Blue Cross Blue Shield of Michigan
Blue Care Network
Prior authorization and step therapy coverage criteria
August 2022

Blue Cross Blue Shield of Michigan and Blue Care Network work to make sure you get the safest, most effective and most reasonably priced prescription drugs. Our pharmacists do this in many different ways. Prior authorization and step therapy are two of our tools.

What is prior authorization?

Blue Cross and BCN require a review of certain medications before your plan will cover them, which is called prior authorization. This ensures you've tried the preferred alternatives — drugs with a proven track record that may be better tolerated, less expensive or less likely to cause interactions — and the drug is being prescribed appropriately. If your doctor doesn't get prior authorization when required, your drug may not be covered. You should consult with your doctor about an alternative therapy in those cases. Most approved prior authorizations last for a set period of time, usually one year. Once they expire, your doctor must request prior authorization again for future coverage.

What is step therapy?

Step therapy requires that you try one or more preferred drugs before coverage for a more expensive alternative is approved. This ensures all clinically sound and cost-effective treatment options are tried before more expensive medications. If your prescribed treatment doesn't meet the step therapy criteria, it may not be covered. You should consult with your doctor about an alternative therapy.

What kinds of drugs need prior authorization or step therapy?

Blue Cross and BCN may require prior authorization or step therapy for drugs that:
Have dangerous side effects or can be harmful when combined with other drugs
Should only be used for certain health conditions
Can be misused or abused
Are prescribed when there are preferred drugs available that are just as effective

The criteria for medications that need prior authorization or step therapy are based on current medical information and the recommendations of Blue Cross and BCN's Pharmacy and Therapeutics Committee, a group of physicians, pharmacists and other experts.

Coverage of drugs depends on your prescription drug plan. Not all drugs included in these prior authorization and step therapy guidelines are necessarily covered by your plan. Also, some medications excluded from your prescription drug plan may be covered under your medical plan. Examples include medications that are generally administered in a physician's office or other sites of care, rather than at home by the patient. For drugs covered under commercial Blue Cross or BCN medical benefits, please see the **Blue Cross and BCN Utilization Management Medical Drug List.** Requests for medications not covered by your prescription drug plan are reviewed by Blue Cross and BCN to determine if they are medically necessary for you or if there are other equally effective treatments already covered by your drug plan. In rare cases, Blue Cross and BCN may approve medications that aren't covered by your drug plan.

Prior authorization and pharmacy programs listed in this guideline:

- **BCN Custom Drug List - 3 tier/5 tier**
- **BCN Custom Drug List – 6 tier**
- **BCBSM Custom Drug List**
- **BCBSM Clinical Drug List**
- **BCN Custom Select Drug List**
- **BCBSM Custom Select Drug List**
- **Lite Prior Authorization Program**
- **Preferred Therapy Program** — This program encourages using more cost-effective drugs rather than higher-priced, brand-name drugs if a prescription for the brand-name drug hasn't been filled in the last 180 days.
- **Off-Label and High-Cost Specialty program —** Off-label means a drug is being used in a way that hasn't been approved by the U.S. Food and Drug Administration. Drugs with potential for off-label use and high-cost specialty drugs on this list require prior authorization for Blue Cross to cover them..

Questions?
Please call the Customer Service number on the back of your Blue Cross or BCN member ID card if you have questions about:
- Your drug plan's coverage or how these pharmacy programs apply
- A drug claim

Electronic prior authorization for doctors and other health care providers

Your doctor can click here to request an electronic review of your covered drugs that require prior authorization or step therapy.

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Accrufer	Coverage requires the following: 1. Diagnosis of iron deficiency 2. Age ≥ 18 years old 3. Trial and failure or intolerance to two over-the-counter iron products Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓
Aciphex sprinkle	Coverage requires failure of or intolerance to all generic alternatives: omeprazole (Prilosec), pantoprazole (Protonix), lansoprazole (Prevacid/Prevacid Solutab), and rabeprazole (Aciphex)	✓	✓	**NC**	✓	✓		**NC**	**NC**

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Actemra SC	Coverage requires the following: 1. Diagnosis of Rheumatoid Arthritis 2. Age ≥ 18 years old 3. Trial and treatment failure of one Disease-Modifying Anti-Rheumatic Drug (DMARD) after a minimum 3-month trial (examples include methotrexate, hydroxychloroquine, leflunomide, sulfasalazine) 4. Trial and treatment failure of two of the following Enbrel, Humira, Rinvoq, or Xeljanz/XR OR 1. Diagnosis of Polyarticular Juvenile Idiopathic Arthritis 2. Age ≥ 2 years old 3. Trial and treatment failure of one Disease Modifying Anti-Rheumatic Drug (DMARD) after a minimum 3-month trial (examples include methotrexate, leflunomide) 4. Trial and treatment failure of two of the following Enbrel, Humira, or Xeljanz OR 1. Diagnosis of Still's disease, including adult-onset Still's disease (AOSD) and systemic juvenile idiopathic arthritis (sJIA) 2. Age ≥ 2 years old 3. Trial and treatment failure of one of the following therapies: methotrexate, leflunomide, glucocorticoids, NSAIDs OR 1. Diagnosis of giant cell arteritis 2. Age ≥ 18 years old **(criteria continued next page)**	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Actemra SC (continued)	OR 1. Diagnosis of systemic sclerosis-associated interstitial lung disease (SSc-ILD) 2. Inadequate response to (as evidenced by disease progression - (e.g. worsening of pulmonary function) or not a candidate for either mycophenolate mofetil OR cyclophosphamide Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Acthar Gel	Coverage is provided for the treatment of infantile spasms (West Syndrome) for children less than 2 years old	✓	✓	**NC**	✓	✓	✓	✓	**NC**
adapalene/benzoyl peroxide (Epiduo Forte)	Coverage requires the following: 1. Diagnosis of acne 2. Trial and failure, contraindication, or intolerance to three generic or preferred topical agents for the treatment of acne, one of which must be benzoyl peroxide and another must be adapalene Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		✓	**NC**

