI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1) Lung function (FEV1, ppFEV1), 2) BMI, 3) Pulmonary exacerbation history to be collected initially and at continuation.
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, pulmonologist.
Coverage Duration	Initial and continuation approval of 6 months to assess required medical info
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

PA_RESTASIS

Products Affected

- RESTASIS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: CLINICAL DOCUMENTATION OF DIAGNOSIS OF MODERATE-SEVERE DRY EYE, AND THAT POTENTIALLY EXACERBATING EXOGENOUS FACTORS SUCH AS ANTIHISTAMINE OR DIURETIC USE, EXPOSURE TO CIGARETTE SMOKE, AND ENVIRONMENTAL FACTORS HAVE BEEN MAXIMALLY MANAGED. RENEWAL: CLINICAL DOCUMENTATION OF IMPROVED RESPONSE TO THERAPY
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

PALIPERIDONE ER, INVEGA SUSTENNA

Products Affected

- INVEGA SUSTENNA
- INVEGA TRINZA
- *paliperidone*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PATIENT HAS TRIED AND FAILED OR WAS INTOLERANT TO 2 OF THE FOLLOWING FOR EACH INDICATION: SCHIZOPHRENIA: ARIPIPRAZOLE, OLANZAPINE, QUETIAPINE, RISPERIDONE, ZIPRASIDONE. PATIENT HAS NO TRIALS REQUIRED FOR THE FOLLOWING INDICATIONS: SCHIZOAFFECTIVE DISORDER.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

PEMAZYRE

Products Affected
- PEMAZYRE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

PERJETA_NVT 2014

Products Affected
- PERJETA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist or Hematology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

PHESGO

Products Affected

- PHESGO SUBCUTANEOUS SOLUTION 1,200 MG-600MG- 30000 UNIT/15ML, 600 MG-600 MG- 20000 UNIT/10ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

PIQRAY

Products Affected

- PIQRAY ORAL TABLET 200 MG/DAY (200 MG X 1), 250 MG/DAY (200 MG X1-50 MG X1), 300 MG/DAY (150 MG X 2)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PATIENT HAS PROGRESSED ON, OR AFTER, PREVIOUS TREATMENT WITH ENDOCRINE-BASED REGIMEN
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST
Coverage Duration	12 MONTHS
Other Criteria	PIQRAY WILL BE USED CONCURRENTLY WITH FULVESTRANT
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

POMALYST_NVT 2014

Products Affected
- POMALYST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist or Hematology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

PROGESTERONE_NVT 2015

Products Affected

- CRINONE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

PROLIA

Products Affected
- PROLIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	ONE OF THE FOLLOWING: (1) HIGH RISK FOR FRACTURES DEFINED AS ONE OF THE FOLLOWING: A) HISTORY OF OSTEOPOROTIC (I.E., FRAGILITY, LOW TRAUMA) FRACTURE(S). B) 2 OR MORE RISK FACTORS FOR FRACTURE (E.G., HISTORY OF MULTIPLE RECENT LOW TRAUMA FRACTURES, BMD T-SCORE LESS THAN OR EQUAL TO -2.5, CORTICOSTEROID USE, OR USE OF GNRH ANALOGS SUCH AS NAFARELIN, ETC.). C) NO PRIOR TREATMENT FOR OSTEOPOROSIS AND FRAX SCORE OF AT LEAST 20% FOR ANY MAJOR FRACTURE OR OF AT LEAST 3% FOR HIP FRACTURE. (2) UNABLE TO USE ORAL THERAPY (I.E., UPPER GASTROINTESTINAL PROBLEMS UNABLE TO TOLERATE ORAL MEDICATION, LOWER GASTROINTESTINAL PROBLEMS UNABLE TO ABSORB ORAL MEDICATIONS, TROUBLE REMEMBERING TO TAKE ORAL MEDICATIONS OR COORDINATING AN ORAL BISPHOSPHONATE WITH OTHER ORAL MEDICATIONS OR THEIR DAILY ROUTINE). (3) ADEQUATE TRIAL OF, INTOLERANCE TO, OR A CONTRAINDICATION TO BISPHOSPHONATES (E.G., ALENDRONATE, RISEDRONATE, IBANDRONATE).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.

2021 Chinese Community Health Plan Senior Value Program (HMO)

Prior Authorization Criteria
Updated 11/2020

PA Criteria	Criteria Details
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

PROMACTA_NVT 2017

Products Affected
- PROMACTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

QINLOCK

Products Affected
- QINLOCK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

RAVICTI_NVT 2016

Products Affected
- RAVICTI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Requires trial of sodium phenylbutyrate powder.
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, a Metabolic Specialist or Geneticist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

RELISTOR_NVT 2015

Products Affected

- RELISTOR SUBCUTANEOUS SOLUTION
- RELISTOR SUBCUTANEOUS SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Initial Therapy: Member must meet both of the following: 1.Opioid-induced constipation. 2. Trial, or intolerance to, 2 laxative/bowel therapies-polyethylene glycol + Lactulose.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	4 Months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

