MedStar Family Choice High-Cost Medication PA Criteria

Requires MFC Physician or Pharmacist review prior to approval.

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

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	**Approval Criteria & Submission Requirements**	**Renewal Criteria**
Allogeneic processed thymus tissue–agdc (**Rethymic**) **J3590** **NDC: 72359-0001-01**	1. Ordered for an approved indication for use: • Transplantation of allogeneic processed thymic tissue-agdc (Rethymic®) may be considered medically necessary for the treatment of congenital athymia based on flow cytometry documenting fewer than 50 naïve T cells/mm3 (CD45RA+, CD62L+) in the peripheral blood or less than 5% of total T cells being naïve in phenotype when one of the following criteria are met: • Patient has congenital athymia associated with one of the following diagnoses: ○ FOXN1 deficiency ○ Complete DiGeorge syndrome (cDGS), also referred to as complete DiGeorge anomaly (cDGA) ○ 22q11.2 deletion ○ CHARGE Syndrome AND ○ a circulating T cell count on flow cytometry demonstrating fewer than 50 naïve T cells/mm3 (CD45RA+ CD62L+) in the peripheral blood OR ○ less than 5% of the total T cells being naïve in phenotype. 2. Severe combined immunodeficiency (SCID) has been conclusively ruled out by the absence of SCID-causing genetic defects. 3. Heart surgery is not anticipated within 4 weeks prior to OR 3 months after Rethymic treatment. 4. Patient does not have HIV infection. 5. Patient is not a poor surgical candidate.	**Not applicable. Maximum approval, one treatment course per lifetime.**

Updated: December 2023

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
	6. Patient has not previously received thymus tissue transplantation in their lifetime. 7. Dosage will not exceed a single, one-time dose not to exceed 42 slices (approximately 55,000 mm^2 of Rethymic).	
Antihemophil FVIII, B-dom del (**Xyntha**) **J7185** **NDC:** **58394-0016-03** **58394-0022-03** **58394-0023-03,** **58394-0024-03** **58394-0025-03** **58394-0012-01** **58394-0013-01** **58394-0014-01** **58394-0015-01**	1. Ordered for an approved indication for use: treatment of adults and children with hemophilia A for control and prevention of bleeding. 2. Patient does not have von Willebrand's disease. 3. Approval Duration: 3 months.	1. Documentation of positive clinical response to Xyntha therapy. 2. Not using for treatment of von Willebrand's disease. 3. Approval Duration: 3 months.
Avalglucosidase alfa-ngpt (**Nexviazyme**) **J0219** **NDC: 58468-0426-01**	1. Ordered for an approved indication for use: • Treatment of patients ≥ 1 year of age with late-onset Pompe disease (lysosomal acid alpha-glucosidase [GAA] deficiency. 2. Patient aged 1 year or older. 3. Documented diagnosis of late-onset acid alpha-glucosidase deficiency (late-onset Pompe disease) established by ONE of the following: a. A laboratory test demonstrating deficient acid alpha-glucosidase activity in a dry blood spot, fibroblasts, lymphocytes, or muscle tissue.	1. Initial criteria met AND 2. Chart notes documenting a positive response to therapy (e.g. improvement, stabilization, or slowing of disease progression for motor function, walking capacity, respiratory function, muscle strength). 3. Approval duration: 3 months

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
	b. A molecular genetic test demonstrating biallelic pathogenic or likely pathogenic variants in the GAA gene. 4. Will not be used in combination with other enzyme replacement therapies (i.e., alglucosidase alfa). 5. Patient is not susceptible to fluid volume overload or has an acute underlying respiratory illness or compromised cardiac or respiratory function for whom fluid restriction is indicated. 6. Patient has documented baseline values for FVC and/or 6MWT. 7. Medication prescribed by, or in consultation with, a geneticist, neurologist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of lysosomal storage disorders. 8. Quantity limit (max daily dose); 100 mg powder for injection, 23 vials every 14 days. Max units: 2300 mg every 14 days. 9. Initial approval duration is up to 3 months.	
Beremagene geperpavec (**Vyjuvek**) **J3590** **NDC: 82194-0510-02**	1. Ordered for an approved indication for use: • Treatment of wounds in patients with diagnosis of dystrophic epidermolysis bullosa (DEB). 2. Patient age ≥ 6 months. 3. Submission of medical records (e.g., chart notes, laboratory values) confirming a mutation in the collagen type VII alpha 1 chain (COL7A1) gene. 4. Patient has at least one recurrent or chronic open wound that meets all of the following: adequate granulation tissue, excellent vascularization AND no evidence of active wound infection. 5. No evidence or history of squamous cell carcinoma. 6. Prescribed by, or in consultation with, a dermatologist with expertise in the treatment of DEB. 7. Dosing is in accordance with FDA approved labeling. 8. Initial authorization limited to no more than 6 months and no more than 26 doses.	1. Patient has previously been treated with Vyjuvek therapy. 2. Patient had a positive clinical response to Vyjuvek therapy (e.g., decrease in wound size, increase in granulation tissue, complete wound closure). 3. Wound(s) being treated to meet all the following criteria: • Adequate granulation tissue • Excellent vascularization • No evidence of active wound infection • No evidence or history of squamous cell carcinoma • Dosing is in accordance with FDA approved labeling.

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
		4. Reauthorization limited to no more than 6 months and no more than 26 doses.
Berotralstat (**Orladeyo**) capsules 110mg, 150mg **J8499** **NDCs:** **72769-0101-01** **72769-0102-01**	1. Ordered for an approved indication for use: • prophylaxis to prevent attacks of hereditary angioedema (HAE) in adults and pediatric patients 12 years and older. 2. Patient age ≥ 12 years. 3. C1 inhibitor (C1-INH) antigenic level below the lower limit of normal as defined by the laboratory performing the test OR Normal X1-inh antigenic level and a low C1-INH functional level (functional C1-INH less than 50% or C1-INH functional level below the lower limit of normal as defined by the laboratory performing the test. 4. Prescriber attestation that all baseline evaluations have been done, prophylactic therapy is medically necessary, and no contraindications to use. 5. Not used in combination with other approved products indicated for prophylaxis against HAE attacks (i.e., Cinryze, Haegarda, Takhzyro). 6. History of failure to BOTH of the following (document date of trial and list reason for therapeutic failure) Haegarda AND Takhzyro. Alternatively- could be failure of one of the following: Haegarda, Cinryze, Takhzyro. 7. Quantity limit of 1 capsule per day 8. Prescriber is a hematologist, immunologist, or allergist. 9. Initial approval duration: 3 months	1. Member meets the criteria for initial approval. 2. Member has experienced a significant reduction in frequency of attacks (≥ 50%) since starting treatment. 3. Member has reduced the use of medications to treat acute attacks since starting treatment. 4. Prescriber attests that patient has had an annual evaluation for the continued need for long-term prophylaxis therapy AND 5. Prescriber attests a recent review of patient's current medication has been completed and there is no concomitant use of P-gp inducers (e.g. rifampin, St John's wort), and dose adjustment has been made based on labeled recommendations for drug interactions if applicable. 6. Approval Duration: 3 months.
Betibeglogene autotemcel (**Zynteglo**) **J3590**	1. Ordered for the treatment: • of adult or pediatric patients with Beta-thalassemia who require regular red blood cell (RBC) transfusions. 2. Patient aged ≥ 5 years and ≤ 50 years.	**Not applicable. Maximum approval, one treatment course per lifetime.**

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
NDC: 73554-3111-01	3. Patient has documented diagnosis of beta-thalessemia (excludes alpha-thalassemia and hemoglobin S/Beta-thalassemia variants) as defined by: • Confirmation by HBB sequence gene analysis showing biallelic pathogenic variants OR • Patient has severe microcytic hypochromic anemia, anisopoikilocytosis with nucleated red blood cells on peripheral blood smear, and hemoglobin analysis that reveals decreased amounts or complete absence of hemoglobin A and increased amounts of hemoglobin F. 4. Patient has transfusion-dependent disease defined as a history of transfusions of at least 100 mL/kg/year of packed red blood cells (RBCs) or with 8 or more transfusions of pRBCs per year in the two yers preceding therapy. 5. Patient does **not** have any of the following: • Severely elevated iron in the heart (i.e., patient with cardiac T2* less than 10 msec by magnetic resonance imaging (MRI) • Advanced liver disease as defined by o Alanine transferases or direct bilirubin greater than 3 times the upper limit of normal (ULN). o Baseline prothrombin time or partial thromboplastin time greater than 1.5 times the ULN suspected of arising from liver disease. • Patients with MRI of the liver with results demonstrating liver iron content ≥ 15 mg/g (unless biopsy confirms absence of advanced disease). • Prior treatment with gene therapy • Prior allogeneic hematopoietic stem cell transplant (HSCT)	

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
	• Positive for the presence of HIV type 1 or 2. • Prior malignancy or current malignancy (with the exception of adequately treated cone biopsied in situ carcinoma of the cervix uteri and basal or squamous cell carcinoma of the skin) or myeloproliferative or significant immunodeficiency disorder. • Concurrent use with Reblozyl (luspatercept-aamt subcutaneous injection). 6. Prescribed by hematologist or transplant specialist.	
blinatumomab (**Blincyto**) Injection 35mcg **J9039** **NDC: 55513-0160-01**	1. Ordered for an approved indication for use: • B-cell precursor acute lymphoblastic leukemia (ALL) in first or second complete remission with minimal residual disease (MRD) greater than or equal to 0.1%. • Relapsed or refractory B-cell precursor acute lymphoblastic leukemia (ALL). 2. Confirmation that drug carries current FDA-approval for indication. All other indications are considered experimental/ investigational and not medically necessary. 3. Testing or analysis confirming CD19 protein on the surface of the B cell. 4. The medication will be used as consolidation or maintenance therapy OR for relapsed or refractory disease. 5. Medication ordered by an Oncologist or hematologist. 6. Initial authorization limited to 3 months.	1. No evidence of unacceptable toxicity (e.g. Cytokine Release Syndrome (CRS), neurological toxicities, serious infections, pancreatitis etc.) disease progression while on current regimen. 2. Confirmation that drug carries current FDA-approval for indication. 3. Limited to 3 months.
brentuximab (**Adcetris**) injection 50mg **J9042**	1. Prescribed for an approved indication for use: • Previously untreated Stage III or IV classical Hodgkin lymphoma (cHL), in combination with doxorubicin, vinblastine, and dacarbazine.	1. There is no evidence of unacceptable toxicity or disease progression. 2. Approval duration: 3 months.

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
NDC: 51144-0050-01	• Classical Hodgkin lymphoma (cHL) at high risk of relapse or progression as post-autologous hematopoietic stem cell transplantation (auto-HSCT) consolidation. • Classical Hodgkin lymphoma (cHL) after failure of auto-HSCT or after failure of at least two prior multi-agent chemotherapy regimens in patients who are not auto-HSCT candidates. • Previously untreated systemic anaplastic large cell lymphoma (sALCL) or other CD30-expressing peripheral T-cell lymphomas (PTCL), including angioimmunoblastic T-cell lymphoma and PTCL not otherwise specified, in combination with cyclophosphamide, doxorubicin, and prednisone. • Systemic anaplastic large cell lymphoma (sALCL) after failure of at least one prior multi-agent chemotherapy regimen. • Primary cutaneous anaplastic large cell lymphoma (pcALCL) or CD30- expressing mycosis fungoides (MF) who have received prior systemic therapy. 2. Documentation of testing/analysis that confirms CD30 expression on the surface of the cell. 3. For B-cell lymphomas: patient is not a candidate for stem-cell transplant. 4. Approval Duration: 3 months.	
burosumab-twza (**Crysvita**) injection 10mg/ml, 20mg/ml, 30mg/ml **Not on MDH list **J0584** **NDCs:**	1. Ordered for an approved indication for use: • Treatment of X-linked hypophosphatemia (XLH) in adult and pediatric patients ≥ 6 months of age. • Treatment of FGF23-related hypophosphatemia in tumor-induced osteomalacia (TIO) associated with phosphaturic mesenchymal tumors that cannot be curatively resected or localized in adult and pediatric patients ≥ 2 years of age. 2. At least one of the following requirements satisfied:	1. Patient has previously received treatment with burosumab. 2. Patient has documented positive clinical response (e.g., enhanced height velocity, improvement in skeletal deformities, reduction in fractures, reduction in generalized bone pain).

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
69794-0304-01 **69794-0203-01** **69794-0102-01**	• Genetic testing results confirming PHEX (phosphate regulating gene with homology to endopeptidases located on the X chromosome) mutation OR • Genetic testing results confirming a PHEX mutation in a direct 3. <u>When used for the treatment of XLH:</u> • Elevated Serum fibroblast growth factor 23 (FGF23) level > 30 pg/ml; AND • Serum phosphate < 3.0 mg/dL (0.97 mmol/L) • Serum Creatinine (SCr) below age adjusted upper limit of normal. • Serum 25(OH)D ≥ 16 mg/mL; • Dosing is in accordance with FDA-approved labeling. • If aged 6 months or greater, than the epiphyseal plate has not fused OR • All of the following: ○ The patient's epiphyseal plate has fused; AND ○ The patient is experiencing clinical signs and symptoms of the disease such as limited mobility, musculoskeletal pain and/or bone fractures; AND ○ Failure, contraindication, or intolerance to vitamin D analog therapy (e.g., calcitriol, paricalcitiol, doxercalciferoll) in combination with an oral phosphate agent (e.g., K-Phos, K-Phos Neutra). 4. <u>When used for the treatment of TIO:</u> • Disease cannot be curatively resected or localized; and • Patient is aged 2 years or greater; and • Failure, contraindication, or intolerance to vitamin D analog therapy (e.g., calcitriol, paricalcitiol, doxercalciferoll) in combination with an oral phosphate agent (e.g., K-Phos, K-Phos Neutra).	3. Dosing is in accordance with FDA-approved labeling. 4. Authorization is limited to a maximum of 12-months.