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Adbry	Coverage requires the following: 1. Diagnosis of moderate to severe atopic dermatitis (AD) 2. Age ≥ 18 years old 3. Trial and treatment failure of one of the following: high potency topical corticosteroid, tacrolimus, pimecrolimus, cyclosporine, methotrexate, azathioprine, or mycophenolate mofetil 4. Trial and treatment failure of Dupixent 5. Cannot be used in combination with other biologic agents indicated for atopic dermatitis Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓	✓	✓	**NC**
Addyi	Coverage requires the following: 1. Premenopausal female ≥ 18 years old 2. Diagnosis of acquired, generalized hypoactive sexual desire disorder (HSDD) that has been ongoing for more than 6 months 3. Other causes (such as relationship difficulty, substance abuse, medication side effects) of HSDD must be ruled out Initial approval: 8 weeks Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓	✓	✓	**NC**

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Adempas	Coverage requires the following: 1. Diagnosis of persistent/recurrent Chronic Thromboembolic Pulmonary Hypertension (CTEPH) (WHO Group 4) after surgical treatment or inoperable CTEPH OR 1. Diagnosis of Pulmonary Arterial Hypertension (PAH)(WHO Group 1)	✓	✓	✓	✓	✓	✓	✓	✓
Adlarity	Coverage requires the following: 1. Diagnosis of mild, moderate, and severe dementia of Alzheimer's type 2. Trial and failure or intolerance to generic oral donepezil Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓
Adzenys ER, amphetamine suspension	Coverage requires the following: 1. Diagnosis of Attention Deficit Hyperactivity Disorder 2. Age ≥ 6 years old 3. Treatment failure or intolerance to both a generic methylphenidate and a generic amphetamine product, one of which must be a long-acting formulation OR 3. Member cannot swallow tablets/capsules and has tried and failed one of the agents that can be opened and sprinkled on applesauce (Metadate CD, Adderall XR) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓	✓	✓	**NC**

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Adzenys XR-ODT	Coverage requires the following: 1. Diagnosis of Attention Deficit Hyperactivity Disorder 2. Age ≥ 6 years old 3. Treatment failure or intolerance to both a generic methylphenidate and a generic amphetamine product, one of which must be a long-acting formulation OR 3. Member cannot swallow tablets/capsules and has tried and failed one of the agents that can be opened and sprinkled on applesauce (Metadate CD, Adderall XR) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓	✓	✓	**NC**
Afrezza	Coverage is provided when the member has experienced treatment failure or intolerance to Novolog	✓	✓	**NC**	✓			✓	**NC**
Aimovig	Coverage requires the following: 1. Age ≥ 18 years old 2. Being used for preventive treatment of migraine headaches 3. Member has history of ≥ 4 headache days per month 4. Trial of two medications from two different classes for the prevention of migraines Initial approval: 1 year Renewal requires at least a 50% or greater reduction in monthly migraine days (MMDs) from baseline	✓	✓	✓	✓	✓	✓	✓	✓

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Ajovy	Coverage requires the following: 1. Age ≥ 18 years old 2. Being used for preventive treatment of migraine headaches 3. Member has history of ≥ 4 headache days per month 4. Trial of two medications from two different classes for the prevention of migraines 5. Trial and treatment failure of Aimovig and Emgality Initial approval: 1 year Renewal requires at least a 50% or greater reduction in monthly migraine days (MMDs) from baseline	✓	✓	✓	✓	✓	✓	✓	✓
Akynzeo	Coverage is provided for the prevention of chemotherapy-induced nausea/vomiting (CINV) and after a trial of all of the following: 1. Generic 5HT3 antagonist (ex. generic Zofran, generic Kytril) 2. Preferred NK1 antagonist (ex. Emend). 3. Glucocorticoid (dexamethasone) Initial approval: 1 year Renewal requires continuation of chemotherapy	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Alecensa	Coverage requires the following: Diagnosis of anaplastic lymphoma kinase (ALK) positive, metastatic non-small cell lung cancer Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓
Alkindi Sprinkle	Coverage requires the following: 1. Diagnosis of adrenocortical insufficiency 2. Age ≤ 6 years old OR 2. Member cannot swallow tablets/capsules Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓		✓	✓
almotriptan (Axert)	Coverage requires trial of 2 of the following generic triptans: Imitrex, Maxalt, Amerge or Zomig/ZMT Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Alunbrig	Coverage requires the following: Diagnosis of anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer (NSCLC) as detected by an FDA-approved test Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓
ambrisentan (Letairis)	Coverage is provided for the treatment of pulmonary arterial hypertension (WHO Group 1)	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
amphetamine sulfate (Evekeo)	Coverage is provided when one of the following have been met. (1, 2 or 3): 1. Narcolepsy: a. ≥ 6 years of age b. Trial and treatment failure or intolerance to generic Adderall IR and a generic methylphenidate product 2. ADHD: (Attention deficit hyperactivity disorder) a. 3-6 years of age i. Trial and treatment failure or intolerance to generic amphetamine product or b. ≥ 6 years of age i. Trial and treatment failure or intolerance to of generic amphetamine and generic methylphenidate product 3. Obesity: a. ≥ 12 years of age b. BMI > 30 kg/m2 c. Previous trials of lifestyle modifications d. Previous trials of weight loss therapies (examples include: repeated diets, group programs, or other weight loss medications) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
anastrazole (Arimidex)	Coverage for $0 copayment will be provided when: 1. The member is a woman at least 35 years of age 2. The medication is being used for prevention of primary breast cancer 3. Members is classified as high risk 4. Does not have a history of breast cancer 5. Member is currently post-menopausal	✓	✓	✓	✓	✓		✓	✓
Aptiom	Coverage requires the following: 1. Treatment of seizures in patients with epilepsy 2. Treatment failure or intolerance to at least 3 generic alternatives for the treatment of seizures	✓	✓	**NC**	✓	✓		✓	**NC**