REMICADE_NVT 2018

Products Affected
- REMICADE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, OR GENITAL AREA. RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSORIASIS PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CROHN'S DISEASE/ULCERATIVE COLITIS: GASTROENTEROLOGIST.
Coverage Duration	INITIAL: CD/UC: 8 MO. RA: 6 MO. PSA/AS/PSO: 4 MO. RENEWAL FOR ALL INDICATIONS: 12 MO.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF ANY TWO PREFERRED AGENTS (HUMIRA, ENBREL, XELJANZ/XELJANZ XR) AND CONCURRENT USE WITH METHOTREXATE. PSORIATRIC ARTHRITIS (PSA): PREVIOUS TRIAL OF ANY TWO PREFERRED AGENTS (HUMIRA, ENBREL, COSENTYX, XELJANZ/XELJANZ XR, STELARA). ANKYLOSING SPONDYLITIS (AS): PREVIOUS TRIAL OF ANY TWO PREFERRED AGENTS (HUMIRA, ENBREL, COSENTYX). PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF ANY TWO PREFERRED AGENTS (HUMIRA, ENBREL, COSENTYX, SKYRIZI, STELARA) AND ONE PREFERRED SYSTEMIC THERAPY (TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE. CROHN'S DISEASE (CD): PREVIOUS TRIAL OF TWO PREFERRED AGENTS (HUMIRA AND

PA Criteria	Criteria Details
	STELARA) AND ONE CONVENTIONAL AGENT SUCH AS A CORTICOSTEROID (I.E., BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE. ULCERATIVE COLITIS (UC): PREVIOUS TRIAL OF BOTH (HUMIRA AND XELJANZ/XELJANZ XR) AND ONE CONVENTIONAL AGENT SUCH AS A CORTICOSTEROID (I.E., BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE.
Indications	All FDA-approved Indications.
Off Label Uses	

REPATHA_2019

Products Affected

- REPATHA PUSHTRONEX
- REPATHA SURECLICK
- REPATHA SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	dual therapy with another PCSK-9 inhibitor, Kynamro (mipomersen), or Juxtapid (lomitapide)
Required Medical Information	For initiation of therapy patient must: A) have one of the following conditions: 1) prior clinical atherosclerotic cardiovascular disease (ASCVD) (see Other Criteria), 2) primary hyperlipidemia [including heterozygous familial hypercholesterolemia (HeFH)] (see Other Criteria), or 3) homozygous familial hypercholesterolemia (HoFH) (see Other Criteria), AND B) for patients with prior clinical ASCVD or primary hyperlipidemia (including HeFH), current LDL-C level is over 70 mg/dL, AND one of the following requirements is met: 1) patient has been treated for 8 weeks or more with a high-intensity statin (atorvastatin 40mg or greater OR rosuvastatin 20mg or greater) in combination with ezetimibe, OR 2) patient is intolerant to statins demonstrated by the failure of 2 or more statins, including an attempt with a low-intensity (pitivastatin OR pravastatin) and alternatively-dosed statin (twice weekly low-dose rosuvastatin OR atorvastatin). For continuation of therapy, patient must: A) have one of the following conditions: 1) prior clinical ASCVD (see Other Criteria), 2) primary hyperlipidemia [including HeFH (see Other Criteria)], or 3) HoFH (see Other Criteria), AND B) demonstrate a reduction of LDL-C on PCSK9 inhibitor therapy
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a Cardiologist, Lipidologist, or Endcrinologist
Coverage Duration	Initial: 3 months. Renewal: contract year subject to formulary change and member eligibility
Other Criteria	Clinical ASCVD defined as acute coronary syndromes, myocardial infarction, stable or unstable angina, coronary or other arterial revascularization procedure, prior stroke or transient ischemic attack, or peripheral arterial disease of presumed atherosclerotic origin. Diagnosis of HeFH must be confirmed by one of the following: 1) DNA-based evidence of mutation in the LDLR, Apo B, OR PCSK9 gain of function

PA Criteria	Criteria Details
	mutation, 2) Untreated LDL-C greater than 190 mg/dl AND tendon xanthomas in patient or first/second degree relative, 3) Untreated LDL-C greater than 190 mg/dl AND either first degree relative less than 60 years of age or second degree relative less than 50 years of age with premature heart disease, OR 4) untreated LDL-C greater than 190 mg/dl AND first or second degree relative with total cholesterol greater than 290 mg/dL. Diagnosis of HoFH confirmed by the following: 1) two parents diagnosed with HeFH OR genetic confirmation of LDL receptor mutation, AND 2) untreated total cholesterol greater 290 mg/dL or LDL-C greater 190 mg/dL, AND 3) either xanthomas present at 10 years of age or younger OR atherosclerotic disease at 20 years of age or younger.
Indications	All FDA-approved Indications.
Off Label Uses	

RETEVMO

Products Affected

- RETEVMO ORAL CAPSULE 40 MG, 80 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

REVATIO_NVT 2017

Products Affected

- *sildenafil (pulm.hypertension) intravenous*
- *sildenafil (pulm.hypertension) oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

REVLIMID_NVT 2015

Products Affected

- REVLIMID

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST OR HEMATOLOGIST
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