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
	• Dosing in accordance with FDA-approved labeling. 5. Approval Duration: up to 12 months.	
c1 Inhibitor [Human] **cinryze** sol 500 unit **J0598** **NDC: 42227-0081-05** **haegarda** injection 2000unit, 3000unit **J5099** **NDCs:** **63833-0828-02** **63833-0829-02**	1. Ordered for an approved indication for use: • Routine prophylaxis to prevent Hereditary Angioedema attacks in patients ≥ 6 years of age. 2. Cinryze will be considered for coverage when ALL of the criteria below are met and confirmed with medical documentation. • Diagnosis of hereditary angioedema (HAE) confirmed by one of the following: ○ Confirmed monoallelic mutation known to cause HAE in either the SERPING1 or F12 gene: OR ○ A C4 level below the lower limit of normal and either C1 inhibitor (C1-INH) antigenic level below the lower limit of normal or C1-INH functional level below the lower limit of normal; AND • Used for prophylaxis of acute HAE attacks: AND • Patient is at least 6 years of age; AND • Patient has experienced the following: ○ History of recurrent laryngeal attacks; OR ○ ≥ 2 severe episodes/month (ex. debilitating GI or cutaneous effects); OR ○ ≥ 5 days/month of debilitating symptoms; AND • Prescribed by an allergist, immunologist, hematologist, or other appropriate specialist; AND • Medications known to cause angioedema (ex. ACE-Inhibitors, estrogens, angiotensin II receptor blockers) have been evaluated and discontinued when appropriate. 3. Length of Authorization: 3 months when criteria are met.	1. All of the criteria for initial therapy must be met; AND 2. Provider attests to a positive clinical response. 3. Continuing therapy will be authorized for 3 months.
caplacizumab-yhdp (**Cablivi**) kit	1. Ordered for an approved indication for use: • Treatment of adult patients with acquired thrombotic	1. A request for continuation of therapy is for extension of therapy after the initial

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
11mg **Not on MDH list **J3590** **NDC: 58468-0225-01**	thrombocytopenic purpura (aTTP), in combination with plasma exchange and immunosuppressive therapy. 2. Medication ordered by hematologist. 3. The patient received the requested medication with plasma exchange. 4. Cablivi will be given in combination with immunosuppressive therapy. 5. The patient will not receive Cablivi beyond 30 days from the cessation of plasma exchange unless the patient has documented, persistent aTTP. 6. The patient has not experienced more than 2 recurrences of aTTP while on the requested medicaton. (A recurrence is when the patient needs to reinitiate plasma exchange, a 28-day extension of therapy is not considered a recurrence.) 7. Approval is for 30 days only.	course of Cablivi. The initial course is treatment with Cablivi during and 30 days after plasma exchange. 2. The patient has either of the following documented signs of persistent, underlying aTTP: • ADAMTS13 activity level of < 10%, OR • All of the following: ○ Microangiopathic hemolytic anemia (MAHA) documented by the presence of schistocytes on peripheral smear ○ Thrombocytopenia and ○ Elevated lactate dehydrogenase (LDH) level 3. Cablivi will be given in combination with immunosuppressive therapy. 4. The patient has not received a prior 28-day extension of therapy after the initial course of Cablivi. 5. The patient has not experienced more than 2 recurrences of aTTP while on Cablivi. 6. Approval duration: 30 days.
casimersen (**Amondys 45**) injection 50mg/ml **J1426**	1. Ordered for an approved indication for use: • Treatment of Duchenne muscular dystrophy (DMD) in patients who have a confirmed mutation of the DMD gene that is amenable to exon 45 skipping. 2. Confirmed diagnosis of DMD with genetic confirmation of the DMD gene that is amenable to exon 45 skipping.	1. Not receiving other antisense therapy or gene therapy. **2.** Not ventilator dependent. **3.** Provider attestation of continued benefit without ADE **4.** Max dose 30 mg/kg/dose/week

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
NDC: 60923-0227-02	3. Provider attestation of baseline and subsequent evaluation and monitoring as appropriate such as hypersensitivity reactions and renal function. 4. Be on a stable dose of corticosteroid for ≥ 24 weeks. 5. Not ventilator dependent 6. Not receiving other RNA antisense therapy or gene therapy for DMD. 7. Maximum dose 30 mg/kg/dose once weekly 8. Prescribed by or in consultation with a pediatric neurologist with expertise in DMD. 9. Approval Duration: 3 months.	**5.** Duration: 3 months **Limitations for use:** This indication is approved under accelerated approval based on an increase in dystrophin production in skeletal muscle observed in patients treated with AMONDYS 45. Continued approval for this indication may be contingent upon verification of a clinical benefit in confirmatory trials.
Ciltacabtagene autoleucel (**Carvykti**) **Not on MDH list **Q2054** **NDCs:** **57894-0111-01** **57894-0111-02**	1. Ordered for the treatment of adult patients with relapsed or refractory multiple myeloma after four or more prior lines of therapy including a proteasome inhibitor (e.g., bortezomib, etc), an immunomodulatory agent (e.g., lenalidomide, thalidomide, etc.), an anti-CD38 monoclonal antibody (e.g., daratumumab, isatuximab, etc). 2. Patient is ≥ 18 years of age. 3. Patient has histologically confirmed diagnosis of relapse or refractory multiple myeloma. 4. Patient has not received prior CAR-T or B-cell maturation antigen (BCMA) targeted therapy. 5. Patient has not received prior allogeneic hematopoietic stem cell transplant within 6 months prior to therapy. 6. Patient does not have an active infection or inflammatory disorder. 7. Patient has not received live vaccines within 6 weeks prior to the start of lymphodepleting chemotherapy. 8. Patient has been screened for cytomegalovirus (CMV), hepatitis B virus (HBV), hepatitis C virus (HCV), and human	**Not applicable. Maximum approval, one treatment course per lifetime.**

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
	immunodeficiency virus (HIV) in accordance with clinical guidelines prior to collection of cells (leukapheresis); 9. Carvykti will be used as a single agent therapy. 10. Patient does not have known central nervous system (CNS) involvement with myeloma or a history or presence of clinically relevant, active, CNS pathology. 11. Patient does not have active or a history of plasma cell leukemia. 12. Approval limited to one dose of up to 100 million autologous CAR-positive viable T-cells.	
Coagulation factor IX (**Benefix**) recombinant **J7195** **NDC: 58394-0633-03, 58394-0634-03, 58394-0635-03, 58394-0636-03, 58394-0637-03**	1. Ordered for an approved indication for use: treatment of hemophilia B in adults and children for on-demand treatment and control of bleeding episodes or perioperative management of bleeding. Or in patients ≥ 16 years of age as routine prophylaxis to reduce the frequency of bleeding episodes. 2. Diagnosis of congenital factor IX deficiency confirmed by blood coagulation testing. 3. Not prescribed for use for induction of immune tolerance in patients with hemophilia B. 4. When prescribed for routine prophylaxis to prevent or reduce the frequency of bleeding episodes: o Patient must have severe hemophilia B (factor IX level of < 1%; OR o Patient must have at least two documented episodes of spontaneous bleeding into joints. 5. Dose is calculated per manufacturer guidelines:	1. Patient continues to meet all initial criteria. 2. Absence of unacceptable toxicity from the drug and development of neutralizing antibodies (inhibitors). 3. Any increases in dose must be supported by an acceptable clinical rationale (i.e., weight gain, half-life study results, increased breakthrough bleeding when patient is fully adherent to therapy. 4. The cumulative amount of medication the patient has on-hand does not exceed five doses. 5. Renewal approval duration: 3 months

<table>
<tr><th>Generic Medication (Brand Name)
Bolded medication specifies whether Brand or Generic is on Formulary with PA requirement</th><th>Approval Criteria & Submission Requirements</th><th>Renewal Criteria</th></tr>
<tr><td></td><td>
<table>
<tr><th>Indication</th><th>Dose</th></tr>
<tr><td>Control and prevention of bleeding episodes Hemophilia B

And

Perioperative management of Hemophilia B</td><td><u>Calculating the Initial Dose</u>
One unit per kilogram body weight increases the circulating Factor IX level by 1% (IU/dL).
– Adult & Child (≥12 years): Number of Factor IX IU required = body wt (kg) x Desired increase in Plasma Factor IX(percent) x 1.3 IU/kg;
– Child (<12 years): Number of Factor IX IU required = body wt (kg) x Desired increase in Plasma Factor IX(percent) x 1.4 IU/kg
<u>Minor</u>
Circulating Factor IX required (% of normal) = 20-30 IU/dL - Repeat every 12-24 hours as needed for 1-2 days
<u>Moderate</u>
Circulating Factor IX required (% of normal) = 25-50 IU/dL - Repeat every 12-24 hours as needed for 2-7 days
<u>Major</u>
Circulating Factor IX required (% of normal) = 50-100 IU/dL - Consider repeat dose after 12-24 hours as needed for 7- 10 days.</td></tr>
<tr><td>Routine prophylaxis Hemophilia B</td><td>For long term prophylaxis against bleeding, the recommended regimen is 100 IU/kg once weekly.
– Children (<12 years) have lower recovery, shorter half-life and higher clearance (based on per kg body weight) as compared to adolescents and adults.
– Adjust the dosing regimen (dose or frequency) based on the patient's clinical response.</td></tr>
</table>
6. Authorization duration: 3 months</td><td></td></tr>
<tr><td>cysteamine bitartrate (Procysbi)
capsules
25mg, 75mg
Granules
75mg, 300mg

J8499

NDC: 75987-0101-08</td><td>1. Ordered for an approved indication for use:
• treatment of nephropathic cystinosis in adults and pediatric patients ≥ 1 years of age.
2. Diagnosis of nephropathic cystinosis.
3. Approval duration: 3 months</td><td>1. Documentation of positive clinical response to Procysbi therapy.
2. Absence of hypersensitivity or other adverse reaction.
3. Approval duration: 3 months</td></tr>
<tr><td>Delandistrogene moxeparvovec (Elevidys)</td><td>1. Prescribed for treatment of Duchenne muscular dystrophy (DMD).</td><td>Not applicable. Maximum approval, one treatment course per lifetime.</td></tr>
</table>

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
J3490, J3590 **NDCs:** **60923-0501-10, 60923-0502-11 60923-0503-12, 60923-0504-13, 60923-0505-14 , 60923-0506-15 60923-0507-16, 60923-0508-17, 60923-0509-18, 60923-0510-19, 60923-0511-20, 60923-0512-21, 60923-0513-22, 60923-0514-23, 60923-0515-24, 60923-0516-25, 60923-0517-26, 60923-0518-27, 60923-0519-28, 60923-0520-29, 60923-0521-30, 60923-0522-31, 60923-0523-32, 60923-0524-33, 60923-0525-34, 60923-0526-35, 60923-0527-36, 60923-0528-37, 60923-0529-38, 60923-0530-39, 60923-0531-40, 60923-0532-41, 60923-0533-42, 60923-0534-43, 60923-0535-44, 60923-0536-45, 60923-0537-46, 60923-0538-47, 60923-0539-48, 60923-0540-49, 60923-**	2. Prescribed by, or in consultation with, a pediatric neuromuscular specialist with expertise in the diagnosis of DMD. 3. Submission of medical records confirming both of the following: • A mutation in the DMD gene AND • The mutation is not a deletion in exon 8 or exon 9 4. Patient is aged 4 or 5 years of age. 5. Submission of documentation confirming that the patient is ambulatory without needing an assistive device (e.g., without side-by-side assist, cane, walker, wheelchair, etc.). 6. Patient does not have an elevated anti-AAVrh74 total binding antibody titer ≥ 1:400. 7. Patient will not receive exon-skipping therapies for DMD [e.g., Amondys (casimersen), Exondys 51 (eteplirsen), Viltepso (viltolarsen), Vyondys 53 (golodirsen)] concomitantly or following Elevidys treatment. 8. Patient has never received Elevidys treatment in their lifetime. 9. Dosing in accordance with FDA guidelines: 1.33×10^{14} vector genomes (vg)/kg. 10. Authorization will be issued for no more than one treatment per lifetime and for no longer than 30 days from approval or until 6 years of age, whichever is first.	

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
0541-50, 60923-0542-51, 60923-0543-52, 60923-0544-53, 60923-0545-54, 60923-0546-55, 60923-0547-56, 60923-0548-57, 60923-0549-58, 60923-0550-59, 60923-0551-60, 60923-0552-61, 60923-0553-62, 60923-0554-63, 60923-0555-64, 60923-0556-65, 60923-0557-66, 60923-0558-67, 60923-0559-68, 60923-0560-69, 60923-0561-70		
Eculizumab (**Soliris**) injection 10mg/ml **J1300** **NDC: 25682-0001-01**	1.Ordered for an approved indication for use: • treatment of adult and pediatric patients ≥ 1 month of age with paroxysmal nocturnal hemoglobinuria (PNH). • treatment of adult and pediatric patients ≥ 1 month of age with atypical hemolytic uremic syndrome (aHUS) to inhibit complement-mediated thrombotic microangiopathy (TMA). • treatment of adult patients with generalized myasthenia gravis (gMG) who are anti-acetylcholine receptor (AChR+) antibody positive. • Treatment of neuromyelitis optica spectrum disorder (NMOSD). 2. FDA approved patient age. 3. Documentation to support diagnosis: **PNH:**	1. Clinical documentation must be provided to confirm that current criteria are met and that the medication is providing clinical benefit. 2. **PNH:** • Age ≥ 18 years • Decrease in serum LDH from pre-treatment baseline. • NO dual therapy with another PA medication for PNH (e.g., Empaveli or Ultomiris). **aHUS:** • Decrease in serum LDH from pre-treatment baseline.

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
	• Flow cytometric confirmation of PNH type III red cells; AND • Patient had at least one transfusion in the preceding 24 months; OR • Documented history of major adverse thrombotic vascular events from thromboembolism; OR • Patient has high disease activity defined as lactic dehydrogenase (LDH) level ≥ 1.5 times the upper limit of normal with one of the following symptoms: weakness, fatigue, hemoglobinuria, abdominal pain, dyspnea, hemoglobin, 10 g/dL, a major vascular event, dysphagia, or erectile dysfunction. • History of failure to/contraindication or intolerance to Empaveli therapy; • Patient age < 18 years or currently pregnant. **aHUS:** • Common causes of aHUS have been ruled out, including infectious causes of HUS and thrombotic thrombocytopenic purpura (TTP). • Ultomiris is not indicated for the treatment of patients with Shiga toxin E. coli related hemolytic uremic syndrome (STEC-HUS). • Must present with the following symptoms: ○ Hemoglobin < 10 g/dL ○ Platelets, 150,000/mm^3 ○ Documented evidence of hemolysis, such as elevated LDH levels, decreased haptoglobin level or schistocytosis. • Increased serum creatinine OR currently undergoing dialysis. **gMG:** • Patient has not failed previous course of Soliris or Ultomiris	• Patient does not have Shiga toxin E.coli related hemolytic uremic syndrome (STEC-HUS). • NO dual therapy with another PA medication for aHUS (e.g., Ultomiris). **gMG**: • Age ≥ 18 years • Improvement and maintenance of at least a 2-point improvement (reduction) in the MG-ADL score from pre-treatment baseline and reduction of signs and symptoms of MG required to show clinical benefit. • **NOTE:** dose escalation of immunosuppressive therapy, or additional rescue therapy from baseline to treat MG or exacerbation of symptoms during use is considered treatment failure. • Not receiving in combination with Empaveli or Ultomiris. **NMOSD:** • Documentation to demonstrate positive clinical response from baseline as demonstrated by both of the following: • Reduction in the number and/or severity of relapses or signs and symptoms of NMOSD; and

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
	therapy; • Positive serologic test for anti-AChR antibodies; AND • One of the following: ○ History of abnormal neuromuscular transmission test demonstrated by single-fiber electromyography (SFEMG) or repetitive nerve stimulation OR ○ History of positive anticholinesterase test (e.g. edrophonium chloride test) OR ○ Pt has demonstrated improvement in MG signs on oral cholinesterase inhibitors as assessed by the treating neurologist; AND • Patient has MGFA clinical classification of II, III, or IV at initiation of treatment; AND • Patient has Myasthenia gravis-specific activities of daily living scale (MG-ADL) total score ≥ 6 at initiation of treatment; AND • One of the following: ○ History of failure to at least two immunosuppressive agents over the previous 12-months (e.g., azathioprine, mtx, cyclosporing, mycophenolate); OR ○ History of failure to at least one immunosuppressive therapy and has required four or more courses of plasmapheresis/plasma exchanges, and/or intravenous immune globulin over the previous 12 months without symptom control; AND **NMOSD:** • Documentation to support diagnosis of NMOSD by a neurologist confirming: ○ Optic neuritis; or ○ Acute myelitis; or ○ Area postrema syndrome: episode of otherwise	• Maintenance, reduction or discontinuation of dose(s) of any baseline immunosuppressive therapy prior to starting Soliris. • **NOTE:** dose escalation of immunosuppressive therapy, or additional rescue therapy from baseline to treat MG or exacerbation of symptoms during use is considered treatment failure. • Not receiving Soliris therapy in combination with any of the following: Disease modifying therapies for the treatment of MS (e.g., Gilenya, Tecfidera, Ocrevus, etc.); Anti-IL6 therapy (e.g., Actemra, Enspryng), B-cell depletion therapy (e.g., rituximab, Uplizna). • Approval Duration: 3 months.