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Arcalyst	Coverage requires the following: 1. Treatment of Cryopyrin-Associated Periodic Syndromes (CAPS), including Familial Cold Autoinflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS) 2. Age ≥ 12 years old 3. Laboratory evidence of a genetic mutation OR elevated inflammatory markers plus at least two of six typical CAPS manifestations: (urticaria-like rash, cold-triggered episodes, hearing loss, musculoskeletal symptoms, chronic aseptic meningitis, or skeletal abnormalities) OR 1. Diagnosis of deficiency of interleukin-1 receptor antagonist (DIRA) 2. Laboratory evidence of homozygous genetic mutations of IL1RN 3. Weight ≥ 10 kg 4. Trial and failure, contraindication, or intolerance to Kineret OR 1. Diagnosis of recurrent pericarditis (RP) 2. Age ≥ 12 years old 3. Trial and treatment failure or intolerance to nonsteroidal anti-inflammatory drugs (NSAIDs) in combination with colchicine 4. Trial and treatment failure or intolerance to Kineret Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Arikayce	Coverage requires the following: 1. Diagnosis of mycobacterium avium complex (MAC) 2. Age ≥ 18 years old Initial approval: 1 year	✓	✓	✓	✓	✓	✓	✓	✓
Austedo	Coverage requires the following: 1. Diagnosis of chorea associated with Huntington's disease 2. Trial and failure or intolerance to Xenazine OR 1. Diagnosis of Tardive Dyskinesia Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Ayvakit	Coverage requires the following: 1. Treatment of unresectable or metastatic gastrointestinal stromal tumor harboring a PDGFRA exon 18 mutation 2. Age ≥ 18 years old OR 1. Diagnosis of advanced systemic mastocytosis (advSM) 2. Age ≥ 18 years old Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓		✓	✓

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
azelastine-fluticasone (Dymista)	Coverage requires the following: 1. Age ≥ 6 years old 2. Diagnosis of allergic rhinitis 3. Trial and treatment failure or intolerance to 2 generic intranasal steroid products, one of which must be intranasal generic fluticasone (Flonase) used in combination with intranasal generic azelastine (Astelin) after a minimum 3-month trial Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		**NC**	**NC**
Azstarys	Coverage requires the following: 1. Diagnosis of attention deficit hyperactivity disorder (ADHD) 2. Age ≥ 6 years old 3. Trial and treatment failure or intolerance to a generic methylphenidate product and a generic amphetamine product, one of which must be a generic long acting formulation OR 3. Member cannot swallow tablets/capsules and has tried and failed one product that can be opened and sprinkled on applesauce, such as extended release methylphenidate (Metadate CD) or generic amphetamine-dextroamphetamine (Adderall XR) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		✓	**NC**

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Balversa	Coverage requires the following: 1. Diagnosis of locally advanced or metastatic urothelial carcinoma with susceptible FGFR3 or FGFR2 genetic alterations 2. Disease progression during or following at least one line of prior platinum-containing chemotherapy, including within 12 months of neoadjuvant or adjuvant platinum-containing chemotherapy Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓
Beconase AQ	Coverage requires trial and failure/intolerance of 2 of the following intranasal steroids: generic fluticasone (Flonase), generic flunisolide (Nasalide), or generic triamcinolone (Nasacort AQ) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓			**NC**	**NC**
Belsomra	Coverage requires treatment failure of 3 of the following: immediate-release zolpidem (Ambien), eszopiclone (Lunesta), zaleplon (Sonata), trazodone (Desyrel), or doxepin (Silenor) Coverage will not be approved for combination therapy with other sedative hypnotics Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓			✓	**NC**

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Benlysta	Coverage requires the following: 1. Age ≥ 18 years old 2. Diagnosis of systemic lupus erythematosus (SLE) 3. Patients have tested positive for serum antibodies at 2 independent time points 4. If patient has lupus nephritis ONLY and no other symptoms of SLE, patient must have active disease of the kidney confirmed on biopsy 5. Does not have severe active CNS lupus 6. Previous treatment courses of at least 12 weeks each with 2 or more of the following have been ineffective: hydroxychloroquine, methotrexate, azathioprine, cyclophosphamide or mycophenolate, unless all are contraindicated or not tolerated 7. Patient is currently receiving, and will continue to receive standard of care regimen (examples include antimalarials, corticosteroids, and non-biologic immunosuppressants) 8. Not to be used in combination with other biologics, B-cell targeted therapies Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Besremi	Coverage requires the following: 1. Treatment of polycythemia vera (PV) 2. Age ≥ 18 years old Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
bexarotene (Targretin)	Coverage requires the following: 1. Diagnosis of cutaneous T-cell lymphoma (CTCL) 2. Treatment failure or intolerance to at least one systemic therapy Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓		✓	✓
Binosto	Coverage requires trial and treatment failure or intolerance to two of the following: 1. Actonel (risedronate) 2. Boniva (ibandronate) 3. Fosamax (alendronate) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		✓	**NC**
Bonjesta	Coverage requires the following: 1. Treatment of nausea and vomiting of pregnancy 2. Trial and treatment failure of the individual agents (doxylamine and pyridoxine) in combination Approval length: 9 months	✓	✓	**NC**	✓	✓	✓	✓	**NC**
bosentan (Tracleer)	Coverage is provided for the treatment of pulmonary arterial hypertension (WHO Group 1)	✓	✓	✓	✓	✓	✓	✓	✓

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Bosulif	Coverage requires the following: 1. Diagnosis of chronic phase Philadelphia chromosome-positive (PH+) chronic myelogenous leukemia (CML) OR 1. Diagnosis of chronic, accelerated, or blast phase PH+ CML with resistance or intolerance to prior therapy Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓
Braftovi	Coverage requires the following: 1. Diagnosis of unresectable or metastatic melanoma with a BRAF V600E or V600K mutation as detected by an FDA-approved test 2. Using in combination with Mektovi OR 1. Diagnosis of metastatic colorectal cancer with a BRAF V600E mutation as detected by an FDA approved test 2. Using in combination with Erbitux 3. Treatment failure or intolerance to prior therapy Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Bronchitol	Coverage requires the following: 1. Using as add-on maintenance therapy to improve pulmonary function in patients with cystic fibrosis (CF) 2. Age ≥ 18 years old 3. Must have passed the Bronchitol Tolerance Test 4. Member will be taking a short-acting bronchodilator 5-15 minutes before every dose of Bronchitol 5. Trial and failure, contraindication, or intolerance to nebulized hypertonic saline Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Briviact oral solution + tablet	Coverage requires the following: 1. Treatment of seizure disorder/epilepsy 2. Treatment failure or intolerance to 3 generic preferred alternatives	✓	✓	✓	✓			✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Brukinsa	Coverage requires the following: 1. Diagnosis of mantle cell lymphoma (MCL) 2. Treatment failure or intolerance to at least one prior therapy OR 1. Diagnosis of Waldenström's macroglobulinemia (WM) OR 1. Diagnosis of marginal zone lymphoma (MZL) 2. Treatment failure or intolerance to one or more rounds of therapy with a CD20 inhibiting antibody Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓
buprenorphine hcl (Belbuca)	Coverage requires the following: 1. Diagnosis of moderate to severe chronic pain requiring around the clock opioid analgesia for an extended period of time 2. Trial and failure or intolerance to two long-acting opioids, one of which must be buprenorphine transdermal patch Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit Note: Coverage will not be provided if the patient is on more than one long acting opioid concurrently	✓	✓	**NC**	✓	✓	✓	✓	**NC**