REXULTI

Products Affected
- REXULTI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PATIENT HAS TRIED AND FAILED OR WAS INTOLERANT TO 2 OF THE FOLLOWING FOR EACH INDICATION: SCHIZOPHRENIA: ARIPIPRAZOLE, OLANZAPINE, QUETIAPINE, RISPERIDONE, ZIPRASIDONE. PATIENT HAS TRIED AND FAILED OR WAS INTOLERANT TO 1 OF THE FOLLOWING FOR EACH INDICATION: MAJOR DEPRESSIVE DISORDER: ARIPIPRAZOLE.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

REYVOW

Products Affected
- REYVOW

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	MIGRAINE IS ACUTE (DEFINED AS LESS THAN 15 MIGRAINE DAYS PER MONTH) AND PHYSICIAN ATTESTATION THAT MIGRAINE IS NOT DUE TO MEDICATION OVERUSE HEADACHE (MOH).
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, A NEUROLOGIST, PAIN SPECIALIST, OR HEADACHE SPECIALIST.
Coverage Duration	12 MONTHS
Other Criteria	PRIOR TRIAL WITH BOTH TRIPTAN (SUMATRIPTAN OR RIZATRIPTAN) AND NON-TRIPTAN (NSAID OR DIHYDROERGOTAMINE) WAS NOT TOLERATED, NOT EFFECTIVE, OR CONTRAINDICATED.
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

RIBOCICLIB_MI_2018

Products Affected

- KISQALI FEMARA CO-PACK ORAL TABLET 200 MG/DAY(200 MG X 1)-2.5 MG, 400 MG/DAY(200 MG X 2)-2.5 MG, 600 MG/DAY(200 MG X 3)-2.5 MG
- KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1), 400 MG/DAY (200 MG X 2), 600 MG/DAY (200 MG X 3)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

RINVOQ

Products Affected
- RINVOQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS: PRESCRIBED BY, OR GIVEN IN CONSULTATION WITH, A RHEUMATOLOGIST,
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	RHEUMATOID ARTHRITIS (RA): INITIAL: PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE.
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

RISPERDAL

Products Affected

- PERSERIS
- RISPERDAL CONSTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PATIENT HAS TRIED AND FAILED OR WAS INTOLERANT TO 2 OF THE FOLLOWING FOR EACH INDICATION: BIPOLAR DISORDER: ARIPIPRAZOLE, OLANZAPINE, QUETIAPINE, RISPERIDONE, ZIPRASIDONE. SCHIZOPHRENIA: ARIPIPRAZOLE, OLANZAPINE, QUETIAPINE, RISPERIDONE, ZIPRASIDONE. PATIENT HAS TRIED AND FAILED OR WAS INTOLERANT TO 1 OF THE FOLLOWING FOR EACH INDICATION: BIPOLAR DEPRESSION: OLANZAPINE. ACUTE MANIC/MIXED EPISODES WITH BIPOLAR DISORDER: ARIPIPRAZOLE.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

ROZLYTREK

Products Affected

- ROZLYTREK ORAL CAPSULE 100 MG, 200 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

RUBRACA_NVT_2017

Products Affected
- RUBRACA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

RUCONEST_NVT 2015

Products Affected
- RUCONEST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

SABRIL_NVT 2017

Products Affected

- *vigabatrin*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, a Neurologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

SAPHRIS

Products Affected
- SAPHRIS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PATIENT HAS TRIED AND FAILED OR WAS INTOLERANT TO 2 OF THE FOLLOWING FOR EACH INDICATION: BIPOLAR DISORDER: ARIPIPRAZOLE, OLANZAPINE, QUETIAPINE, RISPERIDONE, ZIPRASIDONE. SCHIZOPHRENIA: ARIPIPRAZOLE, OLANZAPINE, QUETIAPINE, RISPERIDONE, ZIPRASIDONE. PATIENT HAS TRIED AND FAILED OR WAS INTOLERANT TO 1 OF THE FOLLOWING FOR EACH INDICATION: ACUTE MANIC/MIXED EPISODES WITH BIPOLAR DISORDER: ARIPIPRAZOLE.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

SECUADO

Products Affected
- SECUADO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PATIENT HAS TRIED AND FAILED OR WAS INTOLERANT TO ANY TWO OF THE FOLLOWING FOR EACH INDICATION: SCHIZOPHRENIA: ARIPIPRAZOLE, OLANZAPINE, QUETIAPINE, PALIPERIDONE, RISPERIDONE, ZIPRASIDONE.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

SIGNIFOR_NVT 2015

Products Affected
- SIGNIFOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Prescribed for the treatment of an adult patient with Cushing disease AND Pituitary surgery is not an option OR Pituitary surgery was not curative
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consult with an endocrinologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

SIMPONI_NVT 2018

Products Affected

- SIMPONI
- SIMPONI ARIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS: PRESCRIBED BY, OR IN CONSULTATION WITH, A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY, OR IN CONSULTATION WITH, A RHEUMATOLOGIST OR DERMATOLOGIST. ULCERATIVE COLITIS: PRESCRIBED BY, OR IN CONSULTATION WITH, A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS: PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO PREFERRED AGENTS (HUMIRA, RINVOQ, ENBREL) AND CONCURRENT USE WITH METHOTREXATE. PSORIATIC ARTHRITIS: PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO PREFERRED AGENTS (HUMIRA, ENBREL, COSENTYX). ANKYLOSING SPONDYLITIS: PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO PREFERRED AGENTS (HUMIRA, ENBREL, COSENTYX). ULCERATIVE COLITIS: PREVIOUS TRIAL OF OR CONTRAINDICATION TO PREFERRED AGENT (HUMIRA) AND ONE OF THE FOLLOWING CONVENTIONAL AGENTS SUCH AS A CORTICOSTEROID (I.E., BUDESONIDE, METHYLPREDINSOLONE), AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE.
Indications	All FDA-approved Indications.