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
	unexplained hiccups or nausea and vomiting; or ○ Acute brainstem syndrome; or ○ Symptomatic cerebral syndrome with NMOSD-typical brain lesions; AND • Positive serologic test for anti-aquaporin-4 immunoglobulin G (AQP4-IgG)/NMO-IgG antibodies; and • Diagnosis of multiple sclerosis or other diagnoses have been ruled out; and • Patient has not failed a previous course of Soliris therapy; and • History of failure of, contraindication, or intolerance to rituximab therapy; and • History of at least two relapses in the previous 12-months; or • History of at least three relapses during the previous 24-months, at least one relapse withing the previous 12-months; and • Not receiving Soliris therapy in combination with any of the following: Disease modifying therapies for the treatment of MS (e.g., Gilenya, Tecfidera, Ocrevus, etc.); Anti-IL6 therapy (e.g., Actemra, Enspryng), B-cell depletion therapy (e.g., rituximab, Uplizna). 4. Recommended vaccinations at least 2 weeks prior to administration of first dose Soliris. 5. Cannot be used in combination with other medications in the same class, such as Ultomiris. 6. Medication ordered by Hematologist, Nephrologist, or Oncologist. 7. Approval Duration: 3 months	
Efgartigimod alfa-fcab (**Vyvgart**) injection 400mg/20ml	1. Ordered for an approved indication for use: • Treatment of adult patients with anti-acetylcholine receptor antibody positive (AChR+) generalized myasthenia gravis	1. Patient continues to meet initial approval criteria. 2. Patient has absence of toxicity to drug.

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
**Not on MDH list	(gMG) as monotherapy or in combination with glucocorticoids in patients with glucocorticoid-resistant or glucocorticoid-dependent disease. 2. Patient age ≥ 18 years. 3. Patient has Myasthenia Gravis Foundation of America (MGFA) Clinical Classification of Class II, III, or IV at initiation of therapy. 4. MG activities of daily living (MG-ADL) total score of ≥ 5. 5. Documentation of positive serologic test for anti-AChR antibodies. 6. Greater than 50% of baseline MG-ADL score is due to non-ocular symptoms. 7. Patient is currently receiving a stable dose of at least one gMG treatment (including cholinesterase inhibitors, corticosteroids, or non-steroidal immunosuppressants). 8. Documentation of patient's current weight for appropriate dosing. 9. Trial and failure, contraindication or documentation of intolerance to at least two of the following: • Rituximab or biosimilar (e.g., truxima) • Cyclophosphamide • Azathioprine • Mycophenolate mofetil 10. Not currently prescribed with other immunomodulatory therapies (e.g., rEculizumab (Soliris) 11. Medication ordered by or in consultation with a neurologist. 12. Approval Duration: 3 months	3. Patient has had an improvement (reduction) of at least 2-points from baseline in the Myasthenia Gravis-Specific Activities of Daily Living (MG-ADL) total score sustained for at least 4-weeks; and 4. Improvement in muscle strength testing with fatigue maneuvers as evidenced on neurologic examination when compared to baseline; and 5. Patient requires continuous treatment, after an initial beneficial response, due to new or worsening disease activity (Note: a minimum of 50 days must have elapsed from the start of the previous treatment cycle). 6. Approval Duration: 6 months
Elacestrant (**Orserdu**) **Not on MDH list	1. Ordered for an approved indication for use: • Treatment of postmenopausal women or adult men, with estrogen receptor (ER)-positive, human epidermal growth factor receptor 2 (HER2)-negative, *ESR1*-mutated advanced or	1. Patient does not show evidence of progressive disease while on Orserdu therapy. 2. Approval Duration: 12 months.

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
	metastatic breast cancer with disease progression following at least one line of endocrine therapy. 2. For patient aged < 19 years of age: • If criteria in #1 are met, approval shall be granted for 12 months. For patients ≥ 19 years of age: • Diagnosis of breast cancer that is either advanced or metastatic. • The cancer is ER+, HER2(-) and has a confirmed *ESR1* gene mutation. • Patient is either male or a postmenopausal female. • Disease has progressed following at least one line of endocrine therapy. 3. Authorization Duration: 12 months.	
elapegademase-lvlr (**Revcovi**) Injection 1.6mg/ml **J3590, J3490** **NDC: 57665-0002-01**	1. Ordered for an approved indication for use: • treatment of adenosine deaminase severe combined immune deficiency (ADA-SCID) in pediatric and adult patients. 2. Diagnosis of ADA-SCID confirmed by genetic testing 3. Patient has failed bone marrow transplantation or is not a candidate for bone marrow transplantation; 4. Dose does not exceed 0.4 mg/kg per week. 5. Patient aged 3 months or older. 6. Prescribed by or in consultation with an immunologist. 7. Approval duration: 3 months	1. Patient continues to meet initial approval criteria. 2. Dose does not exceed 0.4 mg/kg per week. 3. Patient is responding positively to therapy (e.g., improvement in immune function (T cell, B cell, and natural killer lymphocytes; reduction in frequency/severity of opportunistic infections and decrease from baseline or maintenance of normal red cell dATP levels. 4. Approval duration limited to 3 months.
Elivaldogene autotemecel (**Skysona**) **J3590**	1. Ordered for an approved indication for use: • To slow the progression of neurologic dysfunction in male patients aged 4 to 17 years with early, active cerebral adrenoleukodystrophy (CALD). Early, active CALD refers	**Not applicable. Maximum approval, one treatment course per lifetime.**

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
NDC: 73554-2111-01	to asymptomatic or mildly asymptomatic (neurological function score ≤ 1) boys who have gadolinium enhancement on brain MRI and Loes scores of 0.5-9. 2. Patient is a male aged 4 to 18 years of age. 3. Diagnosis documented and defined by one or more of the following: ○ Elevated very long chain fatty acids (VLCFA) value for ALL of the following: • Concentration of C26: 0 • Ratio of C24: 0 to C22: 0 • Ratio of C26: 0 to C22: 0 **OR** ○ Pathogenic variants in the ABCD1 gene detected by molecular genetic testing; AND 4. Patient has active CNS disease established by central radiographic review of brain MRI demonstrating both: • Loes score between 0.5 and 9 (inclusive) on a 34-point scale; and • Gadolinium enhancement on MRI of demyelinating lesions, and 5. Neurologic Function Score (NFS) ≤ 1 (asymptomatic or mildly symptomatic disease). 6. Patient does not have a full ABCD1-gene deletion. 7. Patient does not have trauma induced disease. 8. Patient is eligible to undergo hematopoietic stem cell transplant (HSCT) and has not had a prior allogeneic-HSCT. 9. Approval for one time only.	
Elosulfase alfa (**Vimizim**) injection 5mg/5ml	1. Ordered for an approved indication for use: • for patients with Mucopolysaccharidosis type IVA (MPS IVA; Morquio A syndrome). 2. Documented diagnosis of MPS IVA with biochemical/genetic	1. Documented clinically significant improvement or stabilization in symptoms 2. Approval Duration: 3 months

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
J1322 **NDC: 68135-0100-01**	confirmation by one of the following: • Absence or marked reduction in N-acetylgalactosamine 6-sulfatase (GALNS) enzyme activity; OR • Sequence analysis and/or deletion/duplication analysis of the GALNS gene for biallelic mutation. 3. Age ≥ 5 years. 4. Dosing and administration: 1.2 mg/kg IV over 3.5-4.5 hours once weekly. 5. Initial approval duration: 3 months	
Etranacogene dezaparvocec (**Hemgenix**) **J1411** **NDCs: 0053-0099-01, 0053-0100-10, 0053-0110-11, 0053-0120-12, 0053-0130-13, 0053-0140-14 , 0053-0150-15, 0053-0160-16, 0053-0170-17, 0053-0180-18, 0053-0190-19, 0053-0200-20, 0053-0210-21, 0053-0220-22, 0053-0230-23, 0053-0240-24, 0053-0250-25, 0053-0260-26, 0053-0270-27, 0053-0280-28, 0053-0290-29,**	1. Ordered for an approved indication for use: • Treatment of adults with Hemophilia B (congenital Factor IX deficiency) who: ○ Currently use Factor IX prophylaxis therapy, or ○ Have current or historical life-threatening hemorrhage, or ○ Have repeated, serious spontaneous bleeding episodes. 2. Patient is ≥ 18 years of age. 3. Has either both: • Diagnosis of severe hemophilia B and • Documentation of endogenous Factor IX levels less than 1% of normal Factor IX (< 0.01 IU/ml); **OR** ALL of the following: • Diagnosis of moderately severe hemophilia B; and • Documentation of endogenous Factor IX levels ≥ 1% ≤ 2%; and • One of the following: ○ Current of historical life-threatening hemorrhage; or ○ Repeated, serious spontaneous bleeding episodes. AND 4. One of the following:	**Not applicable. Maximum approval, one treatment course per lifetime.**

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
0053-0300-30, 0053-0310-31, 0053-0320-32, 0053-0330-33 , 0053-0340-34, 0053-0350-35, 0053-0360-36, 0053-0370-37, 0053-0380-38, 0053-0390-39, 0053-0400-40, 0053-0410-41, 0053-0420-42, 0053-0430-43, 0053-0440-44, 0053-0450-45, 0053-0460-46, 0053-0470-47, 0053-0480-48	• Patient currently uses Factor IX prophylaxis therapy; or • Patient has been determined an appropriate candidate for Hemgenix by the Hemophilia Treatment Center based on willingness to adhere to initial and long-term monitoring and management; AND 5. Patient has had a minimum of 150 exposure days to a Factor IX agent; and 6. Patient does not have a history of inhibitors to Factor IX ≥ 0.6 Bethesda units (BU); and 7. Patient does not screen positive for active Factor IX inhibitors as defined as ≥ 0.6 BU prior to administration of Hemgenix; and 8. Patient has not gone through Immune Tolerance Induction (ITI); 9. Liver health assessments including enzyme testing ALT, AST, ALP, total bilirubin and hepatic ultrasound and elastography are performed to rule out radiological liver abnormalities and/or sustained liver enzyme elevations; and 10. Documentation that the patient has been evaluated for the presence of preexisting neutralizing antibodies to the adenovirus vector (e.g., AAV-5) used to deliver therapy; and 11. Patient has had pre-existing anti-AAV5 neutralizing antibodies measured through the laboratory developed, CLIAvalidated AAV5 Neutralizing Antibody Test1 made available through CSL Behring; and 12. Patient does not have high anti-AAV antibody (e.g., AAV-5) titers that may be associated with a lack of response to treatment. 13. Patient is HIV negative; or if patient is HIV+, and is virally suppressed with anti-viral therapy (i.e., < 200 copies of HIV per mL) and the patient's hepatitis B surface antigen is negative. 14. Patient's hepatitis C antibody is negative; OR if HCV antibody+, then HCV RNA is negative; and	

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
	15. Patient is not currently using antiviral therapy for hepatitis B or C; 16. Patient has not previously received treatment with Hemgenix and 17. Hemgenix will be administered within a Hemophilia Treatment Center (HTC) that holds Federal designation and is listed within the CDC's HTC directory; and 18. Dosed in accordance with the FDA-approved labeling; and 19. Authorization is for not longer than 45-days from approval and is limited to once per life-time.	
evinacumab-dgnb (**Evkeeza**) injection 345mg/2.3ml, 1200mg/8ml **J1305** **NDCs:** **61755-0010-01** **61755-0013-01**	1. Ordered for an approved indication for use: • An adjunct to other low-density lipoprotein-cholesterol (LDL-C) lowering therapies for the treatment of adult and pediatric patients, ≥ 12 years of age, with homozygous familial hypercholesterolemia (HoFH). 2. Documented genetic test confirming homozygous familial hypercholesterolemia (HoFH). 3. Baseline laboratory information required (full lipid panel, genetic testing, negative pregnancy test and documentation of use/counseling regarding contraception to prevent pregnancy 4. Prior trial/failure and/or documented intolerance to one high potency statin (atorvastatin, rosuvastatin) and concurrent ezetimibe. • Must provide laboratory data to support failure/intolerance (full lipid panel, creatinine kinase). • If failure, but no intolerance, lipid lowering therapy should be continued with aa statin and/or ezetimibe. 5. Dosing 15 mg/kg IV every 4 weeks. 6. Initial Approval Duration: 3 months.	1. Meets all initial criteria 2. Must provide documentation of laboratory information to support continued use (full lipid panel) and continued use of concurrent therapies to lower cholesterol 3. Renewal Approval Duration: 3 months
factor VIIa, recombinant human (**NovoSeven RT**) injection	1. Ordered for an approved indication for use: • treatment of bleeding episodes and perioperative management in adults and children with hemophilia A or B	1. Patient continues to meet indication-specific criteria 2. Absence of unacceptable toxicity from

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
1mg, 2mg, 5mg, 8mg **J7189** **NDC: 00169-7201-01**	with inhibitors, congenital Factor VII (FVII) deficiency, and Glanzmann's thrombasthenia with refractoriness to platelet transfusions, with or without antibodies to platelets. • treatment of bleeding episodes and perioperative management in adults with acquired hemophilia. 2. Diagnosis of congenital factor VIII deficiency confirmed by blood coagulation testing. 3. Confirmation that patient has acquired inhibitors to Factor VIII 4. Used as treatment in at least one of the following: • Control and prevention of acute bleeding episodes; or • Perioperative management; or • Routine prophylaxis to prevent or reduce the frequency of bleeding episodes when the following criteria are also met: o Patient has at least two documented episodes of spontaneous bleeding into joints; or o Patient has documented trial and failure of Immune Tolerance Induction (ITI). 5. When ordered for Hemophilia B: • Diagnosis of congenital Factor IX deficiency has been confirmed by blood coagulation testing; and • Confirmation that patient has acquired inhibitors to Factor IX. 6. When ordered for Congenital Factor VII Deficiency: • Diagnosis confirmed by blood coagulation testing. 7. When ordered for Glanzmann's Thromboasthnia: • Diagnosis confirmed by blood coagulation testing; and • The use of platelet transfusions is known or suspected to be ineffective or contraindicated. 8. Medication ordered by a Hematologist. 9. Approval Duration:	drug; and 3. Any dose increases must be supported by an acceptable clinical rationale (i.e., weight gain, half-life study results, increase in break-through bleeding when patient is fully adherent to therapy, etc). 4. The cumulative amount of medication that the patient has on-hand will be considered. The authorization will allow up to 5 doses on hand for the treatment of acute bleeding episodes as needed for the duration of the authorization. 5. Renewal duration: 3 months.