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Bylvay	Coverage requires the following: 1. Diagnosis of progressive familial intrahepatic cholestasis (PFIC) 2. Age ≥ 3 months old 3. Genetic testing does not show presence of the ABCB11 variants resulting in a nonfunctional or complete absence of the bile salt export pump protein (BSEP-3). 4. No history of liver transplant or planned future liver transplant 5. No clinical evidence of decompensated cirrhosis 6. Trial and failure, contraindication, or intolerance to generic ursodiol Initial approval: 6 months Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Cablivi	Coverage requires the following: 1. Diagnosis of acquired aTTP 2. Administered in addition to plasma exchange and immunosuppressive therapy 3. Continued 30 days after discontinuation of plasma exchange Approve for 2 months	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Cabometyx	Coverage requires the following: 1. Diagnosis of advanced renal cell carcinoma 2. Age ≥ 18 years old 3. Using as a single agent or in combination with Opdivo (nivolumab) OR 1. Diagnosis of hepatocellular carcinoma (HCC) 2. Previous treatment with sorafenib 3. Age ≥ 18 years old OR 1. Diagnosis of locally advanced or metastatic differentiated thyroid cancer (DTC), radioactive iodine-refractory or ineligible 2. Previous treatment with VEGFR-targeted therapy 3. Age ≥ 12 years old Initial approval: 1 year Continuation of treatment requires of a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓
calcipotriene + betamethasone ointment / suspension (Taclonex)	Coverage requires the following: 1. Age ≥ 12 years old 2. Diagnosis of psoriasis 3. Trial and treatment failure with a high potency topical steroid in combination with generic Dovonex Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓		✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Calquence	Coverage requires the following: 1. Diagnosis of mantle cell lymphoma (MCL) 2. Treatment failure or intolerance to at least one prior therapy OR 1. Diagnosis of chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL) Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓
Camzyos	Coverage requires the following: 1. Diagnosis of symptomatic obstructive hypertrophic cardiomyopathy (HCM) 2. New York Heart Association (NYHA) class II-III 3. Age ≥ 18 years old 4. Left ventricular ejection fraction (LVEF) > 55% 5. Trial and failure, contraindication, or intolerance to a beta blocker or calcium channel blocker Initial approval: 1 year Renewal requires that the medication is providing clinical benefit and that LVEF is ≥ 50%	✓	✓	✓	✓	✓	✓	✓	✓
Caprelsa	Coverage will be provided for the treatment of patients with metastatic or unresectable locally advanced medullary thyroid cancer Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Caplyta	Coverage requires the following: Trial and failure, contraindication, or intolerance to two preferred or generic second generation antipsychotics (examples include: aripiprazole, clozapine, risperidone, quetiapine, olanzapine, ziprasidone) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓
carglumic acid (Carbaglu)	Coverage requires the following: 1. Treatment of hyperammonemia due to NAGSD, a deficiency of the hepatic enzyme N-acetylglutamate synthase (NAGS) 2. Deficiency must be confirmed by enzyme or DNA mutation analysis Initial approval for NAGSD: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit OR 1. Adjunctive treatment of acute hyperammonemia due to propionic acidemia (PA) or methylmalonic acidemia (MMA) 2. Diagnosis must be confirmed by analysis of organic acids in urine and assessment of the acylcarnitine profile in blood Approval for PA or MMA: maximum duration of 7 days	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Cayston	Coverage is provided for the treatment of Pseudomonas aeruginosa infection in members with cystic fibrosis Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓
Cerdelga	Treatment of adult patients with Gaucher disease type 1 who are cytochrome P450 (CYP-450) 2D6 extensive metabolizers, intermediate metabolizers or poor metabolizers as detected by an FDA-cleared test Renewal requires stability or improvement in disease (this may include, but is not limited to, hematologic indices, and/or MRI of spine/femurs)	✓	✓	✓	✓	✓	✓	✓	✓
Cetrotide	Coverage requires the following: 1. It is being prescribed to treat infertility in accordance with generally accepted medical practice 2. The members benefit provides for coverage for infertility medications 3. Will not be covered if being used as part of assisted reproductive treatment (ART)			**NC**				✓	**NC**
Chenodal	Coverage requires the following: 1. Treatment of gallstones 2. Ineligible for surgery 3. Treatment failure or intolerance to Actigall (ursodiol) Coverage is limited to 24 months	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Cholbam	Coverage requires the following: 1. Prescribed by or in consultation with hepatologist or gastroenterologist 2. Treatment of bile acid synthesis disorder due to single enzyme defects (SEDs) OR 1. Adjunctive treatment of peroxisomal disorders (PDs) including Zellweger spectrum disorders in patients who exhibit manifestation of liver disease, steatorrhea or complications from decreased fat-soluble vitamin deficiency 2. Prescribed by or in consultation with a hepatologist or gastroenterologist	✓	✓	✓	✓	✓	✓	✓	✓
chorionic gonadotropin (HCG) (Novarel)	Coverage requires the following: 1. The treatment is being provided by a board-certified infertility specialist 2. It is being prescribed to treat infertility in accordance with generally accepted medical practice. 3. The members benefit provides for coverage for infertility medications 4. Coverage may be provided in accordance with your medical fertility benefit OR For the diagnosis of: 1. Hypogonadotrophic hypogonadism secondary to a pituitary deficiency in males OR 1. Prepubertal cryptorchidism not caused by anatomic obstruction	✓	✓	**NC**	✓	✓	✓	✓	**NC**

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Cibinqo	Coverage requires the following: 1. Diagnosis of moderate to severe atopic dermatitis (AD) 2. Age ≥ 18 years old 3. Trial and treatment failure of one of the following: high potency topical corticosteroid, tacrolimus, pimecrolimus, cyclosporine, methotrexate, azathioprine, or mycophenolate mofetil 4. Trial and treatment failure of Rinvoq 5. Cannot be used in combination with other biologic agents indicated for severe atopic dermatitis Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓	✓	✓	**NC**