2021 Chinese Community Health Plan Senior Value Program (HMO)

Prior Authorization Criteria
Updated 11/2020

PA Criteria	Criteria Details
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

SIRTURO_NVT

Products Affected
- SIRTURO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, an infectious disease specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

SIVEXTRO_NVT 2015

Products Affected
- SIVEXTRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Restricted to Infectious Disease Specialist or in consult with Infectious Disease Specialist.
Coverage Duration	Approved for 6 months subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

SKYRIZI

Products Affected
- SKYRIZI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE OR GENITAL AREA. RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY, SUCH AS PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

SOLARAZE_NVT 2017

Products Affected

- *diclofenac sodium topical gel 3 %*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

SOLTAMOX_NVT

Products Affected
- SOLTAMOX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

SOMAVERT_NVT 2017

Products Affected

- SOMAVERT SUBCUTANEOUS RECON SOLN 15 MG, 20 MG, 25 MG, 30 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, an Endocrinologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

SOVALDI_NVT PA 2018

Products Affected

- SOVALDI ORAL PELLETS IN PACKET 150 MG, 200 MG
- SOVALDI ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HCV RNA LEVEL WITHIN PAST 6 MONTHS.
Age Restrictions	MEMBER MUST BE 3 YEARS OF AGE OR OLDER.
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATIONS WITH: GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST)
Coverage Duration	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

SPRITAM_NVT 2017

Products Affected

- SPRITAM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Member must have a trial or contraindication to generic levetiracetam.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

SPRYCEL_NVT 2017

Products Affected
- SPRYCEL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an Oncologist or Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

STELARA

Products Affected
- STELARA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, OR FACE. RENEWAL FOR PSORIATIC ARTHRITIS OR PLAQUE PSORIASIS: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PLAQUE PSORIASIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST. CROHN'S DISEASE: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO AT LEAST ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION AT LEAST ONE CONVENTIONAL THERAPY SUCH AS PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE. CROHN'S DISEASE (CD): PREVIOUS TRIAL OF OR CONTRAINDICATION TO AT LEAST ONE CONVENTIONAL THERAPY SUCH AS CORTICOSTEROIDS

PA Criteria	Criteria Details
	(I.E. BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE.
Indications	All FDA-approved Indications.
Off Label Uses	

STIVARGA_NVT 2014

Products Affected
- STIVARGA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

STRENSIQ (CCHP)

Products Affected

- STRENSIQ SUBCUTANEOUS SOLUTION 40 MG/ML, 80 MG/0.8 ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, a Pediatric Endocrinologist, Metabolic Specialist, or Genetic Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

SUCRAID_NVT 2017

Products Affected
- SUCRAID

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

SUNOSI

Products Affected

- SUNOSI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	FOR NARCOLEPSY: 1) DIAGNOSIS OF EXCESSIVE DAYTIME SLEEPINESS SECONDARY TO NARCOLEPSY PERSISTING FOR AT LEAST 3 MONTHS. FOR OBSTRUCTIVE SLEEP APNEA: 1) DIAGNOSIS OF EXCESSIVE DAYTIME SLEEPINESS SECONDARY TO OBSTRUCTIVE SLEEP APNEA PERSISTING FOR AT LEAST 3 MONTHS AND 2) THE PATIENT IS ON ONGOING TREATMENT TO ADDRESS THE OBSTRUCTIVE CAUSES OF OSA, FOR AT LEAST ONE MONTH SINCE INITIATION, AND HAVE BEEN COUNSELED ON WEIGHT-LOSS INTERVENTION (IF BMI GREATER THAN 30).
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, A NEUROLOGIST, PSYCHIATRIST, PULMONOLOGIST, OR SLEEP MEDICINE SPECIALIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: FOR NARCOLEPSY: A PRIOR TRIAL OF STIMULANTS (E.G. AMPHETAMINE, METHYLPHENIDATE) AND MODAFINIL WAS NOT EFFECTIVE OR NOT TOLERATED. FOR OBSTRUCTIVE SLEEP APNEA: A PRIOR TRIAL OF MODAFINIL WAS NOT EFFECTIVE OR NOT TOLERATED. RENEWAL: THERE IS CLINICAL DOCUMENTATION OF A SUSTAINED IMPROVEMENT OF SYMPTOMS COMPARED TO BASELINE. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.
Indications	All FDA-approved Indications.
Off Label Uses	