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
	• For perioperative management of bleeding: 1 month. • All other indications: up to 3 months.	
Factor VIII, recombinant human with VWF fusion (Altuviiio) **J3490, J3590** **NDCs:** **71104-0978-01** **71104-0979-01** **71104-0980-01** **71104-0981-01** **71104-0982-01** **71104-0983-01** **71104-0984-01**	1. Ordered to treat an approved indication: • Routine prophylaxis to reduce the frequency of bleeding episodes. • On-demand treatment and control of bleeding episodes • Perioperative management of bleeding Altuviiio is not indicated for the treatment of von Willebrand disease. 2. Diagnosis of hemophilia A. 3. Patient is not a suitable candidate for treatment with shorter acting half-life Factor VIII (recombinant) products [e.g., Advate, Kogenate FS, Kovaltry, Novoeight, Nuwiq, or Recombinate] as attested by the prescribing physician. 4. Both of the following: (1) Dose does not exceed 50 IU/kg -AND- Patient is infusing no more frequently than every 7 days. 5. Authorization of therapy will be issued for 3 months.	1. Documentation of positive clinical response to Altuviiio therapy. 2. Dose does not exceed 50 IU/kg 3. Patient is infusing no more frequently than every 7 days. 4. Duration of therapy will be issued for 3 months.
factor VIII, recombinant human pegylated (**Jivi**) injection 500 unit, 1000unit, 2000unit, 3000unit **Not on MDH list	1. Ordered for an approved indication for use: • On-demand treatment and control of bleeding episodes in adults and adolescents ≥ 12 years of age with hemophilia A. • Perioperative management of bleeding. • Routine prophylaxis to reduce the frequency of bleeding episodes. 2. Patient has previously received Factor VIII replacement therapy. 3. Not for the treatment of von Willebrand disease. 4. Medication ordered by a Hematologist. 5. Authorization Duration: 12 months.	1. Documentation of positive clinical response to Jivi therapy. 2. Authorization Duration: 12 months.
Factor VIII rec, Fc fusion prot (**Eloctate**) **J7205**	1. Ordered for an approved indication for use: • Treatment of adults and children with Hemophilia A (congenital Factor VIII deficiency) for:	1. Documentation of positive response to Eloctate therapy. 2. Dosing is within guidelines for initial authorization.

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
NDC: 71104-0801-01, 71104-0802-01, 71104-0803-01, 71104-0805-01, 71104-0806-01;71104-0807-01 71104-0808-01, 71104-0809-01, 71104-0810-01	○ On-demand treatment and control of bleeding episodes. ○ Perioperative management of bleeding; ○ Routine prophylaxis to reduce the frequency of bleeding episodes. 2. Patient is not being treated for von Willebrand disease. 3. Patient is not a suitable candidate for treatment with shorter acting half-life Factor VIII products (e.g., Novoeight) as attested by the prescribing physician. 4. Dose does not exceed 50 IU/kg **AND** 12.5 IU/kg/day **AND** patient is infusing no more frequently than every 4 days **UNLESS**: 5. Patient is less than 6 years of age; and • Pharmacokinetic testing (PK) results suggest that dosing more intensive than 50 IU/kg is required: OR • PK testing results suggest that dosing more frequent than every 3.5 days is required; OR • PK testing results suggest that dosing more intensive than 14.5 IU/kg/day is required. 6. Authorization duration: 3 months.	3. Approval Duration: 3 months.
Fosdenopterin (**Nulibry**) injection 9.5mg **J3490** **NDC: 73129-0001-01**	1. Ordered for an approved indication for use: • To reduce mortality risk in patients with molybdenum cofactor deficiency (MoCD) Type A. • Diagnosis confirmed by genetic testing. 2. Will not be used in combination with other substrate replacement therapy (e.g., recombinant cyclic pyranopterin monophosphate, etc.); AND 3. Must be prescribed by, or in consultation with, a specialist in medical genetics or pediatric neurology. 4. Diagnosis of MoCD Type A is confirmed by molecular genetic testing, by a mutation in the *MOCS1* gene suggestive of disease.	1. Patient continues to meet initial approval criteria as listed. 2. Absence of unacceptable toxicity from the drug (e.g., severe phototoxicity, clinically significant infection). 3. Disease response compared to pre-treatment baseline as evidenced by the following: • Reduction in urinary SSC normalized to creatinine; and

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
	5. Patient has biochemical features suggestive of MoCD Type A (i.e., elevated sulfites in urine, low serum uric acid, elevated urinary xanthine and hypoxanthine) and will be treated presumptively while awaiting genetic confirmation; and 6. Patient has baseline values for the following: • Elevated urinary s-sulfocysteine (SSC) normalized to creatinine; and • Clinical notes regarding signs and symptoms of disease which may include, but are not limited to, seizure frequency/duration, growth, and developmental milestones. 7. Approval Duration: 3 months	• Stabilization or improvement in one or more signs and symptoms of disease including, but not limited to, seizure frequency/duration, growth, achievement of developmental milestones; OR 4. Patient initiated therapy as an inpatient based on presumptive diagnosis of MoCD Type A which was subsequently confirmed by genetic testing; AND patient is responding to therapy compared to one or more pre-treatment baseline parameters which prompted the workup for MoCD. 5. Approval Duration: 3 months
Givosiran (**Givlaari**) **J0223** **NDC: 71336-1001-01**	1. Ordered for an approved indication for use: • Treatment of adults with acute hepatic porphyria (AHP). 2. Diagnosis of acute hepatic AHP (i.e., acute intermittent porphyria, hereditary coproporphyria, variegate porphyria, ALA dehydratase deficient porphyria. 3. One of the following: • Patient has active disease as defined in the clinical trial by having at least two documented porphyria attacks within the previous 6 months; or • Patient is currently receiving treatment with prophylactic hemin to prevent porphyria attacks; and 4. Provider attestation that the patient's baeline (pre-treatment) hemin administration requirements and rate and/or number of porphyria attacks has been documented; and	1. Patient has previously received Givlaari for the treatment of AHP; and continues to meet initial approval criteria. 2. Documentation that the patient has experienced a positive clinical response while on Givlaari by demonstrating all of the following from pre-treatment baseline: • Reduction in hemin administration requirements. • Reduction in the rate and/or number of porphyria attacks

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
	5. Patient has not had a liver transplant; and 6. Patient will not receive concomitant prophylactic hemin treatment while on Givlaari; and 7. Prescribed by, or in consultation with, a hematologist, or a specialist with expertise in the diagnosis and management of AHPs; and 8. Dosing is in accordance with FDA-approved labeling. 9. Authorization Duration: 3 months.	• Improvement in signs and symptoms of AHPs (pain, neurological, gastrointestinal, renal, quality of life, etc). 3. Authorization Duration: 3 months.
glycerol phenylbutyrate (**Ravicti**) Liquid 1.1grams/ml **J8499** **NDC: 75987-0050-06**	1. Ordered for an approved indication for use: • chronic management of patients with urea cycle disorders (UCDs) who cannot be managed by dietary protein restriction and/or amino acid supplementation alone. 2. Confirmed diagnosis of urea cycle disorders (UCD's) as evidenced by plasma ammonia concentration of 150 micromole/L or higher associated with a normal anion gap and a normal plasma glucose concentration; and molecular genetic testing or measurement of enzyme activity. 3. Age ≥ 2 years of age. 4. Patient must have tried and failed Buphenyl® as evidenced by unmanaged chronic hyperammonia over a 12-month period. 5. Patient must have history of inadequate response to either dietary protein restriction or amino acid supplementation AND must be actively on dietary protein restriction. 6. Prescriber is a geneticist or other experienced clinician familiar with the management of UCD's. 7. Authorization Duration: 3 months.	1. All initial criteria are met; and 2. Documentation of positive clinical response to Ravicti therapy; and 3. Patient is actively on dietary protein restriction and, in some cases, dietary supplements (e.g., essential amino acids, arginine, citrulline, protein-free calorie supplements) 4. Approval Duration: 3 months. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trials.
Golodirsen (**Vyondys 53**) injection 100mg/2ml	1. Ordered for an approved indication for use: • treatment of Duchenne muscular dystrophy (DMD) in patients who have a confirmed mutation of the DMD gene that is amenable to exon 53 skipping.	1. All initial criteria are met; and 2. Patient has experienced a benefit from therapy, is tolerating therapy, AND

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
J1429 **NDC: 60923-0465-02**	2. Genetic testing must confirm patient's DMD gene is amenable to exon 53 skipping. 3. Patient is older than 6 years of age or older, but age ≤ 15 years at therapy initiation. 4. Be on stable dose of corticosteroid for ≥ 24 weeks; and 5. Not ventilator dependent; and 6. Not receiving other RNA antisense therapy or gene therapy for DMD. 7. Baseline renal function test (GFR) and Urine protein-to-creatinine ratio prior to starting treatment. 8. Documented baseline function testing using a tool to demonstrate physical functions, including, but not limited to: Brooke Upper Extremity Scale, Baseline 6-minute walk test, Pediatric Evaluation of Disability Inventory. 9. Prescribed by or in consultation with a neurologist with expertise in DMD. 10. Maximum dose 30 mg/kg/dose once weekly. 11. Initial authorization period: 3 months.	medical records documenting that the patient is maintaining ambulatory status. **3. Total course of therapy has not exceeded 12 months.** 4. Approval Duration: 3 months
Human plasma-derived plasminogen (**Ryplazim**) **J2998** **NDCs:** **70573-0099-01** **70573-0099-02**	1. Ordered for an approved indication for use: • Treatment of patients with plasminogen deficiency type 1 (hypoplasminogenemia). 2. Patient has symptomatic internal or external lesions consistent with plasminogen deficiency Type 1 (i.e., ligeneous conjunctivitis, ligeneous gingivitis, and/or pseudomembranous lesions on mucus membranes (middle ear, respiratory tract, GI tract); and 3. The patient's baseline (pre-treatment) plasminogen activity has been assessed; and 4. Prescribed by, or in consultation with, a specialist in the area of the patient's diagnosis (e.g., ophthalmologist, specialist from a hemophilia and thrombosis treatment center).	1. The patient continues to meet the criteria for initial approval. 2. The patient has at least one of the following: • At least a 10% increase in plasminogen activity from baseline. • At least a 50% improvement in symptomatic internal or external lesion numbers or size from baseline; or

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
	5. Approval Duration: 3 months.	• Information has been provided to support the continued use of Ryplazim. 3. Approval Duration: 3 months.
idecabtagene vicleucel (**Abecma**) injection **Not on MDH list **J3490, J3590** **NDCs:** **59572-0515-01** **59572-0515-02** **59572-0515-03**	1. Ordered for an approved indication for use: • To treat relapsed or refractory multiple myeloma in adults after ≥4 prior therapies, including an immunomodulatory agent, a proteasome inhibitor, and an anti-CD38 monoclonal antibody. 2. Verification that product continues to carry FDA-approved indication for use. 3. Lymphodepleting chemotherapy (with fludarabine and cyclophosphamide) is ordered for administration for 3 days followed by Abecma dose infusion 2 days after completion of lymphodepleting therapy. 4. Diagnosis of relapsed or refractory multiple myeloma (MM) 5. Age ≥ 18 years 6. Must have received at least 4 prior MM therapies (induction with or without hematopoietic stem cell transplant with or without maintenance therapy is considered a single regimen) 7. Must have received an immunomodulatory drug (iMiD), proteasome inhibitor (PI), and an anti-CD38 antibody 8. ECOG performance status of 0 or 1 9. HBV, HCV, and HIV screening within previous 30 days. 10. Provider attestation: Drug specific baseline evaluation and monitoring completed according to package insert (CBC/CMP, screening for HBV, hepatitis C, HIV), patient is not pregnant and is using effective contraception, counseling/assessment of recent live vaccine use.	**Not applicable. Maximum approval, one treatment course per lifetime.**

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	**Approval Criteria & Submission Requirements**	**Renewal Criteria**
	11. Monitor immunoglobulin levels, blood counts, and for cytokine release syndrome during and after therapy. 12. Patient has not received prior CAR-T or B-cell maturation antigen (BCMA) targeted therapy. 13. Patient has not received prior allogeneic hematopoietic stem cell transplant. 14. Medication ordered by Hematologist or Oncologist enrolled in ABECMA REMS and compliance with REMS program criteria. 15. Approval Duration: 1 treatment course, cannot be renewed.	
idursulfase (**Elaprase**) injection 6mg/3ml **Not on MDH list **J1743** **NDC: 54092-0700-01**	1. Ordered for an approved indication for use: • Patients with Hunter syndrome (Mucopolysaccharidosis II, MPS II). 2. Patient age ≥ 16 months; and 3. Patient has absence of severe cognitive impairment; 4. Diagnosis confirmed by one of the following: • Deficient iduronate 2-sulfatase (I2S) enzyme activity in white cells, fibroblasts, or plasma in the presence of normal activity of at least one other sulfatase; OR • Detection of pathogenic mutations in the IDS gene by molecular genetic testing; AND 5. Documented baseline value for urinary glycosamnoglycan (uGAG); and 6. Documented baseline values for one or more of the following: • **Patients ≥ 5 years of age:** 6-minute walk test (6-MWT), percent predicted forced vital capacity (FVC), joint range of motion, left ventricular hypertrophy, quality of life (CHAQ/HAQ/MPS HAQ); or • **Patients < 5 years:** spleen volume, liver volume, FVC, and/or 6-MWT. 7. Approval Duration: 12 months	1. Patient meets criteria for initial approval; and 2. Absence of unacceptable toxicity from the drug (e.g., anaphylactic reactions, antibody development, acute respiratory complications, etc.); and 3. Patient does not have progressive or irreversible severe cognitive impairment. 4. Patient has documented reduction in uGAG levels; 5. Patient has demonstrated positive clinical response to therapy compared to pre-treatment baseline in one or more of the following: • **Patients ≥ 5 years:** stabilization or improvement in percent predicted FVC and/or 6-MWT, increased joint range of motion, decreased left ventricular hypertrophy, improved growth, improved QOL; OR

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
		• **Patients < 5 years:** spleen volume, and/or liver volume or stabilization/improvement in FVC and/or 6-MWT. 6. Approval Duration: 12 months.
imiglucerase (**Cerezyme**) injection 400 unit **Not on MDH list **J1786** **NDC: 58468-4663-01**	1. Ordered for an approved indication for use: • Treatment of adults and pediatric patients 2 years of age and older with Type 1 Gaucher disease that results in one or more of the following conditions: anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly. • Administration under the supervision of a health care provider experienced in the treatment of Gaucher disease. 2. Diagnosis of Type 1 Gaucher disease confirmed by enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing. 3. Symptoms of one of the following complications associated with Type 1 Gaucher disease: • Anemia • Thromobocytopenia • Bone disease • Hepatomegaly • Splenomegaly 4. Patient ≥ 2 years of age. 5. Quantity limited to no more than three times weekly administration. 6. Approval Duration: 12 months.	1. Patient meets criteria for initial approval. 2. Patient has documentation of beneficial response (e.g., reduced severity or resolution of anemia, thrombocytopenia, bone disease, hepatomegaly or splenomegaly. 3. Patient is not experiencing an inadequate response or any intolerable adverse events from therapy. 4. Approval Duration: 12 months.
interferon gamma-1b (**Actimmune)** injection 2 million IU/0.5ml	1. Ordered for an approved indication for use: • To reduce frequency and severity of serious infections associated with chronic granulomatous disease (CGD).	1. Patient does not show evidence of progressive disease while on Actimmune. 2. Reauthorization is for 3 months. 3. Continued approval for this indication