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Cimzia	Coverage requires the following: 1. Diagnosis of Crohn's Disease 2. Age ≥ 18 years old 3. Treatment with an adequate course of conventional therapy (such as steroids for at least 7 days (examples include prednisone, methylprednisolone, or budesonide) or immunomodulators for at least 2 months (examples include methotrexate, azathioprine, or sulfasalazine)) 4. Trial and treatment failure of Humira and Stelara OR 1. Diagnosis of Rheumatoid Arthritis 2. Age ≥ 18 years old 3. Trial and treatment failure of Disease Modifying Anti-Rheumatic Drug (DMARD) after a minimum 3-month trial (examples include methotrexate, leflunomide, hydroxychloroquine, sulfasalazine) 4. Trial and treatment failure of two of the following: Enbrel, Humira, Rinvoq, or Xeljanz/XR 5. Trial and treatment failure of Actemra and Orencia OR 1. Diagnosis of Ankylosing Spondylitis 2. Age ≥ 18 years old 3. Trial and treatment failure of four of the following: Humira, Enbrel, Xeljanz/XR, Taltz, or Rinvoq OR 1. Diagnosis of Psoriatic Arthritis 2. Age ≥ 18 years old 3. Trial and treatment failure of two of the following: Enbrel, Humira, Otezla, Stelara, Rinvoq, Skyrizi, Tremfya, or Xeljanz/XR 4. Trial and treatment failure of Taltz and Orencia **(criteria continued next page)**	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Cimzia (continued)	OR 1. Diagnosis of Psoriasis 2. Age ≥ 18 years old 3. Trial and treatment failure of one topical steroid 4. Trial and treatment failure of four of the following: Enbrel, Humira, Otezla, Skyrizi, Stelara, or Tremfya OR 1. Diagnosis of active Non-Radiographic Axial Spondyloarthritis with objective signs of inflammation 2. Age ≥ 18 years old 3. Trial and treatment failure of Taltz Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Cometriq	Coverage is provided for the treatment of patients with progressive, metastatic medullary thyroid cancer. Therapy is considered investigational for all other conditions Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓
Compounds	Coverage requires the following: 1. The compound is medically necessary for the member's condition 2. The compound contains only FDA-approved drugs 3. There are no appropriate FDA-approved commercial formulations of the compound available 4. There is medical literature to support the safety, effectiveness and route of administration of the compound	✓	✓	✓	✓	✓		✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Continuous Glucose Monitors Dexcom G6 Freestyle Libre 14 day Freestyle Libre 2 14 day	Coverage is provided for the diagnosis of diabetes	✓	✓	✓	✓	✓	✓	✓	✓
Contraceptives	Coverage for $0 copayment will be provided when: 1. Used for the prevention of pregnancy 2. Trial and treatment failure or intolerance to at least three generic contraceptive medications	✓	✓	✓	✓	✓		✓	✓
Contrave	Coverage requires the following: 1. 18 years and older 2. BMI ≥ 30, or ≥ 27 with one weight related comorbid condition 3. Current weight (within 30 days) must be submitted to the plan for review 4. Concurrent of lifestyle modification program 5. Not to be used in combination with other weight loss products Initial approval: 1 year Continued coverage will be reviewed annually and may be provided if the member has maintained at least a 5% weight loss from baseline	✓	✓	**NC**	✓	✓	✓	✓	**NC**

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Copiktra	Coverage requires the following: 1. Diagnosis of relapsed or refractory chronic lymphocytic leukemia (CLL or small lymphocytic lymphoma (SLL)) after at least two prior therapies	✓	✓	✓	✓	✓	✓	✓	✓
Cotellic	Coverage requires the following: 1. Diagnosis of unresectable or metastatic melanoma with a BRAF V600E or V600K mutation 2. Using in combination with Zelboraf Initial approval: 1 year Continuation of coverage requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓
Crinone 8%	Coverage requires the following: 1. It is being prescribed to treat infertility in accordance with generally accepted medical practice 2. The members benefit provides for coverage for infertility medications 3. Will not be covered if being used as part of assisted reproductive treatment (ART)			**NC**				✓	**NC**
Cutaquig	Requires appropriate diagnosis for coverage, subcutaneous administration and other criteria may apply depending on diagnosis. Dosing must be based on ideal body weight (IBW) unless the patient's BMI is greater than 30. If the patient's BMI is greater than 30 or if actual body weight is 20-30% greater than IBW, adjusted body weight must be used Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Cuvitru	Requires appropriate diagnosis for coverage, subcutaneous administration and other criteria may apply depending on diagnosis. Dosing must be based on ideal body weight (IBW) unless the patient's BMI is greater than 30. If the patient's BMI is greater than 30 or if actual body weight is 20-30% greater than IBW, adjusted body weight must be used Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓	✓	✓	**NC**
Cycloset	Coverage requires the following: 1. Diagnosis of type 2 diabetes 2. Treatment failure or intolerance to at least 2 generic oral diabetes medications	✓	✓	✓	✓	✓	✓	✓	✓
Cystadrops	Coverage is provided for the treatment of corneal cystine crystal accumulation in patients with cystinosis, when taking in combination with oral Cystagon.	✓	✓	✓	✓	✓	✓	✓	✓
Cystaran	Coverage is provided for the treatment of corneal cystine crystal accumulation in patients with cystinosis, when taking in combination with oral Cystagon	✓	✓	✓	✓	✓	✓	✓	✓
Daurismo	Coverage requires the following: Treatment of newly diagnosed acute myeloid leukemia (in combination with low-dose cytarabine) in adult patients who are ≥ 75 years of age or who have comorbidities that preclude use of intensive induction chemotherapy Limitations of use: Has not been studied in patients with severe renal impairment or moderate to severe hepatic impairment	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Dayvigo	Coverage requires treatment failure of 3 of the following: immediate-release zolpidem (Ambien), eszopiclone (Lunesta), zaleplon (Sonata), trazodone (Desyrel), or doxepin (Silenor) Coverage will not be approved for combination therapy with other sedative hypnotics Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓			✓	**NC**
deferasirox (Exjade)	Coverage requires the following: 1. Chronic iron overload due to transfusions: 2. ≥ 2 years of age 3. Trial and failure of Desferal OR 1. Chronic iron overload in nontransfusion-dependent thalassemia syndromes: 2. ≥ 10 years of age 3. Trial and failure of Desferal Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
deferasirox (Jadenu)	Coverage requires the following: 1. Chronic iron overload due to transfusions: a. ≥ 2 years of age b. Trial and failure of Desferal. OR 2. Chronic iron overload in nontransfusion-dependent thalassemia syndromes: a. ≥ 10 years of age b. Trial and failure of Desferal Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓	✓	✓	**NC**
deferiprone tablets (Ferriprox)	Coverage requires the following: 1. Age ≥ 8 years old 2. Diagnosis of transfusional iron overload due to thalassemia syndromes when current chelation therapy is inadequate 3. Treatment failure or intolerance to Desferal and Exjade Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
deferiprone solution (Ferriprox)	Coverage requires the following: 1. Age ≥ 3 years old 2. Diagnosis of transfusional iron overload due to thalassemia syndromes when current chelation therapy is inadequate 3. Treatment failure or intolerance to Desferal and Exjade Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Descovy	Coverage with $0 copayment will be provided when: 1. Using for pre exposure prophylaxis (PrEP) for HIV 2. Negative HIV test within the past 3 months 3. Trial and intolerance or contraindication to generic Truvada 200mg/300mg OR Coverage will be provided for the treatment of HIV infection Initial approval: 2 years Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓		✓	✓
Desvenlafaxine ER	Coverage requires trial and failure of at least three antidepressant agents	✓	✓	**NC**	✓	✓		✓	**NC**
Dexilant / dexlansoprazole	Coverage requires failure of or intolerance to all generic alternatives: omeprazole (Prilosec), pantoprazole (Protonix), lansoprazole (Prevacid/Prevacid Solutab), and rabeprazole (Aciphex)	✓	✓	**NC**	✓	✓		**NC**	**NC**