SUTENT_NVT 2017

Products Affected
- SUTENT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

SYLATRON_NAVITUS

Products Affected

- SYLATRON SUBCUTANEOUS KIT
  200 MCG, 300 MCG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consult with an Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

SYNAGIS_NVT 2015

Products Affected

- SYNAGIS INTRAMUSCULAR SOLUTION 50 MG/0.5 ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Approve up to five (MAXIMUM) monthly doses of Synagis when an infant or child meets the criteria for one of the following conditions: Infants and children younger than 24 months with chronic lung disease of prematurity (CLD previously known as bronchopulmonary dysplasia) receiving medical therapy within 6 months before the start of the RSV season OR Infants born before 32 weeks of gestation even if they do not have CLD OR Infants born at 32 to less than 35 weeks of gestation, particularly when at least 1 of the following 2 risk factors is present: the infant attends child care, or 1 or more siblings or other children younger than 5 years live permanently in the same household OR Infants with congenital abnormalities of the airway or neuromuscular disease OR Infants and children 24 months or younger with hemodynamically significant cyanotic or acyanotic congenital heart disease (CHD).
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, an ICU physician, Neonatologist, Pediatric Specialist, Pulmonologist, Cardiologist, Infectious Disease Specialist, or Neurologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

SYPRINE_NVT 2017

Products Affected

- *trientine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

TABRECTA

Products Affected
- TABRECTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

TAFINLAR_NVT 2016

Products Affected
- TAFINLAR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consult with an Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

TAGRISSO_NVT

Products Affected
- TAGRISSO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by an Oncology Specialist or in consultation with an Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

TALZENNA_2019

Products Affected

- TALZENNA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	RESTRICTED TO OR IN CONSULTATION WITH AN ONCOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

TARCEVA_NVT 2017

Products Affected

- *erlotinib*
- TARCEVA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

TARGRETIN_NVT 2015

Products Affected

- *bexarotene*
- TARGRETIN TOPICAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Restricted to or in consult with Oncology or Dermatology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

TASIGNA_NVT 2017

Products Affected

- TASIGNA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consult with Oncology Specialist or Hematology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Requires trial of Sprycel for FDA indications that are shared.
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

TAZVERIK

Products Affected

- TAZVERIK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

TECENTRIQ_NVT

Products Affected

- TECENTRIQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH ONCOLOGY SPECIALIST.
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

TECFIDERA_MI_2018

Products Affected

- TECFIDERA ORAL CAPSULE,DELAYED RELEASE(DR/EC) 120 MG, 120 MG (14)- 240 MG (46), 240 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

TESTOSTERONE

Products Affected

- *testosterone transdermal gel in metered-dose pump 10 mg/0.5 gram /actuation, 12.5 mg/ 1.25 gram (1 %), 20.25 mg/1.25 gram (1.62 %)*
- *testosterone transdermal gel in packet 1 % (25 mg/2.5gram), 1 % (50 mg/5 gram), 1.62 % (20.25 mg/1.25 gram), 1.62 % (40.5 mg/2.5 gram)*
- *testosterone transdermal solution in metered pump w/app*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Two morning testosterone levels fall below the normal range for a healthy adult male. Patient must have tried and failed ANDRODERM and ANDROGEL.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

THALOMID_NVT 2015

Products Affected
- THALOMID

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Restricted to or in consult with Oncology Specialist or infectious disease specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

TIBSOVO

Products Affected
- TIBSOVO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	IDH1 mutation detected by an FDA-approved test
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN ONCOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

TIGAN_NVT 2017

Products Affected

- *trimethobenzamide oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

TIRF

Products Affected

- *modafinil*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.
Indications	All FDA-approved Indications.
Off Label Uses	

TOBI_NVT 2015

Products Affected

- TOBI PODHALER INHALATION CAPSULE, W/INHALATION DEVICE
- *tobramycin in 0.225 % nacl*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Restricted to or in consult with Infectious Disease or Pulmonology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Approval will be based off BvD coverage determination.
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

TOPICAL STEROIDS_NVT 2017

Products Affected

- APEXICON E
- *clocortolone pivalate*
- DESONATE
- *desonide topical gel*
- *halcinonide*
- HALOG TOPICAL CREAM
- HALOG TOPICAL OINTMENT
- PANDEL
- TRIDESILON

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Requires trial of two formulary topical steroids
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

TOTAL PARENTERAL NUTRITION AGENT

Products Affected

- AMINOSYN 7 % WITH ELECTROLYTES
- AMINOSYN 8.5 %-ELECTROLYTES
- AMINOSYN II 10 %
- AMINOSYN II 15 %
- AMINOSYN II 7 %
- AMINOSYN II 8.5 %
- AMINOSYN II 8.5 %-ELECTROLYTES
- AMINOSYN-HBC 7%
- AMINOSYN-PF 10 %
- AMINOSYN-PF 7 % (SULFITE-FREE)
- AMINOSYN-RF 5.2 %
- CLINIMIX 5%/D15W SULFITE FREE
- CLINIMIX 5%/D25W SULFITE-FREE
- CLINIMIX 4.25%-D25W SULF-FREE
- CLINIMIX 4.25%/D10W SULF FREE
- CLINIMIX 4.25%/D5W SULFIT FREE
- CLINIMIX 5%-D20W(SULFITE-FREE)
- CLINIMIX E 2.75%/D5W SULF FREE
- CLINIMIX E 4.25%/D10W SUL FREE
- CLINIMIX E 4.25%/D5W SULF FREE
- CLINIMIX E 5%/D15W SULFIT FREE
- CLINIMIX E 5%/D20W SULFIT FREE
- CLINISOL SF 15 %
- FREAMINE HBC 6.9 %
- HEPATAMINE 8%
- NEPHRAMINE 5.4 %
- PLENAMINE
- PREMASOL 10 %
- PROCALAMINE 3%
- PROSOL 20 %
- TRAVASOL 10 %
- TROPHAMINE 10 %
- TROPHAMINE 6%