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
J9216 **NDCs:** **75987-0111-11** **75987-0111-10**	• To delay time to disease progression in patients with severe, malignant osteopetrosis (SMO). 2. Patient age is less than 19 years. 3. When prescribed for: • Chronic Granulomatous Disease (CGD); • Osteopetrosis; or • Primary Cutaneous Lymphomas when the patient has a diagnosis of: ○ Mycosis fungoides (MF) or ○ Sezary Syndrome (SS) 4. Approval Duration: 3 months.	may be contingent upon verification and description of clinical benefit in a confirmatory trial.
Ipilimumab (**Yervoy**) injection 50mg, 200mg **Not on MDH list **J9228** **NDC: 00003-2328-22**	1. Ordered for an approved indication for use. 2. Patient is at least 18 years of age. 3. Criteria as outlined below for specific indications. **Ampullary Adenocarcinoma:** • Patient disease is microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) disease; and • Used in combination with nivolumab; and used as first-line therapy for unresectable or metastatic intestinal type disease or used as subsequent therapy for disease progression. **Biliary Tract Cancers (Gallbladder Cancer or Intra/Extra-hepatic Chloangiocarcinoma** • Patient has tumor mutational burden-high (TMB-H) [≥ 10 mutations/megabase (mut/Mb)] disease as determined by an FDA-approved or CLIA-compliant test; and • Used as subsequent treatment for progression on or after systemic treatment for unresectable, resected gross residual (R2), or metastatic disease; and • Used in combination with nivolumab. **Bone Cancer**	1. Patient continues to meet requirements of initial approval. 2. Absence of unacceptable toxicity. 3. Disease response with treatment as defined by stabilization of disease or decrease in size of tumor or tumor spread. **4. COVERAGE CAN NOT BE RENEWED FOR THE FOLLOWING INDICATIONS:** • Ampullary Adenocarcinoma • Colorectal Cancer • Appendiceal Adenocarcinoma • CNS metastases from Melanoma • Hepatocellular Carcinoma • Renal Cell Carcinoma • Cutaneous Melanoma (either 1st line or subsequent therapy or adjuvant therapy in combination with nivolumab). • Small Bowel Adenocarcinoma

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
	• Patient has one of the following: Ewing sarcoma, Chondrosarcoma (excluding mesenchymal chondrosarcoma), Osteosarcoma, or Chordoma; and • Patient has TMB-H disease as determined by FDA-approved or CLIA-compliant test; and • Used in combination with nivolumab; and • Patient has unresectable or metastatic disease that progressed following prior treatment; and • Patient has no satisfactory alternative treatment options. **CNS Cancer** • Used for the treatment of brain metastases in patients with BRAF non-specific melanoma; and • Used as initial treatment in patients with small asymptomatic brain metastases; or • Relapsed limited brain metastases with either stable systemic disease or reasonable systemic treatment options; or • Recurrent extensive brain metastases with stable systemic disease or reasonable systemic treatment options. **Colorectal Cancer** • Patient is at least 12 years of age; and • Has MSI-H or dMMR disease; and • Patient has not previously received treatment with a checkpoint inhibitor (e.g., nivolumab, pembrolizumab, etc.; • Used in combination with nivolumab*; AND • Used as subsequent therapy; AND • Patient has metastatic, unresectable, or medically inoperable disease, OR • Used as primary treatment; AND • Used as neoadjuvant therapy for clinical T4b colon cancer; or	• Uveal Melanoma **5. COVERAGE RENEWABLE IF THE PATIENT HAS NOT EXCEEDED A MAXIMUM OF TWO YEARS OF THERAPY:** • Biliary Tract Cancer • Bone Cancer • Esophageal and Esophagogastric/Gastroesophageal Junction Cancer • Kaposi Sarcoma • Malignant Peritoneal Mesothelioma • Malignant Pleural Mesothelioma • Non-Small Cell Lung Cancer 6. Cutaneous Melanoma (single agent adjuvant treatment – maintenance therapy is limited to a maximum of three years of therapy.

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria

	• Used as neoadjuvant therapy of resectable liver and/or lung metastases, OR
	• Used for isolated pelvic/anastomotic recurrence of rectal cancer, OR
	• Patient has metastatic, unresectable, or medically inoperable disease; or
	• Single agent nivolumab should be used in patients who are not candidates for intensive therapy.
	
	<u>Cutaneous Melanoma</u>
	• Used as a first line therapy for unresectable or metastatic disease in combination with nivolumab; OR
	• Used as initial therapy for limited resectable local satellite/in-transit recurrence AND used as a single agent in patients with previous exposure to anti-PD-1 therapy; OR
	• Used as subsequent therapy for unresectable or metastatic disease; AND
	  ○ Used after disease progression or maximum clinical benefit from BRAF-targeted therapy (e.g., dabrafenib/trametinib, vemurafenib/cobimetinib, encorafenib/binimetinib, etc); and
	  ○ Used as a single agent in patients of at least 12 years of age if not previously used along or in combination with anti-PD-1 immunotherapy; OR
	  ○ In combination with nivolumab if not previously used for patients who progress on a single agent anti-PD-1 therapy; OR
	  ○ In combination with pembrolizumab, if not previously used, for patients who progress on single agent anti-PD-1 therapy; OR	

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria

	• Used as reinduction therapy in patients who experienced disease control from prior use, but subsequently have disease progression/relapse > 3 months following treatment discontinuation; or
	• Used as a single agent for adjuvant therapy; and
	  ○ Patient has pathologic involvement of regional lymph nodes of more than 1 mm and has undergone complete resection including total lymphadenectomy; OR
	  ○ Patient has prior exposure to anti-PD-1 therapy (e.g., nivolumab or pembrolizumab); AND
	  • Patient has local satellite/intransit recurrence and no evidence of disease after complete excision; or
	  • Patient has undergone complete therapeutic lymph node dissection and/or complete resection of nodal recurrence; OR
	  • Patient has oligometastatic disease and no evidence of disease following metastasis-directed therapy or systemic therapy.
	Appendiceal Adenocarcinoma – Colon Cancer
	• Patient has MSI-H or dMMR disease; and
	• Patient not previously treated with a checkpoint inhibitor (e.g., nivolumab, pembrolizumab, etc.); and
	• Used in combination with nivolumab and a candidate for intensive therapy; and
	• Used for advanced or metastatic disease.
	Esophageal Cancer and Esophagogastric/Gastroesophageal Junction Cancers
	• Patient has esophageal squamous cell carcinoma (ESCC); and	

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
	• Patient not previously treated with a checkpoint inhibitor; • Used as a first-line treatment in combination with nivolumab; • Patient is not a surgical candidate or has unresectable advanced, recurrent, or metastatic disease. **Hepatocellular Carcinoma** • Used in combination with nivolumab; and • Used as subsequent therapy for progressive disease; and • Patient has Child-Pugh Class A hepatic impairment; and • Patient was previously treated with sorafenib; or • Patient has unresectable disease and is not a transplant candidate; or • Patient has liver-confined disease that is inoperable by performance status, comorbidity, or with minimal or uncertain extrahepatic disease; or • Patient has metastatic disease or extensive liver tumor burden. **Kaposi Sarcoma** • Used in combination with nivolumab as subsequent therapy; • Patient has classic disease; and • Used for relapsed/refractory advanced cutaneous, oral, visceral, or nodal disease; and • Disease has progressed on or not responded to first-line therapy and has progressed on an alternate first-line therapy. **Renal Cell Carcinoma (RCC)** • Used in combination with nivolumab for clear cell histology; AND • First line therapy in patients with advanced, relapsed or stage IV disease with poor or intermediate risk; OR • First line therapy in patients with relapsed or stage IV disease with favorable risk; OR	

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
	• Subsequent therapy in patients with relapsed or stage IV disease. **Malignant Peritoneal Mesothelioma (MPeM)** • Used in combination with nivolumab; and • Used as subsequent therapy (if chemotherapy was administered first line); OR • Used as first line therapy AND patient has unresectable diffuse disease; OR • Patient has unresectable recurrent benign multi-cystic or well-differentiated papillary disease. • May also be used for pericardial mesothelioma and tunica vaginalis testis mesothelioma. **Malignant Pleural Mesothelioma (MPM)** • Used in combination with nivolumab; and • Used as subsequent therapy (if chemotherapy was administered first line); OR • Used as first line therapy AND patient has stage IIIB or IV disease; OR • Patient has sarcomatoid or biphasic histology; OR • Disease is medically inoperable or unresectable; OR • Patient has stage I-IIIA disease with epithelioid histology and did not receive induction therapy. • May also be used for pericardial mesothelioma and tunica vaginalis testis mesothelioma. **Uveal Melanoma** • Patient has metastatic or unresectable disease. **Merkel Cell Carcinoma** • Used for M1 disseminated disease; and • Patient progressed on anti-PD-L1 or anti-PD-1 therapy OR anti-PD therapies are contraindicated.	

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
	Non-Small Cell Lung Cancer (NSCLC) If first line therapy, one of the following criteria: • Patients with a performance status (PS) of 0-1 who have tumors that are negative for actionable molecular biomarkers and PD-L1 < 1% • Patients with PS 0-1 who are positive for one of the following biomarkers: EGFR exon 20, KRAS G12C, BRAF V600E, NTRK 1/2/3 gene fusion, MET exon 14 skipping, or RET rearrangement. • PD-L1 expression positive (PD-L1 ≥ 1%) tumors, as detected by an approved FDA or CLIA compliant test that are negative for actionable molecular biomarker AND used in combination with nivolumab +/- platinum-doublet chemotherapy. If used as subsequent therapy, one of the following criteria: • Patients with PS 0-1 who received prior targeted therapy for one of the following molecular biomarkers: EGFR S768I, L861Q, and/or G719X, or ROS1 rearrangement. • Patients with PS 0-1 who are positive for one of the following molecular biomarkers BRAF V600E, NTRK 1/2/3 gene fusion, MET exon 14 skipping, or RET rearrangement; AND • Used in combination with nivolumab +/- pemetrexed and either carboplatin or cisplatin for non-squamous cell histology. **Small Bowel Adenocarcinoma (SBA)** • Patient has advanced or metastatic disease that is microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR); and • Patient has not previously received treatment with a check-point inhibitor (e.g., nivolumab, pembrolizumab, etc); and • Used as initial therapy in combination with nivolumab; OR	

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
	• Used as subsequent therapy for patients with no prior oxaliplatin exposure in the adjuvant treatment setting and no contraindication to oxaliplatin therapy. **<u>Soft Tissue Sarcoma</u>** • Used in combination with nivolumab • Used as subsequent therapy • Patient has no satisfactory treatment alternatives • Patient has myxofibrosarcoma, undifferentiated pleomorphic sarcoma (UPS), dedifferentiated liposarcoma, cutaneous angiosarcoma, or undifferentiated sarcomas **OR** • Patient has tumor mutational burden-high (TMB-H) [≥ 10 mutations/megabase (mut/Mb)] disease as determined by an FDA-approved or CLIA-compliant test. 4. Medication ordered by an Oncologist. 5. Approval Duration: 6 months.	
Lanadelumab-flyo (**Takhzyro**) injection 300mg/2ml **J0593** **NDC: 47783-0644-01**	1. Ordered for an approved indication for use: • hereditary angioedema (HAE) prophylaxis in adult and pediatric patients ≥ 12 years of age. 2. Prescribed by or in consultation with a specialist in allergy, immunology, hematology, pulmonology, or medical genetics. 3. Patient aged 12 years or older. 4. History of one of the following criteria for long-term HAE prophylaxis: • History of two or more severe HAE attacks per months (i.e., airway swelling, debilitating cutaneous or GI episodes. • Patient is disabled by HAE more than 5 days per month. • History of at least one laryngeal attack caused by HAE AND 5. Treatment with “on-demand” therapy (e.g., Kalbitor, Firazyr, Ruconest or Berinert) did not provide satisfactory control or access to “on-demand therapy is limited” AND	1. Documentation of positive clinical response from Takhzyro therapy. 2. Not used in combination with other products indicated for prophylaxis against HAE attacks (Cinryze, Haegarda, Orladeyo). 3. Approval Duration: 3 months.

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
	6. Not used in combination with C1 inhibitor prophylaxis (e.g., Cinryze, Haegarda, or Orladeyo) AND 7. Confirmation that patient is avoiding the following triggers for HAE attacks: • Estrogen-containing oral contraceptive agents AND hormone replacement therapy • Antihypertensive agents containing ACE inhibitors. 8. Approval Duration: 3 months.	
Leniolisib (**Joenja**) **J8499** **NDC: 71274-0170-60**	1. Prescribed for an approved indication for use; treatment of activated phosphoinositide 3-kinase delta (PI3Kδ) syndrome (APDS) in adult and pediatric patients 12 years of age and older. 2. Diagnosis confirmed by the presence of an APDS-associated genetic variant in either PIK3CD or PIK3R1. 3. Patient aged ≥ 12 years. 4. Patient weight is ≥ 45 kg. 5. Documentation of other clinical findings and manifestations consistent with APDS (e.g., recurrent respiratory tract infections, recurrent herpesvirus infections, lymphadenopathy, hepatosplenomegaly, autoimmune cytopenia). 6. Patient has a history of trial and failure, intolerance, or contraindication to current standard of care for APDS (e.g., antimicrobial prophylaxis, immunoglobulin replacement therapy, immunosuppressive therapy). 7. Prescribed by, or in consultation with a hematologist or immunologist. 8. Approval duration: 3 months.	1. Documentation of positive clinical response to Joenja therapy (e.g., reduced lymph node size, increased naïve B-cell percentage, decreased frequency or severity of infections, decreased frequency of hospitalizations). 2. Patient weight is ≥ 45 kg. 3. Prescribed by, or in consultation with a hematologist or immunologist. 4. Approval duration: 3 months.
lisocabtagene maraleucel (**Breyanzi**) injection **Not on MDH list **J3490, J3590**	1. Ordered for an approved indication for use: • Treatment of adult patients with large B-cell lymphoma (LBCL) including diffuse large B-cell lymphoma (DLBCL) not otherwise specified (including DLBCL arising from indolent	**Not applicable. Maximum approval, one treatment course per lifetime.**

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
NDC: 73153-0900-01	lymphoma), high-grade B-cell lymphoma, primary mediastinal large B-cell lymphoma, and follicular lymphoma grade 3B, who have: a. refractory disease to first-line chemoimmunotherapy or relapse within 12 months of first-line chemoimmunotherapy; or b. refractory disease to first-line chemoimmunotherapy or relapse after first-line chemoimmunotherapy and are not eligible for hematopoietic stem cell transplantation (HSCT) due to comorbidities or age; or c. relapsed or refractory disease after two or more lines of systemic therapy. 2. Age ≥ 18 years of age. 3. Prescriber attestation that all baseline evaluations have been done, and no contraindications to use are present. 4. Prescriber attests that subsequent appropriate evaluation and monitoring will be done based on the package insert. 5. Dose: 50-110 x 10^6 CAR positive viable T cells, one time dose. 6. Medication ordered by an Oncologist or Hematologist. 7. Approval limited to once per lifetime.	**Limitations of Use:** • BREYANZI is not indicated for the treatment of patients with primary central nervous system lymphoma.
Loncastuximab tesirine-lpyl (**Zynlonta**) solution 10mg **Not on MDH list **J9359**	1. Ordered for an approved indication for use: • the treatment of adult patients with relapsed or refractory large B-cell lymphoma after two or more lines of systemic therapy, including diffuse large B-cell lymphoma (DLBCL) not otherwise specified, DLBCL arising from low-grade lymphoma, and high-grade B-cell lymphoma. 2. Patient is at least 18 years of age. 3. Used as a single-agent therapy.	1. Patient continues to meet initial criteria for use. 2. Positive disease response from treatment defined as stabilization of disease or decrease in size of tumor or tumor spread. 3. Absence of unacceptable drug toxicity. 4. Approval Duration: 6 months.