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Diacomit	Coverage requires the following: 1. Diagnosis of Dravets Syndrome 2. Currently taking Clobazam	✓	✓	✓	✓	✓	✓	✓	✓
diclofenac 2% external solution (Pennsaid 2%)	Coverage requires the following: 1. Diagnosis of osteoarthritis of the knee 2. Trial of or intolerance to generic oral diclofenac and at least two other oral, traditional NSAIDs 3. Trial of generic Pennsaid 1.5% topical solution Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit Please note: Coverage will not be provided in the presence of concurrent therapy with oral NSAIDs	✓	✓	**NC**	✓	✓		✓	**NC**
diclofenac potassium (Zipsor)	Coverage requires the following: 1. Age ≥ 12 years old 2. Diagnosis of acute pain 3. Trial and failure of oral diclofenac 4. Trial and failure of two other preferred oral NSAIDs Initial approval: 3 months	✓	✓	**NC**	✓	✓		✓	**NC**

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
diclofenac sodium 3% gel (Solaraze)	Coverage requires the following: 1. Age ≥ 18 years old 2. Diagnosis of actinic keratosis 3. Trial and failure or intolerance to cryotherapy or phototherapy 4. Trial and treatment failure or intolerance to a generic or preferred topical fluorouracil 5. Trial and treatment failure or intolerance to generic imiquimod 5% Initial approval: 3 months Renewal requires recurrence and/or new lesions	✓	✓	✓	✓	✓	✓	✓	✓
Dojolvi	Coverage requires the following: 1. Treatment of molecularly confirmed long-chain fatty acid oxidation disorders 2. Following low fat/high carbohydrate diet and avoiding fasting 3. Trial of medium chain triglycerides at a maximally tolerated dose	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Doptelet	Coverage requires the following: 1. Diagnosis of thrombocytopenia in chronic liver disease a. Age ≥ 18 years old b. Platelet count < 50,000/mcL c. Scheduled to undergo a procedure OR 2. Diagnosis of chronic immune thrombocytopenia (ITP) and persistent thrombocytopenia (platelet count < 100,000/mcL) for ≥ 3 months and requires all of the following: a. Age ≥ 18 years old b. Current platelet count is < 20,000/mcL or < 30,000/mcL and has symptoms of active bleeding c. Diagnosis confirmed by, or in consultation with a hematologist d. Inadequate response to (e.g. unable to maintain platelet count ≥ 30,000/mcL) OR are not candidates for therapy with corticosteroids, immunoglobulins, or splenectomy with an insufficient response to previous treatment Initial approval for diagnosis of thrombocytopenia in chronic liver disease: 1 month with no renewal Initial approval for diagnosis of chronic ITP: 3 months Renewal requires a recent platelet count between 50,000 and 200,000/mcL	✓	✓	✓	✓	✓	✓	✓	✓
Doryx MPC	Coverage requires the following: Trial and treatment failure or intolerance to generic doxycycline monohydrate (Monodox) or generic doxycycline hyclate immediate release (Vibramycin) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		✓	**NC**

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Doxepin topical cream	Coverage requires the following: 1. Diagnosis of atopic pruritis or lichen simplex chronicus 2. Trial and treatment failure of two topical steroids, one of which must be a medium or high potency product 3. Trial and treatment failure to one preferred topical calcineurin inhibitor (tacrolimus, pimecrolimus) OR 1. Diagnosis of peripheral neuropathic pain 2. Trial and treatment failure of two over-the-counter topical analgesics 3. Trial and treatment failure of one preferred topical non-steroidal anti-inflammatory drug (NSAID) Iniital approval: 1 month	✓	✓	✓	✓	✓	✓	✓	✓
doxycycline hyclate (Doryx)	Coverage requires the following: Trial and treatment failure or intolerance to generic doxycycline monohydrate (Monodox) or generic doxycycline hyclate immediate release (Vibramycin) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		✓	**NC**
doxycycline monohydrate (Adoxa / Adoxa Pak)	Coverage requires the following: Trial and treatment failure or intolerance to generic doxycycline monohydrate (Monodox) or generic doxycycline hyclate immediate release (Vibramycin) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		✓	**NC**