PA Criteria	Criteria Details
Exclusion Criteria	PATIENTS RECEIVING TOTAL PARENTERAL NUTRITION FOR A NONFUNCTIONING DIGESTIVE TRACT.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

TRACLEER_NVT 2015

Products Affected

- TRACLEER ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Restricted to or in consult with Pulmonology or Cardiology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

TREANDA_NVT 2015

Products Affected

- TREANDA INTRAVENOUS RECON SOLN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

TRODELVY

Products Affected
- TRODELVY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

TROKENDI_NVT 2014

Products Affected

- *topiramate oral capsule,sprinkle,er 24hr*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has tried and failed topiramate (TOPAMAX) AND patient has a diagnosis of partial-onset seizures, primary generalized tonic-clonic seizures, seizures associated with Lennox-Gastaut syndrome, or migraines where topiramate ER is being used for migraine prophyaxis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

TUKYSA

Products Affected
- TUKYSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN ONCOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

TURALIO

Products Affected

- TURALIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

TYKERB_NVT

Products Affected

- TYKERB

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Tykerb is prescribed in combination with capecitabine (Xeloda) AND The patient has advanced or metastatic breast cancer with tumor over-expression of HER2 AND The patient has recieved prior therapy including an anthracycline and a taxane and trastumab. Tykerb is prescribed in combination with letrozole for the treatment of postmenopausal women with hormone receptor positive metastatic breast cancer that overexpresses the HER2 receptor for whom hormonal therapy is indicated.
Age Restrictions	
Prescriber Restrictions	Approval requires the prescriber to be an Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

TYSABRI_NVT 2018

Products Affected
- TYSABRI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	CROHN'S DISEASE: GASTROENTEROLOGIST.
Coverage Duration	MULTIPLE SCLEROSIS: 12 MONTHS. CROHN'S DISEASE: 6 MONTHS. RENEWAL: CROHN'S: 12 MONTHS
Other Criteria	MULTIPLE SCLEROSIS: TRIAL OF ONE OF THE FOLLOWING PREFERRED AGENTS FOR MULTIPLE SCLEROSIS: GILENYA, MAYZENT, MAVENCLAD, COPAXONE, REBIF, AVONEX, PLEGRIDY, TEDFIDERA, OR AUBAGIO. CROHN'S DISEASE: TRIAL OF A HUMIRA AND STELARA. NOT APPROVED FOR PATIENTS ON CONCURRENT THERAPY WITH A TNF (TUMOR NECROSIS FACTOR) INHIBITOR: ENBREL, CIMZIA, REMICADE, SIMPONI, OR SIMPONI ARIA.
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

UCERIS_NVT

Products Affected

- *budesonide oral tablet,delayed and ext.release*
- UCERIS RECTAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has active mild to moderate ulcerative colitis and has tried and failed or was intolerant to mesalamine.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

UPTRAVI_NVT 2017

Products Affected

- UPTRAVI ORAL TABLET
- UPTRAVI ORAL TABLETS,DOSE PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

VALCHLOR_NVT 2017

Products Affected

- VALCHLOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has received prior skin-directed therapy such as topical steroids.
Age Restrictions	
Prescriber Restrictions	Prescribed by Oncology Specialist or Dermatology Specialist or in consultation with an Oncology or Dermatology Specialist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

VASCEPA_NVT 2016

Products Affected

- VASCEPA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PATIENT HAS TRIGLYCERIDE LEVEL GREATER THAN OR EQUAL TO 150 MG/DL.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

VENCLEXTA_NVT

Products Affected

- VENCLEXTA
- VENCLEXTA STARTING PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist or Hematologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

VENTAVIS_NVT 2015

Products Affected
- VENTAVIS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis confirmed by right heart catheterization.
Age Restrictions	
Prescriber Restrictions	Restricted to or on consult with Pulmonology or Cardiology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

VERZENIO_CCHP_2018

Products Affected
- VERZENIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of HR+ HER2- advanced or metastatic breast cancer
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

VITRAKVI_2018

Products Affected
- VITRAKVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY AN ONCOLOGY SPECIALIST OR IN CONSULTATION WITH AN ONCOLOGY SPECIALIST.
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

VIZIMPRO

Products Affected
- VIZIMPRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	RESTRICTED TO OR IN CONSULTATION WITH AN ONCOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