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
	4. Patient has not received prior anti-CD19 therapy (e.g., tafasitamab, CAR-T) or patient previously received anti-CD19 therapy and re-biopsy indicates CD-19 positive disease; and 5. Patient does not have graft-versus-host disease; and 6. Patient has not had an autologous stem cell transplant (ASCT) within 30 days or allogeneic stem cell transplant within 60 days prior to start of therapy; and 7. Medication ordered by an Oncologist. 8. Approval Duration: 6 months	
Lumasiran (**Oxlumo**) injection 94.5mg/0.5ml **J0224** **NDC: 71336-1002-01**	1. Ordered for an approved indication for use: • treatment of primary hyperoxaluria type 1 (PH1) to lower urinary and plasma oxalate levels in pediatric and adult patients. 2. Diagnosis of primary lyperoxaluria type 1 (PH1) confirmed by documentation of genetic test results showing a mutation in the alanine:glyoxylate aminotransferase (AGXT) gene OR liver enzyme analysis demonstrating absent or significantly reduced alanine: glyoxylate aminotransferase (AGT) activity. 3. Metabolic testing demonstrating one of the following: • Increased urinary oxalate excretion (e.g., > 1 mm/1,73 m^2 per day [90 mg/1.73 m^2]), increased urinary oxalate: creatinine ratio relative to normative values for age OR • Increased plasma oxalate and glyoxylate concentrations. 4. Patient has not received a liver transplant. 5. Prescribed by or in consultation with a nephrologist or other provider (i.e., geneticist, urologist) with experience in treating PH1. 6. Approval Duration: 3 months.	1. All initial approval criteria is met, and 2. Submission of medical records documenting a positive clinical response to therapy from pre-treatment baseline. 3. Approval Duration: 3 months.

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
Maralixibat (**Livmarli**) **J8499** **NDC: 79378-0110-01**	1. Diagnosis of Alagille syndrome (ALGS) confirmed by genetic testing with the presence of a mutation in JAG1 or NOTCH2 deletion or mutation. 2. Patient is experiencing cholestatic pruritus associated with ALGS. 3. Patient has serum bile acid concentration above upper limit of normal reference range. 4. Patient age ≥ 3 months of age. 5. Failure of at least two systemic medications for Alagille syndrome unless contraindicated (e.g., cholestyramine, rifampicin, or ursodeoxycholic acid aka ursodiol). 6. Patient does not have cirrhosis, portal hypertension or history of a hepatic decompensation event. 7. Documentation of patient's current weight in kg. 8. Maximum dose 380 mcg/kg/day, not to exceed 28.5 mg (3 ml) per day. 9. Prescribed by or in consultation with a hepatologist or gastroenterologist. 10. Approval Duration: 3 months.	1. Documentation of positive clinical response to Livmarli therapy as determined by the prescriber. 2. Patient does not have cirrhosis, portal hypertension or history of hepatic decompensation event. 3. Documentation of patient's current weight in kg. 4. Maximum dose 380 mcg/kg/day, not to exceed 28.5 mg (3 ml) per day. 5. Approval duration: 3 months
Metreleptin (**Myalept**) injection 11.3mg **J3490** **NDC: 76431-0210-01**	1. Ordered for an approved indication for use: • An adjunct to diet as replacement therapy to treat the complications of leptin deficiency in patients with congenital or acquired generalized lipodystrophy. 2. Diagnosis of congenital or acquired generalized lipodystrophy associated with leptin deficiency. 3. Myalept is being used as an adjunct to diet modification. 4. Prescribed by an endocrinologist. 5. Patient has at least ONE of the following: • Diabetes mellitus or insulin resistance with persistent hyperglycemia (A1c > 7.0) despite BOTH of the following: ○ Dietary intervention	1. Documentation of positive clinical response to Myalept therapy. 2. Myalept is being used as an adjunct to diet modification. 3. Prescribed by an endocrinologist. 4. Approval Duration: 3 months.

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
	○ Optimized insulin therapy at maximum tolerated doses; OR • Persistent hypertriglyceridemia (TG > 250) despite BOTH of the following: ○ Dietary intervention ○ Optimized therapy with at least TWO triglyceride-lowering agents from different classes (e.g., fibrates, statins) at maximum tolerated doses. 6. Approval Duration: 3 months.	
mifepristone (**Korlym**) tablets Korlym-300mg ONLY **Not on MDH list **J8499** **NDCs:** **76346-0073-01** **76346-0073-02**	1. Ordered for an approved indication for use: • Control of hyperglycemia secondary to hypercortisolism in adult patients with endogenous Cushing's syndrome who have type 2 diabetes mellitus or glucose intolerance and have failed surgery or are not candidates for surgery. 2. Patient is ≥ 18 years of age. 3. Diagnosis of endogenous Cushing's syndrome (i.e., hypercortisolism is not a result of chronic administration of high dose glucocorticoids). 4. Patient has type 2 diabetes mellitus OR the patient has glucose intolerance as defined by a 2-hour glucose tolerance test value of 140-199 mg/dL. 5. The patient has either failed surgery or is not a candidate for pituitary surgery. 6. Prescribed by or in consultation with an endocrinologist. 7. The dose does not exceed 20 mg/kg/day. 8. Approval Duration: 3 months.	5. Documentation of one of the following: • Patient has improved glucose tolerance while on Korlym therapy; or • Patient has stable glucose tolerance while on Korlym therapy. 6. Dose does not exceed 20 mg/kg/day. 7. Approval duration: 3 months per authorization. **No other indications approved, can redirect requests for Mifeprex brand to appropriate formulary alternatives.
Mirvetuximab (**Elahere**) **Not on MDH list **J9063**	1. Prescribed for an approved indication for use: treatment of adult patients with folate receptor alpha (FRα)–positive, platinum-resistant epithelial ovarian, fallopian tube, or primary peritoneal	8. Disease response with treatment as defined by stabilization of disease or decrease in tumor size or tumor spread.

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
NDC: 72903-0853-01	cancer, who have received one to three prior systemic treatment regimens. 2. Patient is ≥ 18 years of age. 3. Verification that the FDA indication remains valid. 4. Confirmation that patient has folate receptor alpha positive disease. 5. Patient does not have moderate or severe hepatic impairment. 6. Patient has platinum-resistant disease. 7. Patient has tried at least one systemic regimen (e.g., bevacizumab, cyclophosphamide, docetaxel, etoposide, gemcitabine, paclitaxel, carboplatin, Lynparza (Olaparib) or Zejula (niraparib). 8. Prescribed by or in consultation with an oncologist. 9. Dosing is up to 6 mg/kg adjusted ideal body weight dosed once every 3-weeks. 10. Approval duration: 3 months.	9. There is no evidence of unacceptable toxicity or disease progression. 10. The patient does not have moderate or severe hepatic impairment. 11. Approval duration: 3 months.
mobocertinib (**Exkivity**) capsules 40mg **Not on MDH list	1. Ordered for an approved indication for use: • Treatment of adult patients with locally advanced or metastatic non-small cell lung cancer (NSCLC) with epidermal growth factor receptor (EGFR) exon 20 insertion mutations, as detected by an FDA-approved test, whose disease has progressed on or after platinum-based chemotherapy. 9. Patient is ≥ 18 years of age. 10. Patient has locally advanced or metastatic disease; and 11. Patient has EGFR exon 20 insertion-positive disease; and 12. Patient has failed at least one platinum-based chemotherapy. 13. Medication ordered by an oncologist. 14. Approval Duration: 12 months.	1. Disease response with treatment as defined by stabilization of disease or decrease in tumor size or tumor spread. 2. No evidence of disease progression or unacceptable toxicity 3. Renewal Duration: 12 months.

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	**Approval Criteria & Submission Requirements**	**Renewal Criteria**
Mogamulizumab-kpkc (**Poteligeo**) injection 20mg/5ml **Not on MDH list **J9204** **NDC: 42747-0761-01**	**1.** Ordered for an approved indication for use: • the treatment of adult patients with relapsed or refractory mycosis fungoides or Sézary syndrome after at least one prior systemic therapy. 2. Patient is ≥ 18 years of age. 3. Poteligeo is used as a single-agent therapy. 4. Patient has relapsed or refractory disease. 5. Approval Duration: 6 months.	1. Disease response with treatment as defined by stabilization of disease or decrease in tumor size or tumor spread. 2. No evidence of disease progression or unacceptable toxicity 3. Renewal Duration: 6 months.
Nanoparticle albumin bound sirolimus (**Fyarro**) **Not on MDH list **J9331** **NDC: 80803-0153-50**	1. Ordered for the treatment of adult patients with locally advanced unresectable or metastatic malignant perivascular epithelioid cell tumor (PEComa). 2. Patient age ≥ 18 years 3. Medication used as a single agent. 4. Patient does not have severe hepatic impairment. 5. Dosage is 100 mg/m2 on days 1 and 8 of each 21-day cycle until disease progression or unacceptable toxicity. 6. Initial approval: 6 months	1. No evidence of disease progression or unacceptable toxicity 2. Renewal Duration: 6 months.
Naxitamab (**Danyelza**) **J9348** **NDC:73042-0201-01**	1. Ordered for an approved indication for use: • In combination with granulocyte-macrophage colony-stimulating factor (GM-CSF), for the treatment of pediatric patients ≥ 1 year of age and adult patients with relapsed or refractory high-risk neuroblastoma in the bone or bone marrow who have demonstrated a partial response, minor response, or stable disease prior to therapy. 2. Patient age ≥ 1 year with relapsed or refractory disease in the bone or bone marrow. 3. The patient has demonstrated a partial or minor response or stable disease with prior therapy. 4. Danyelza will be used in combination with GM-CSF (e.g., sargramostim).	1. No evidence of disease progression or unacceptable toxicity. 2. Approval Duration: 3 months.

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
	5. Prescribed by or in consultation with an oncologist. 6. Approval Duration: 3 months.	
Nitisinone (Orfadin) capsules **Not on MDH list Nitisinone is preferred for 2mg, 5mg 10mg **Orfadin** 20mg **J8499** **NDC: 66658-0204-90**	1. Ordered for an approved indication for use: • treatment of adult and pediatric patients with hereditary tyrosinemia type 1 (HT-1) in combination with dietary restriction of tyrosine and phenylalanine. 2. Diagnosis of type 1 tyrosinemia by biochemical or DNA testing. 3. Patient adherent to dietary restrictions of tyrosine and phenylalanine. 4. Patient is under the care of a nutritionist. 5. Dose not to exceed 2 mg/kg/day. 6. Patient is not enrolled in any study involving the requested drug. 7. PA form completed completely. 8. Approval Duration: 3 months	ORFADIN PRIOR AUTH FORM 1. Meets all initial approval criteria. 2. MDH provided PA form completed with all required documentation. 3. Approval duration: 3 months.
Nusinersen (**Spinraza**) **J2326** **NDC: 64406-0058-01**	1. Ordered for an approved indication for use: • Diagnosis of SMA Type I, II, or III. • Diagnosis by a neurologist with expertise in the diagnosis of SMA; 2. Genetic testing confirming both: • 5q SMA homozygous gene deletion, homozygous gene mutation, or compound heterozygous mutation: AND • At least 2 copies of SMN2 3. AND • Patient is not dependent on invasive ventilation or tracheostomy. • Patient is not dependent on non-invasive ventilation beyond use for naps and nighttime sleep; • Patients with Type II and III SMA must have some functional upper extremity use.	1. Cannot be used in combination with Zolgensma (onasemnogene abeparvovec). 2. Each Spinraza maintenance dose must be preauthorized; 3. Approval period is 3 months. 4. All the criteria for initial therapy must be met: • Medical records must be submitted that document repeat motor testing since the most recent Spinraza® dose using the same motor test done to establish baseline motor ability, unless it is determined that the original test is no longer appropriate;

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
	4. **Initial therapy** • Medical records must be submitted documenting all of the above criteria; • Medical records must be submitted documenting a baseline motor examination utilizing at least one of the following exams (based on patient age and motor ability) to establish baseline motor ability. • Hammersmith infant neurological exam (HINE); • Hammersmith Functional Motor Scale Expanded (HFMSE); • Upper Limb Module Test (non-ambulatory; or • Childrens Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP-INTEND) 5. Prescribed by a neurologist with expertise in the treatment of SMA. 6. Spinraza must be given according to the current FDA labelling guidelines for dosage and timing; 7. Must be administered intrathecally by a physician or other healthcare professional experienced in performing lumbar punctures. 8. Initial and Renewal Approval Duration: 4 loading doses for initiation, 3 months each approval period thereafter.	• Repeat motor testing must document a response to treatment as defined by the following: **HINE:** 1. Improvement or maintenance of previous improvement of at least 2 points (or max score of 4) in ability to kick (improvement in at least 2 milestones); **OR** 2. Improvement or maintenance of previous improvement of at least 1 point increase in motor milestones of head control, rolling, sitting, crawling, standing, or walking (consistent with improvement by at least 1 milestone); **AND** 3. Improvement or maintenance of previous improvement in more HINE motor milestones. **HFMSE:** 1. Improvement or maintenance of improvement of at least a 3-point increase in score; **ULM:** 1. Improvement or maintenance of previous improvement of at least 2-point increase in score; **CHOP-INTEND:** 8. Improvement or maintenance of previous improvement of at least a 4-point increase in score.

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
Odevixibat (**Bylvay**) **J8499** **NDCs:** **74528-0040-01** **74528-0120-01**	1.Prescribed for an approved indication for use: • Treatment of pruritus in patients 3 months of age and older with progressive familial intrahepatic cholestasis (PFIC) type 1, 2, or 3. 1. Patient age ≥ 3 months. 2. Patient does not have concomitant liver disease (e.g., biliary atresia, benign recurrent intrahepatic cholestasis (BRIC), liver cancer, alternate non-PFIC related etiology of cholestasis). 3. Genetic testing results confirming a diagnosis of progressive familial intrahepatic cholestasis. Coverage will not be provided for patients with PFIC type 2 with variants in the ABCB11 gene that predict non-functional or complete absence of bile salt export pump protein (BSEP-3). 4. Provider attestation of drug specific baseline evaluation and monitoring with subsequent evaluation and monitoring performed as required. 5. Prior or continued use of ursodiol. 6. Prescribed by or in consultation with a prescriber with experience working with PFIC, hepatologist or gastroenterologist. 7. Dosing 40 mcg/kg once daily for first 3 months. May increase in 40 mcg/kg increments to maximum daily dose of 6 mg. 8. Initial Approval Duration: 3 months.	1. Chart notes or medical records documenting a benefit from therapy (e.g., improvement in pruritis). 2. Liver function tests are monitored, and treatment is interrupted if new onset liver test abnormalities occur, or symptoms consistent with clinical hepatitis are observed. 3. Patient has not experienced hepatic decompensation (e.g., variceal hemorrhage, ascites, hepatic encephalopathy). 4. Approval Duration: 3 months.
Olipudase alfa (**Xenpozyme**) **J0218** **NDC: 58468-0050-01**	1. Prescribed for an approved indication for use; treatment of non-central nervous system manifestations of acid sphingomyelinase deficiency (ASMD) in adult and pediatric patients. 2. Acid sphingomyelinase enzyme assay (as measured in peripheral leukocytes, cultured fibroblasts, or lymphocytes) or genetic testing results documenting a mutation in the sphingomyelin phosphodiesterase-1 (SMPD1) gene.	1. Documented response to therapy improvement or stabilization in disease (e.g., improvement in lung function, reduction in spleen volume, reduction in liver volume, improvement in platelet count, improvement in linear growth progression).