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
droxidopa (Northera)	Coverage requires the following: 1. Diagnosis of orthostatic hypotension 2. Age ≥18 years old 3. Trial and treatment failure of midodrine 4. Trial and treatment failure of fludrocortisone	✓	✓	**NC**	✓	✓	✓	✓	**NC**
Duopa	Coverage requires the following: 1. Diagnosis of advanced Parkinson's disease 2. Member has a feeding tube	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Dupixent	Coverage requires the following: 1. Diagnosis of moderate to severe atopic dermatitis 2. Age ≥ 6 months old 3. Trial and treatment failure of one of the following: high potency topical corticosteroid, tacroliumus, pimecrolimus, cyclosporine, methotrexate, azathioprine, or mycophenolate mofetil 4. Cannot be used in combination with other biologic agents indicated for severe atopic dermatitis OR 1. Diagnosis of eosinophilic asthma 2. Age ≥ 6 years old 3. Patient is currently receiving, and will continue to receive standard of care regimen 4. Eosinophil count ≥ 150 cells/microliter at initiation of treatment 5. Failure to maintain adequate control after at least a 3 month trial of daily oral corticosteroids or high dose inhaled corticosteroids in combination with: a. LABA (long acting inhaled β2 agonist) OR b. Leukotriene modifier OR c. LAMA (long acting muscarininc antagonist) in adults and children ≥ 12 years old 6. Cannot be used in combination with other biologic agents indicated for asthma **(criteria continued next page)**	✓	✓	✓	✓	✓	✓	✓	✓

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Dupixent (continued)	OR 1. Diagnosis of oral corticosteroid dependent asthma 2. Age ≥ 6 years old 3. Patient is currently receiving, and will continue to receive standard of care regimen 4. Failure to maintain adequate control after at least a 3 month trial of daily oral corticosteroids AND high dose inhaled corticosteroids in combination with: a. LABA (long acting inhaled β2 agonist) OR b. Leukotriene modifier OR c. LAMA (long acting muscarininc antagonist) in adults and children ≥ 12 years old 5. Cannot be used in combination with other biologic agents indicated for asthma OR 1. Diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP) 2. Age > 18 years old 3. Patient is currently receiving, and will continue to receive standard of care regimen 4. CRSwNP is recurring despite previous treatment with intranasal corticosteroids 5. Cannot be used in combination with other biologic agents indicated for CRSwNP Approval length: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Dyanavel XR	Coverage requires the following: 1. Diagnosis of Attention Deficit Hyperactivity Disorder 2. Age ≥ 6 years old 3. Treatment failure or intolerance to both a generic methylphenidate and a generic amphetamine product, one of which must be a long-acting formulation OR 3. Member cannot swallow tablets/capsules and has tried and failed one of the agents that can be opened and sprinkled on applesauce (Metadate CD, Adderall XR) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓	✓	✓	**NC**
Ecoza	Coverage requires the following: 1. Diagnosis of tinea pedis 2. Treatment failure of 2 topical over-the-counter antifungal agents 3. Treatment failure of two oral generic antifungal agents (fluconazole, itraconazole or terbinafine)	✓	✓	**NC**	✓			✓	**NC**
Edarbi	Coverage requires that the member has experienced treatment failure or intolerance to two generic Angiotensin II Receptor Blockers (ARB) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓		✓				✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Edarbyclor	Coverage requires that the member has experienced treatment failure or intolerance to two generic Angiotensin II Receptor Blockers (ARB) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓		✓				✓	✓
Edluar	Coverage requires treatment failure of 3 of the following: immediate-release zolpidem (Ambien), eszopiclone (Lunesta), zaleplon (Sonata), trazodone (Desyrel), or doxepin (Silenor) Coverage will not be approved for combination therapy with other sedative hypnotics Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		✓	**NC**
Egrifta	Coverage requires the following: 1. Diagnosis of HIV 2. Currently receiving antiretroviral therapy (ART) 3. Medical complication caused by excess abdominal fat 4. Medical complication due to excess abdominal fat is not responsive to conventional therapy Initial approval: 6 months Renewal requires a decrease in waist circumference and reduction of complications caused by excess abdominal fat	✓	✓	**NC**	✓	✓	✓	✓	**NC**

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Elepsia XR	Coverage requires the following: 1. Treatment of seizure disorder/epilepsy 2. Treatment failure or intolerance to three generic or preferred alternatives, one of which must be generic Keppra	✓	✓	**NC**	✓	✓		✓	**NC**
eletriptan (Relpax)	Coverage requires trial of 2 of the following generic triptans: Imitrex, Maxalt, Amerge, or Zomig/ZMT Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓
Emflaza	Coverage requires the following: 1. Diagnosis of Duchenne Muscular Dystrophy (DMD) 2. Prescribed by or in consultation with a physician who specializes in the treatment of DMD 3. Trial and treatment failure of prednisone or prednisolone	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Emgality	Coverage requires the following: 1. Age ≥ 18 years old 2. For preventive treatment of migraine headaches 3. Member has history of ≥ 4 headache days per month 4. Trial of two medications from two different classes for the prevention of migraines OR 1. For the treatment of episodic cluster headache 2. Age ≥18 years old 3. Trial and failure, contraindication, or intolerance to at least ONE of the following: lithium, verapamil, melatonin, frovatriptan, prednisone, suboccipital steroid injection, topiramate and valproate Initial approval for episodic cluster headache: 6 months Renewal approval for episodic cluster headache: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Empaveli	Coverage requires the following: 1. Diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) 2. Age ≥ 18 years old 3. Prescribed by or in consultation with a hematologist 4. Flow cytometric confirmation of PNH type III red cells 5. Had at least 1 transfusion in 12 months preceding Empaveli OR 5. History of major adverse thrombotic vascular events from thromboembolism OR 5. Patient has high disease activity defined as a lactic dehydrogenase (LDH) level ≥ 1.5 times the upper limit of normal with one of the following symptoms: i. Weakness ii. Fatigue iii. Hemoglobinuria iv. Abdominal pain v. Dyspnea vi. Hemoglobin < 10 g/dL vii. A major vascular event viii. Dysphagia ix. Erectile dysfunction 6. Must not be used in combination with Soliris®, Ultomiris®, or other medications used to treat PNH Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Emsam	Coverage requires the following: 1. Treatment of major depressive disorder 2. Age ≥ 18 years old 3. Member has experienced treatment failure or intolerance to at least three different generic antidepressants	✓	✓	✓	✓	✓		✓	✓
emtricitabine 200mg-tenofovir 300mg (Truvada)	Coverage for $0 copayment will be provided when: 1. For prevention of HIV infection in members who are at a high risk of getting HIV 2. Member is not taking concomitant antiretroviral therapy	✓	✓	✓	✓	✓		✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Enbrel	Coverage requires the following: 1. Diagnosis Psoriatic Arthritis 2. Age ≥ 18 years old OR 1. Diagnosis of Rheumatoid Arthritis 2. Age ≥ 18 years old 3. Trial and treatment failure of one Disease Modifying Anti-Rheumatic Drug (DMARD) after a minimum 3-month trial (examples include methotrexate, hydroxychloroquine, leflunomide, sulfasalazine) OR 1. Diagnosis of Ankylosing Spondylitis 2. Age ≥ 18 years old OR 1. Diagnosis of Psoriasis 2. Age ≥ 4 years old 3. Trial and treatment failure of one topical steroid OR 1. Diagnosis of Juvenile Idiopathic Arthritis (JIA) 2. Age ≥ 2 years old 3. Trial and treatment failure of one Disease Modifying Anti-Rheumatic Drug (DMARD) after a minimum 3-month trial (examples include methotrexate, leflunomide) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Endari	Coverage requires the following: 1. Diagnosis of sickle cell disease 2. Age ≥ 5 years old 3. Prescribed by or in consultation with a hematologist 4. Patient has experienced 2 or more sickle cell-related crises in the past 12 months 5. Trial and treatment failure for at least 6 months, contraindication, or intolerance to hydroxyurea 6. Trial and failure of over-the-counter (OTC) L-glutamine Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Endometrin	Coverage requires the following: 1. The treatment is being provided by a board-certified infertility specialist 2. It is being prescribed in accordance with generally accepted medical practice 3. Requires a previous trial of Crinone 4. The members benefit provides coverage for infertility medications Coverage is provided in accordance with your medical fertility benefit	✓	✓	**NC**	✓	✓	✓	✓	**NC**