VORICONAZOLE_NVT 2015

Products Affected

- *voriconazole*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Infectious Disease Specialist or Oncologist or in consultation with an Infectious Disease Specialist or Oncologist concerning the patient.
Coverage Duration	Approved for six months subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

VOSEVI_CCHP_2018

Products Affected

- VOSEVI

PA Criteria	Criteria Details
Exclusion Criteria	MODERATE OR SEVERE HEPATIC IMPAIRMENT (CHILD-PUGH B OR C).
Required Medical Information	HCV RNA level within past 6 months
Age Restrictions	
Prescriber Restrictions	Prescribed by or given in consultation with: gastroenterologist, infectious disease specialist, physician specializing in the treatment of hepatitis (hepatologist), or a specially trained group such as ECHO (extension for community healthcare outcomes) model.
Coverage Duration	Criteria will be applied consistent with current AASLD/IDSA guidance.
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance. Patient is not concurrently taking any of the following medications not recommended by the manufacturer: amiodarone, carbamazepine, phenytoin, phenobarbital, oxcarbazepine, rifampin, rifabutin, rifapentine, cyclosporine, pitavastatin, pravastatin (doses above 40mg), rosuvastatin, methotrexate, mitoxantrone, imatinib, irinotecan, lapatinib, sulfasalazine, topotecan, or HIV regimen that contains efavirenz, atazanavir, lopinavir or tipranavir/ritonavir.
Indications	All FDA-approved Indications.
Off Label Uses	

VOTRIENT_NVT

Products Affected
- VOTRIENT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Require the prescriber to be an Oncologist or be in under the direct consultation with an Oncologist.
Coverage Duration	Approved for duration of plan year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

VRAYLAR

Products Affected
- VRAYLAR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PATIENT HAS TRIED AND FAILED OR WAS INTOLERANT TO 2 OF THE FOLLOWING FOR EACH INDICATION: BIPOLAR DISORDER: ARIPIPRAZOLE, OLANZAPINE, QUETIAPINE, RISPERIDONE, ZIPRASIDONE. SCHIZOPHRENIA: ARIPIPRAZOLE, OLANZAPINE, QUETIAPINE, RISPERIDONE, ZIPRASIDONE. PATIENT HAS TRIED AND FAILED OR WAS INTOLERANT TO 1 OF THE FOLLOWING FOR EACH INDICATION: BIPOLAR DEPRESSION: OLANZAPINE. ACUTE MANIC/MIXED EPISODES WITH BIPOLAR DISORDER: ARIPIPRAZOLE.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

XALKORI_NVT

Products Affected
- XALKORI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consult with Oncology Specialist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

XCOPRI

Products Affected

- XCOPRI MAINTENANCE PACK
- XCOPRI ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG
- XCOPRI TITRATION PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	TRIAL OF TWO GENERIC FORMULARY ANTICONVULSANT AGENTS INDICATED FOR PARTIAL-ONSET SEIZURES
Indications	All FDA-approved Indications.
Off Label Uses	

XELJANZ_NVT_18

Products Affected

- XELJANZ
- XELJANZ XR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS: PRESCRIBED BY, OR IN CONSULTATION WITH, A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY, OR IN CONSULTATION WITH, A RHEUMATOLOGIST OR DERMATOLOGIST. ULCERATIVE COLITIS: PRESCRIBED BY, OR IN CONSULTATION WITH, A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS: PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS (HUMIRA, ENBREL, RINVOQ) AND ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. INITIAL: PSORIATIC ARTHRITIS: PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS (HUMIRA, ENBREL, COSENTYX) AND ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. ULCERATIVE COLITIS: PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA AND ONE CONVENTIONAL THERAPY SUCH AS CORTICOSTEROIDS (I.E., BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE.

2021 Chinese Community Health Plan Senior Value Program (HMO)

Prior Authorization Criteria
Updated 11/2020

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

Prior Authorization Criteria
Updated 11/2020

XENAZINE_NVT 2015

Products Affected

- *tetrabenazine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has chorea due to Huntington's Disease.
Age Restrictions	
Prescriber Restrictions	Prescribed by a Neurologist or in consultation with a Neurologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

XGEVA_NVT 2015

Products Affected

- XGEVA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

XIFAXAN 550MG_NVT 2017

Products Affected

- XIFAXAN ORAL TABLET 550 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Prior Authorization required for quantities greater than 2 tablets per day. For quantities of 3 tablets per day, a diagnosis of IBS-D is required.
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

XOLAIR_NVT PA 2015

Products Affected

- XOLAIR SUBCUTANEOUS RECON SOLN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1. If for moderate to severe persistent asthma: There must be objective evidence of reversible airway obstruction AND the patient's lgE level must be within the following range (patients 12 years or older: between 30 IU/ml and 700 IU/ml, OR patients 6 to 12 years: up to 1,300IU/mL), AND the patient must have a positive skin test or RAST test for specific allergic sensitivity and one of the following: Inadequately controlled asthma despite medium dose of inhaled corticosteroids for at least 3 months in combination with a trial of long-acting inhaled beta-agonists OR a leukotriene modifier and systemic steroids OR high dose inhaled corticosteroids are required to maintain adequate asthma control OR intolerance or contradindication to the previously listed drugs. 2. If for chronic idiopathic urticaria, patient remains symptomatic despite H1 antihistamine treatment or has intolerance or contraindication to H1 antihistamine treatment.
Age Restrictions	If for moderate to severe persistent asthma, patient must be at least 6 years old. If for chronic idiopathic urticaria, patient must be at least 12 years old.
Prescriber Restrictions	Prescribed by, or in consultation with, an Allergy Specialist, Pulmonary Specialist, Dermatologist, or Immunologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