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
	3. Prior to initiation of Xenpozyme, baseline transaminase (alanine aminotransferase [ALT] and aspartate aminotransferase [AST]) levels recorded within past 30 days. 4. Documentation of patient's current weight. 5. Prescribed by or in consultation with a metabolic disease specialist or geneticist. 6. Dose does not exceed 3 mg/kg IV every 2 weeks. 7. Approval duration: 3 months	2. Documentation of patient's current weight. 3. Dose does not exceed 3 mg/kg IV every 2 weeks. 4. Approval duration: 3 months.
Onasemnogene abeparvovec-xioi (**Zolgensma**) injection **J3399** **NDCs:** **71894-0120-02, 71894-0121-03** **71894-0122-03, 71894-0123-03, 71894-0124-04, 71894-0125-04, 71894-0126-04, 71894-0127-05, 71894-0128-05, 71894-0129-05, 71894-0130-06, 71894-0131-06, 71894-0132-06, 71894-0133-07** **71894-0134-07, 71894-0135-07, 71894-0136-08, 71894-0137-08, 71894-0138-08, 71894-0139-09, 71894-0140-09, 71894-0141-09**	1. Ordered for an approved indication for use: • treatment of pediatric patients < 2 years of age with spinal muscular atrophy (SMA) with bi-allelic mutations in the survival motor neuron 1 (SMN1) gene. 2. Genetic testing confirming bi-allelic mutations in the SMN1 gene on chromosome 5q 3. Patient age less than 2 years 4. Prescriber attests that baseline evaluation has been done and there are no contraindications to use. 5. Prescriber attests that subsequent appropriate evaluation and monitoring will be done based on package insert. 6. Continued approval for this medication may be contingent upon verification of clinical benefit in confirmatory trials. 7. Patient is not receiving concomitant SMA disease modifying therapy (e.g., Spinraza). 8. Use of Zolgensma in patients with advanced SMA (e.g. complete limb paralysis, permanent ventilator dependence) has not been evaluated. 9. Prescribed by a pediatric neurologist with experience in the diagnosis of SMA. 10. One time approval only	**Not applicable. Maximum approval, one treatment course per lifetime.**

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
Patisiran (**Onpattro**) Solution 10mg/5ml **Not on MDH list **J0222** **NDC: 71336-1000-01**	1. Ordered for an approved indication for use: • Treatment of polyneuropathy in adults with hereditary transthyretin-mediated (hATTR) amyloidosis. 2. Patient age ≥ 18 years. 3. Medication ordered by a rheumatologist, neurologist, or a specialist in the treatment of amyloidosis. 4. Diagnosis of hATTR with polyneuropathy confirmed by the presence of a transthretin (TTR) gene mutation (e.g., V30M, A97S, T60A, E89Q, S50R). 5. Documentation of one of the following baseline tests: • Modified Neuropathy Impairment Scale +7 (mNIS+7) composite score. • Polyneuropathy disability (PND) score of ≤ IIIb • Familial amyloid polyneuropathy (FAP) Stage 1 or 2 6. Patient has clinical signs and symptoms of polyneuropathy (i.e., weakness, sensory loss, decreased motor strength, decreased gait speed) 7. Other causes of peripheral neuropathy have been assessed and ruled out. 8. Patient will not be receiving Onpattro in combination with oligonucleotide agents (Onpattro, Tegsedi) 9. Prescribed by, or in consultation with, a neurologist, geneticist, or physician specializing in the treatment of amyloidosis. 10. Approval Duration: 12 months	1. Patient continues to meet the initial approval criteria. 2. Documentation of therapeutic response as evidenced by the stabilization or improvement from baseline in one of the following: • mNIS+7 score • polyneuropathy disability (PND) score ≤ IIIb • familial amyloid polyneuropathy (FAP) Stage 1 or 2. 3. Approval Duration: 12 months.
Pegcetacoplan (**Empaveli**) injection 1080mg **Not on MDH list **J3490, J3590, C9399**	1. Ordered for an approved indication for use: • Treatment of adult patients with paroxysmal nocturnal hemoglobinuria (PNH). 2. Documentation supporting diagnosis of PNH as confirmed by both of the following:	1. Documentation of positive clinical response to Empaveli therapy (e.g, increased or stabilization of hemoglobin levels, reduction in transfusions, improvement in hemolysis, decrease in LDH, increased reticulocyte count, etc.)

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
NDC: 73606-0010-01	• Flow cytometry analysis confirming presence of PNH clones; and • Laboratory results, signs and/or symptoms attributed to PNH (e.g., abdominal pain, anemia, dyspnea, extreme fatigue, smooth muscle dystonia, unexplained or unusual thrombosis, hemolysis/hemogobinuria, kidney disease, pulmonary hypertension, etc.) 3. Patient age ≥ 18 years. 4. Patient is not receiving Empaveli in combination with another complement inhibitor used for the treatment of PNH (e.g., Soliris, Ultomiris); OR 5. Patient is currently receiving Soliris (eculizumab) which will be discontinued after an initial 4-week overlap period with Empaveli; OR 6. Patient is currently receiving Ultomiris (ravulizumab-cwvz) which will be discontinued and Empaveli will be initiated no more than 4 weeks after the last dose. 7. Prescribed by either a hematologist or oncologist. 8. Approval Duration: 6 months.	2. Patient is not receiving Empaveli in combination with another complement inhibitor used for the treatment of PNH (e.g., Soliris, Ultomiris). 3. Prescribed by or in consultation with an oncologist or hematologist. 4. Approval Duration: 12 months.
pegloticase (**Krystexxa**) injection 8mg/ml **J2507** **NDC: 75987-0080-10**	1. Ordered for an approved indication for use: • Treatment of chronic gout in adults refractory to conventional therapy. 2. Verified there is no G6PD deficiency prior to therapy initiation. 3. Patient aged 18 years or older. 4. Not for the treatment of asymptomatic hyperuricemia. Patient as symptomatic gout. 5. Inadequate treatment response, intolerance, or contraindication to ONE of the following: allopurinol or probenecid. 6. Oral anti-hyperuricemic agents are discontinued.	1. Patient must have chronic, symptomatic gout. 2. Documented improvement in serum uric acid level 3. NO glucose-6-phosphate dehydrogenase (G6PD) deficiency 4. Renewal request may be denied if patient has 2 or more consecutive uric acid levels above 6 mg/dl. 5. Renewal duration: 3 months.

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
	7. Prescriber agrees to monitor serum uric acid levels prior to subsequent infusions and consider discontinuing treatment if levels rebound and exceed 6 mg/dl. 8. Medication ordered by Rheumatologist, Nephrologist or Podiatrist. 9. Approval duration: 3 months.	
Pegunigalsidase alfa (**Elfabrio**) **Not on MDH list **J3490, J3590** **NDCs:** **10122-0160-02** **10122-0160-05** **10122-0160-10**	1. Ordered for an approved indication for use: 2. Treatment of adults with confirmed Fabry disease 3. Patient aged 18 years or older. 4. Submission of alpha-glactosidase enzyme assay or genetic testing results to support diagnosis by one of the following: • a*galactosidase A (a*Gal A) activity in plasma, isolated leukocytes, and/or cultured cells (males only) **OR** • Detection of pathogenic mutations in the GLA-gene by molecular genetic testing **AND** • Baseline value for plasma GL-3 and/or inclusions, plasma or urinary globotriaosylceramide (Gb_3/GL-3); or plasma globotriaosylsphingosine (lyso* Gb_3). 5. The medication with not be used in combination with Galafold, migalastat or agalsidase beta. 6. Quantity limits: 6 vials q14 days, max: 120 mg q14 days. 7. Approval Duration: 3 months	1. Patient continues to meet criteria for initial approval, **AND** 2. Absence of unacceptable toxicity from drug such as anaphylaxis, severe hypersensitivity reactions, severe infusion-associated reactions, glomerulonephritis AND 3. Disease response with treatment as defined by a reduction or stabilization in one or more of the following as compared to pre-treatment baseline: • Reduction in Plasma GL-3 and/or GL-3 inclusions • Reduction in plasma or urinary Gb_3/GL-3. • Improvement and/or stabilization in renal function, pain reduction. 4. Renewal duration: 3 months
Ravulizumab-cwvz **(Ultomiris)** injection 100mg/ml 300mg/30ml **Not on MDH list **J1303** **NDCs:**	1. Ordered for an approved indication for use: • treatment of adult and pediatric patients ≥ 1 month of age with paroxysmal nocturnal hemoglobinuria (PNH). • treatment of adult and pediatric patients ≥ 1 month of age with atypical hemolytic uremic syndrome (aHUS) to inhibit complement-mediated thrombotic microangiopathy (TMA). • treatment of adult patients with generalized myasthenia gravis (gMG) who are anti-acetylcholine receptor (AChR+)	1. Clinical documentation must be provided to confirm that current criteria are met and that the medication is providing clinical benefit. 2. **gMG**: Improvement and maintenance of at least a 2-point improvement (reduction) in the MG-ADL score from pre-treatment baseline and reduction of signs

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
25682-0022-01 **25682-0025-01** **25682-0028-01**	antibody positive. 9. FDA approved patient age. 10. Documentation to support diagnosis: **PNH:** • Flow cytometric confirmation of PNH type III red cells; AND • Patient had at least one transfusion in the preceding 24 months; OR • Documented history of major adverse thrombotic vascular events from thromboembolism; OR • Patient has high disease activity defined as lactic dehydrogenase (LDH) level ≥ 1.5 times the upper limit of normal with one of the following symptoms: weakness, fatigue, hemoglobinuria, abdominal pain, dyspnea, hemoglobin, 10 g/dL, a major vascular event, dysphagia, or erectile dysfunction. • History of failure to/contraindication or intolerance to Empaveli therapy; • Patient age < 18 years or currently pregnant. **aHUS:** • Common causes of aHUS have been ruled out, including infectious causes of HUS and thrombotic thrombocytopenic purpura (TTP). • Ultomiris is not indicated for the treatment of patients with Shiga toxin E. coli related hemolytic uremic syndrome (STEC-HUS). • Must present with the following symptoms: ○ Hemoglobin < 10 g/dL ○ Platelets, 150,000/mm^3 ○ Documented evidence of hemolysis, such as elevated LDH levels, decreased haptoglobin level or	and symptoms of MG required to show clinical benefit. 3. **NOTE:** dose escalation of immunosuppressive therapy, or additional rescue therapy from baseline to treat MG or exacerbation of symptoms during use is considered treatment failure. 4. Not receiving in combination with Empaveli or Soliris. 5. Approval Duration: up to 12 months.

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
	schistocytosis. • Increased serum creatinine OR currently undergoing dialysis. **gMG:** • Patient has not failed previous course of Soliris or Ultomiris therapy; • Positive serologic test for anti-AChR antibodies; AND • One of the following: ○ History of abnormal neuromuscular transmission test demonstrated by single-fiber electromyography (SFEMG) or repetitive nerve stimulation OR ○ History of positive anticholinesterase test (e.g. edrophonium chloride test) OR ○ Pt has demonstrated improvement in MG signs on oral cholinesterase inhibitors as assessed by the treating neurologist; AND • Patient has MGFA clinical classification of II, III, or IV at initiation of treatment; AND • Patient has Myasthenia gravis-specific activities of daily living scale (MG-ADL) total score ≥ 6 at initiation of treatment; AND • One of the following: ○ History of failure to at least two immunosuppressive agents over the previous 12-months (e.g., azathioprine, mtx, cyclosporing, mycophenolate); OR ○ History of failure to at least one immunosuppressive therapy and has required four or more courses of plasmapheresis/plasma exchanges, and/or intravenous immune globulin over the previous 12 months without symptom control; AND 11. Recommended vaccinations at least 2 weeks prior to administration of first dose Ultomiris.	

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
	12. Cannot be used in combination with other medications in the same class, such as Soliris. 13. Medication ordered by Hematologist, Nephrologist, or Oncologist registered with Ultomiris REMS program. 14. Approval Duration: 12 months.	
Sastralizumab-mwge (**Enspryng**) injection **Not on MDH list	1. Ordered for an approved indication for use: • Treatment of neuromyelitis optica spectrum disorder (NMOSD) in adult patients who are anti-aquaporin-4 (AQP4) antibody positive. 2. Must submit FDA-approved testing showing antibody positive. 3. Age ≥ 18 years. 4. Prescriber attests that baseline evaluation has been done and there are no contraindications to use (e.g., Hep B, TB, LFT's, live or live-attenuated vaccines 4 weeks prior or 2 weeks for non-live vaccines). 5. Prescriber attests that subsequent appropriate evaluation and monitoring will be done based on the package insert (e.g., infections, LFT's, CBCs – neutrophils) 6. Medication ordered by neurologist, immunologist, or ophthalmologist experienced in treatment of this disease. 7. Approval Duration: 12 months.	1. Meets all initial criteria, AND 2. Provider attestation of continued benefit. 3. Use in caution if ALT/AST > 1.5 x ULN. 4. Contraindicated in patients with active hepatitis B infection or active or untreated latent tuberculosis. 5. Approval duration: 12 months
Sodium phenylbutyrate (**Olpruva**) Suspension **J8499** **NDC: 72542-0002-01, 72542-0200-02, 72542-0200-09, 72542-0003-01, 72542-0300-02, 72542-**	1. Ordered for an approved indication for use: • As an adjunctive therapy to the stand of care, in the chronic management of adult and pediatric patients, weighing ≥ 20 kg and a BSA of 1.2 m^2 or greater, with urea cycle disorders (UCDs), involving deficiencies of carbamylphosphate synthetase (CPS), ornithine transcarbamylase (OTC), or argininosuccinic acid synthetase (AS). 2. Not prescribed for the treatment of acute hyperammonemia.	1. Patient continues to meet initial criteria for approval. 2. The patient has a documented clinical benefit from baseline (e.g., normal fasting glutamine, low-normal fasting ammonia levels, improved mental status clarity). 3. Approval Duration: 3 months.

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
0300-09, 72542-0400-02, 72542-0400-18, 72542-0500-02, 72542-0500-18, 72542-0600-02, 72542-0600-18, 72542-0367-01, 72542-0667-02, 72542-0667-18	3. Documentation submitted to confirm diagnosis of UCD via enzymatic, biochemical or genetic testing. 4. Olpruva is being used as an adjunctive therapy along with dietary protein restriction. 5. The patient cannot be managed by dietary protein restriction or amino acid supplementation alone. 6. The patient has had a failed trial of/or contraindication to generic sodium phenylbutyrate power; OR the patient is unable to swallow Buphenyl (sodium phenylbutyrate) tablets. 7. Approval duration: 3 months.	
Tebentafusp (**Kimmtrak**) **J9274** **NDC: 80446-0401-01**	1. Prescribed for an approved indication for use: • Treatment of HLA-A*02:01-positive adult patients with unresectable or metastatic uveal melanoma. 2. Patient has HLA-A*02:01 genotype positive disease as determined by an FDA-approved or CLIA compliant test. 3. Patient is at least 18 years of age. 4. Verification of non-pregnant status for females. 5. Patient does not have symptomatic or untreated brain metastases. 6. Patient does not have: • clinically significant cardiac disease or impaired cardiac function (i.e., CHF (NYHA grade ≥ 2) • uncontrolled hypertension or • clinically significant arrhythmia requiring medical treatment. • Acute myocardial infarction or unstable angina pectoris < 6 months prior to the start of therapy. 7. Quantity limits: 1 vial per 7 days, max 68 mcg/week 8. Approval Duration: 1 month	1. Patient has received the first 3 infusions (i.e., Day 1, 8, and 15) in an appropriate healthcare setting and did not experience any Grade 2 or worse hypotension (hypotension requiring medical intervention). 2. Patient has not had disease progression or unacceptable toxicity (e.g., persistent/severe cytokine release syndrome, severe dermatological reactions, severe elevated liver enzymes). 3. Disease response with treatment as defined by stabilization of disease or decrease in the size of tumor or tumor spread. 4. Renewal Duration: 3 months

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
Teclistamab (**Tecvayli**) **Not on MDH list **J9380** **NDCs:** **57894-0449-01** **57894-0450-01**	1. Prescribed for an approved indication: treatment of adult patients with relapsed or refractory multiple myeloma. 2. Confirmation of current FDA approved indications due to this medication receiving accelerated approval. Indications are contingent upon verification and description of clinical benefit in confirmatory trials. 3. Patient age ≥ 18 years. 4. Patient has had at least four prior therapies, including an anti-CD38 monoclonal antibody (e.g., daratumumab), a proteasome inhibitor (e.g., bortezomib, ixazomib, or carfilzomib) and an immunomodulatory agent (e.g., lenalidomide or pomalidomide) 5. Patient has had no prior treatment with any B cell maturation antigen (BCMA) targeted therapy. 6. Patient does not have any of the following comorbidities: stroke, seizure, CNS involvement or clinical signs of meningeal involvement of multiple myeloma. 7. Patient has not had an allogenic stem cell transplant within the previous six months or an autologous stem cell transplant within the previous 12 weeks. 8. Prescribed by or in consultation with a hematologist or oncologist. 9. Approval duration: 3 months	1. Patient continues to meet all of the initial criteria. 2. Documented response with treatment as defined by stabilization of disease or decrease in size of tumor/tumor spread. 3. Absence of unacceptable toxicity from the drug (e.g., Immune Effector Cell-Associated Neurotoxicity Syndrome (ICANS), severe infusion-related reactions, cytokine release syndrome (CRS), hepatotoxicity, neutropenia, etc. 4. Approval duration: 3 months.
teduglutide (**Gattex**) **J3490** **NDCs:** **68875-0101-01** **68875-0102-01** **68875-0103-01**	1. Ordered for an approved indication for use: • the treatment of adults and pediatric patients ≥ 1 year of age with Short Bowel Syndrome (SBS) who are dependent on parenteral support. 2. 200 cm or less of remaining small intestine 3. Chart notes documenting the use of parenteral nutrition, including recent PN orders specifying frequency of Phosphatidylserine (PS), caloric requirements, fluid and	1. Chart notes documenting at least a 20% reduction in parental nutrition use from baseline. **2.** Submission of recent PN orders required. **3.** Attestation of continued benefit **4.** Free from intestinal obstruction

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
	electrolyte needs, current volume of PS per week and duration of use of PS. 4. Patient weight over 22 pounds (10 kg) 5. Adult patients must have coloscopy with polyp removal within past 6 months. 6. Pediatric patients must have fecal occult blood testing, with follow up colonoscopy/sigmoidoscopy if unexplained blood in stool. 7. Must have recommended lab values checked every 6 months: bilirubin, alkaline phosphatase, and amylase levels 8. Approval Duration: 3 months	**5.** Repeat colonoscopy after initial 1 year of treatment shows no signs of intestinal malignancy. **6.** No significant changes in bilirubin, alkaline phosphatase, or amylase levels **7.** Approval duration: 3 months.
Teplizumab (**Tzield**) **Not on MDH list **J9381** **NDCs:** **73650-0316-01** **73650-0316-10** **73650-0316-14**	1. Ordered for an approved indication for use: • To delay the onset of Stage 3 type 1 diabetes (T1D) in adults and pediatric patients aged 8 years and older with stage 2 T1D. 2. Patient is ≥ 8 years of age. 3. Documentation of stage 2, T1D confirmed by: • Presence of two or more of the following pancreatic islet cell autoantibodies: ○ Glutamic acid decarboxylase 65 (GAD) autoantibodies; ○ Insulin autoantibody (IAA); ○ Insulinoma-associated antigen 2 autoantibody (IA-2A); ○ Zinc transporter 8 autoantibody (ZnT8A); ○ Islet cell autoantibody (ICA) 4. Dysglycemia on an oral glucose-tolerance test 5. May NOT be approved for patients with: • Stage 3 T1D; or • Clinical history consistent with T2D; or • Serious infection or chronic infection, including, but not limited to Epstein-Barr virus or cytomegalovirus.	**Not applicable. Maximum approval, one treatment course per lifetime.**

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	**Approval Criteria & Submission Requirements**	**Renewal Criteria**
	6. Approval Duration: one treatment course per lifetime.	
Teprotumumab-trbw (**Tepezza**) injection 500mg **Not on MDH list **J3241** **NDC: 75987-0130-15**	1. Ordered for an approved indication for use: • treatment of Thyroid Eye Disease (TED). 2. Requested dose and frequency in accordance with FDA-approved labeling. 3. Is age-appropriate according to FDA-approved labeling. 4. Adult patient > 18 years of age. 5. Patient has clinical diagnosis of Grave's disease. 6. Must be euthyroid or have thyroxine and free triiodothyronine levels less than 50% above or below normal limits. 7. Must have a Clinical Activity Score ≥ 4. 8. Onset of TED symptoms within past 9 months. 9. Must provide documentation that member has tried and failed and/or has intolerance or contraindication to at least one of the following: • Intravenous Corticosteroids • Rituximab or any of its biosimilars • Surgical management 10. Approval duration: limited to 8 infusions.	**Not applicable. Maximum approval, one treatment course per lifetime.**
Tisotumab vedotin-tftv (**Tivdak**) injection 40mg **Not on MDH list	1. Ordered for an approved indication for use: • the treatment of adult patients with recurrent or metastatic cervical cancer with disease progression on or after chemotherapy. 2. Patient is ≥ 18 years of age. 3. Member does not have active ocular surface disease or history or cicatricial conjunctivitis AND 4. Member has not had prior Steven-Johnson syndrome AND 5. Member does not have Grade ≥ 2 peripheral neuropathy AND 6. Member does not have known coagulation defects leading to increased risk of bleeding AND	1. Initial criteria continue to be met. 2. Disease response with treatment as defined by stabilization of disease or decrease in tumor size or tumor spread. 3. Absence of unacceptable toxicity from the drug (e.g., peripheral neuropathy, hemorrhage, recurrent or persistent grade 2 or higher pneumonitis, keratitis, conjunctival ulceration, etc). 4. Approval Duration: 3 months.

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
	7. Member has had an ophthalmic exam at baseline, and as clinically indicated AND 8. Tivdak is used as a single agent therapy. 9. Ordered by or in consultation with an oncologist. 10. Approval Duration: 3 months	
Trofinetide (**Daybue**) **J8499** **NDC: 63090-0660-01**	1. Prescribed for an approved indication for use: • Treatment of Rett syndrome in adults and pediatric patients 2 years of age or older. 2. Patient aged 2 years or older. 3. Documentation of mutation of the MECP2 gene. 4. Quantity limited to 24 bottles per 90-days. 5. Approval Duration: 3 months.	1. Documentation of clinical benefit from therapy (e.g., slowed decline in the severity in signs and symptoms). 2. Approval duration: 3 months
Valoctocogene roxaparvovec (**Roctavian**) **J3490, J3590** **NDC: 68135-0927-01** **68135-0927-48**	1. Prescribed for the treatment of Hemophilia A (Factor VIII Deficiency). 2. Patient is ≥ 18 years of age. 3. Patient has diagnosis of severe Hemophilia A with documentation of endogenous Factor VIII levels < 1% of normal Factor VIII (< 0.01 IU/ml, < 1 IU/dL). 4. One of the following: • Currently receiving chronic prophylactic Hemlibra (emicizumab) therapy; OR • BOTH of the following: ○ Currently uses Factor VIII prophylaxis therapy; AND ○ Has had a minimum of 150 exposure days to a Factor VIII agent; OR • Determined to be an appropriate candidate for therapy by the Hemophilia Treatment Center based on patient willingness to adhere to initial and long-term monitoring. 5. Patient does not have a history of inhibitors to Factor VIII ≥ 0.6 Bethesda units (BU).	**Not applicable. Maximum approval, one treatment course per lifetime.**

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
	6. Patient does not screen positive for active Factor VIII inhibitors as defined as ≥ 0.6 BU prior to administration of Roctavian. 7. Patient does not have pre-existing immunity to the AAV5 capsid as detected by FDA-approved test. 8. Patient has not Immune Tolerance Induction (ITI). 9. Liver function testing, hepatic ultrasound, and elastography have been performed to rule-out radiological liver abnormalities and/or sustained liver enzyme elevations. 10. One of the following: • Patient is not HIV+; or • Patient is HIV+ and is virally suppressed with anti-viral therapy (i.e., < 200 copies of HIV/mL). 11. The patient's hepatitis B surface antigen is negative. 12. One of the following: • The patient's hepatitis C virus (HCV) antibody is negative; OR • The patient's HCV antibody is positive, and the HCV RNA is negative. 13. The patient is not currently using antiviral therapy for either hepatitis B or C. 14. The patient has not previously received treatment with Roctavian or other gene therapy for hemophilia during their lifetime. 15. Treatment is administered within a Hemophilia Treatment Center (HTC) that holds Federal designation as evidenced by being listed within the CDC's HTC directiory. 16. Prescriber attests that patient will be able to adhere to weekly monitoring for at least 26 weeks following administration and regularly thereafter as recommended in the package insert.	

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
	17. Prescriber attests that patient has received counseling to abstain from alcohol for at least one year after administration and regarding how much alcohol may be acceptable thereafter. 18. Dosing is in accordance with FDA-approved labeling. 19. Authorization is for a single administration only.	
Velmanase alfa (**Lamzede**) **J3490, J3590** **NDCs:** **10122-0180-02** **10122-0180-05** **10122-0180-10**	1. Prescribed for an approved indication: treatment of non-central nervous system manifestations of alpha-mannosidosis (AM) in adult and pediatric patients. 2. Confirmation of diagnosis by enzyme assay demonstrating alpha-mannosidase activity < 10% of normal in blood leukocytes or fibroblasts or genetic testing confirmation of a mutation in the MAN2B1 gene. 3. Patient age ≥ 3 years. 4. Verification for female patients of non-pregnant status. 5. Patient does not have a history of HSCT or bone marrow transplant. 6. Patient is not wheelchair bound due to illness. 7. Prescribed by, or in consultation with a geneticist, metabolic disease sub-specialist, or physician who specializes in the treatment of lysosomal storage disorders. 8. Approval Duration: 3 months.	1. Patient has demonstrated response to therapy (e.g., improvement in the 3-minute stair climbing test (3MSCT) from baseline, improvement in 6-minute walking test (6MWT) from baseline, improvement in forced vital capacity (FVC, % predicted), reduction in serum or urine oligosaccharide concentration from baseline). 2. Approval Duration: 3 months
Viltolarsen (**Viltepso**) 50 mg/ml solution **J1427** **NDC: 73292-0011-01**	1. Ordered for an approved indication for use: 2. treatment of Duchenne muscular dystrophy (DMD) in patients who have a confirmed mutation of the DMD gene that is amenable to exon 53 skipping. 2. Genetic testing must confirm patient's DMD gene is amenable to exon 53 skipping. 3. Current patient weight, including date weight was obtained and within 30 days of requested date.	1. Documentation and provider attestation of continued benefit, including respiratory status assessment, without adverse effects. 2. Not receiving another antisense therapy or gene therapy. 3. Verification that drug continues to carry FDA-approval for indication. 4. Approval duration: 3 months

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
	4. Baseline renal function test (GFR) and Urine protein-to-creatinine ratio prior to starting treatment. 5. Documented baseline function testing using a tool to demonstrate physical functions, including, but not limited to: Brooke Upper Extremity Scale, Baseline 6-minute walk test, Pediatric Evaluation of Disability Inventory. 6. Stable dose of glucocorticoid for at least 3 months. 7. Confirmation that drug continues to carry FDA-approval for indication. 8. Prescribed by a neurologist with expertise in treatment of DMD. 9. Approval duration: 3 months	
Vutrisiran (**Amvuttra**) **Not on MDH list **J0225** **NDC: 71336-1003-01**	1. Prescribed for an FDA-approved indication: Amvuttra is indicated for the treatment of the polyneuropathy of hereditary transthyretin-mediated amyloidosis in adults. (ICD-10: E85.1) 2. Documentation is provided that the patient has a TTR mutation confirmed by genotyping. 3. Documentation is provided that the patient has associated mild to moderate polyneuropathy. 4. Prescribed by or in consultation with a neurologist, geneticist, or physician specializing in the treatment of amyloidosis. 5. **Cannot** be approved if the patient has any of the following: • History of liver transplant, or moderate or severe hepatic impairment • Has severe renal impairment or end-stage renal disease • NYHA class III or IV heart failure • Sensorimotor or autonomic neuropathy not related to aATTR amyloidosis (including, but not limited to monoclonal gammopathy, autoimmune disease).	1. Patient must have met all initial authorization criteria. 2. Patient must have demonstrated a beneficial response to therapy with Amvuttra compared to baseline (e.g., improvement of neuropathy severity and rate of disease progression as demonstrated by the modified Neuropathy Impairment Scale+7 (mNIS+7) composite score, the Norfolk Quality of Life Diabetic Neuropathy (QoL-DN) total score, polyneuropathy disability (PND) score, FAP disease stage, manual grip strength). Documentation from the medical record must be provided. 3. Approval duration: 3 months.

Generic Medication (Brand Name) **Bolded** medication specifies whether Brand or Generic is on Formulary with PA requirement	Approval Criteria & Submission Requirements	Renewal Criteria
	6. Amvuttra will not be used in combination with inotersen (Tegsedi), patisiran (Onpattro) or tafamidis (Vyndaqel, Vyndamax) 7. Quantity limited to one Amvuttra 25 mg/0.5 ml syringe per 3 months. 8. Initial approval duration: 3 months.	