XOSPATA

Products Affected

- XOSPATA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	RESTRICTED TO OR IN CONSULTATION WITH AN ONCOLOGIST OR HEMATOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

XPOVIO

Products Affected

- XPOVIO ORAL TABLET 100 MG/WEEK (20 MG X 5), 40 MG/WEEK (20 MG X 2), 40MG TWICE WEEK (80 MG/WEEK), 60 MG/WEEK (20 MG X 3), 60MG TWICE WEEK (120 MG/WEEK), 80 MG/WEEK (20 MG X 4), 80MG TWICE WEEK (160 MG/WEEK)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	RESTRICTED TO, OR IN CONSULTATION WITH, AN ONCOLOGIST OR HEMATOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	MULTIPLE MYELOMA: XPOVIO IS USED IN COMBINATION WITH DEXAMETHASONE.
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

XTANDI_NVT

Products Affected

- XTANDI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY, OR IN CONSULTATION WITH, AN UROLOGY OR ONCOLOGY SPECIALIST.
Coverage Duration	12 MONTHS
Other Criteria	INITIAL: CASTRATION RESISTANT PROSTATE CANCER (CRPC) THAT IS NOT METASTATIC: THE PATIENT HAS HIGH RISK PROSTATE CANCER (I.E. RAPIDLY INCREASING PROSTATE SPECIFIC ANTIGEN [PSA] LEVELS). CRPC (INCLUDES NON-METASTATIC AND METASTATIC) OR METASTATIC CASTRATION-SENSITIVE PROSTATE CANCER (MCSPC): PATIENT MEETS ONE OF THE FOLLOWING: (1) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) AGONIST OR ANTAGONIST OR (2) PREVIOUSLY RECEIVED A BILATERAL ORCHIECTOMY. RENEWAL: A DIAGNOSIS OF CRPC (INCLUDES NON-METASTATIC AND METASTATIC) OR MCSPC.
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

XYREM_NVT 2017

Products Affected
- XYREM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist, pulmonologist, or sleep specialist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

YERVOY_NVT 2015

Products Affected

- YERVOY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with Oncologist or Dermatologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Approval based on BvD determination
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

YONDELIS_NVT_2017

Products Affected
- YONDELIS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

YONSA_2018

Products Affected
- YONSA

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval

Prior Authorization Criteria
Updated 11/2020

ZALTRAP_NVT 2014

Products Affected

- ZALTRAP INTRAVENOUS SOLUTION
  100 MG/4 ML (25 MG/ML)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consult with Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

ZAVESCA_NVT 2017

Products Affected

- *miglustat*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, a Clinical Geneticist, Medical Biochemical Geneticist, Hematologist, or Metabolic Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

ZELBORAF_NVT 2017

Products Affected
- ZELBORAF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

ZEPZELCA

Products Affected

- ZEPZELCA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ZOLINZA_NVT 2015

Products Affected

- ZOLINZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Restricted to or in consult with Oncology or Dermatology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

ZONTIVITY_NVT

Products Affected
- ZONTIVITY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by a Cardiology Specialist or in consultation with an Cardiology Specialist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

ZORTRESS_NVT 2015

Products Affected

- *everolimus (immunosuppressive)*
- ZORTRESS ORAL TABLET 1 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	Coverage determination based on Med-B vs. Med-D review.
Indications	All FDA-approved Indications.
Off Label Uses	

ZYDELIG_NVT

Products Affected
- ZYDELIG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	DIAGNOSIS A: Patient has relapsed CLL, defined as CLL progression less than 24 months since the completion of the last prior therapy AND Idelalisib (ZYDELIG) will be used in combination with rituximab (RITUXAN). DIAGNOSIS B and C: Patient has relapsed follicular B-cell non-Hodgkin lymphoma (FL) OR Patient has relapsed small lymphocytic lymphoma (SLL) AND Patient has received at least two (2) prior systemic therapies.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an Oncologist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ZYKADIA_NVT

Products Affected

- ZYKADIA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Zykadia requires the prescriber to be an Oncologist or under the direct consultation of an Oncologist.
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Prior Authorization Criteria
Updated 11/2020

ZYTIGA_NVT 2015

Products Affected

- *abiraterone*
- ZYTIGA ORAL TABLET 500 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consult with Oncology Specialist or Urology Specialist
Coverage Duration	Approved for duration of contract year subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ZYVOX_NVT 2015

Products Affected

- *linezolid*
- *linezolid in dextrose 5%*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Infectious Disease Specialist or in consultation with an Infectious Disease Specialist concerning the patient.
Coverage Duration	Approved for 6 months subject to formulary change and member eligibility.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

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