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Enspryng	Coverage requires the following: 1. Diagnosis of neuromyelitis optica spectrum disorder (NMOSD) in adult patients who are anti-aquaporin-4 (AQP4) antibody positive 2. Trial and failure of at least 6 weeks or contraindication or intolerance to rituximab or biosimilar Enspryng will not be approved for use in combination with Soliris or Uplizna Initial approval: 1 year Continuation of treatment requires of a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓
Enstilar	Coverage requires the following: 1. Diagnosis of psoriasis 2. Trial and treatment failure with a high potency topical steroid in combination with generic Dovonex 3. Trial and treatment failure with generic Taclonex ointment (requires prior authorization) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		✓	**NC**

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Epclusa, Sofosbuvir + Velpatasvir	Coverage requires the following: 1. Age ≥ 3 years old or weight ≥ 17kg 2. Diagnosis of chronic hepatitis C genotype 1, 2, 3, 4, 5, or 6 3. If treatment experienced, documentation of previous treatment experience for Hepatitis C 4. If cirrhosis is present: documentation of decompensated or compensated cirrhosis Drug will be reviewed based on a case by case basis utilizing AASLD guidelines and FDA approved package labeling	✓	✓	✓	✓	✓	✓	✓	✓
Epidiolex	Coverage requires the following: 1. Diagnosis of Lennox-Gastaut syndrome 2. Trial and failure, contraindication, OR intolerance to at least 2 generic alternatives for the treatment of seizures OR 1. Diagnosis of Dravet syndrome 2. Trial and failure, contraindication, OR intolerance to 2 of the following generic options: valproic acid, clobazam, or topiramate OR 1. Treatment of seizures associated with tuberous sclerosis complex 2. Trial and failure, contraindication, OR intolerance to 3 generic alternatives for the treatment of seizures Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Eprontia	Coverage requires the following: 1. Treatment of seizure disorder/epilepsy 2. Treatment failure or intolerance to at least 3 generic alternatives, one of which must be generic topiramate (Topamax) OR 2. Member is unable to swallow tablets/capsules OR 1. Diagnosis of Lennox-Gastaut Syndrome 2. Treatment failure or intolerance to at least 2 generic alternatives, one of which must be generic topiramate (Topamax) OR 2. Member is unable to swallow tablets/capsules OR 1. For preventative treatment of migraine headaches 2. Age ≥ 12 years old 3. Treatment failure or intolerance to 3 generic alternatives for the prevention of migraines, one of which must be generic topiramate (Topamax) OR 3. Member is unable to swallow tablets/capsules Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Erivedge	Coverage requires the following: 1. Diagnosis of locally advanced basal cell carcinoma 2. Carcinoma occurred again following surgery OR the member not able to have surgery 3. Not a candidate for radiation OR 1. Diagnosis of metastatic basal cell carcinoma Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓
Erleada	Coverage requires the following: 1. Metastatic castration-sensitive prostate cancer OR 1. Non-metastatic castration-resistant prostate cancer	✓	✓	✓	✓	✓	✓	✓	✓
erlotinib (Tarceva)	Coverage is provided for the treatment of the FDA approved indications	✓	✓	✓	✓	✓	✓	✓	✓
Eucrisa	Coverage requires trial and treatment failure of one of the following: a topical steroid, generic Protopic, or generic Elidel Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
everolimus (Afinitor)	Coverage requires the following: 1. Diagnosis of HR-positive, HER-2 negative advanced breast cancer (in combination with exemestane) 2. Previous treatment failure with letrozole or anastrozole OR 1. Treatment of progressive pancreatic neuroendocrine tumors in patients with unresectable, locally advanced or metastatic disease OR 1. Treatment of progressive, well-differentiated nonfunctional gastrointestinal or lung neuroendocrine tumors in patients with unresectable, locally advanced or metastatic disease OR 1. Treatment of advanced renal cell carcinoma after Sutent (sunitinib) or Nexavar (sorafenib) failure OR 1. Treatment of renal angiomyolipoma with tuberous sclerosis complex (TSC) not requiring immediate surgery OR 1. Treatment of subependymal giant cell astrocytoma (SEGA) associated with TSC that requires therapeutic intervention but cannot be curatively resected 2. Age > 1 year old Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
everolimus (Afinitor Disperz)	Coverage requires the following: 1. Adjunctive treatment of partial-onset seizures associated with tuberous sclerosis complex (TSC) 2. Age ≥ 2 years old OR 1. Treatment of subependymal giant cell astrocytoma (SEGA) associated with TSC that requires therapeutic intervention but cannot be curatively resected 2. Age ≥ 1 year old Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Evrysdi	Coverage requires the following: Diagnosis of type 1, 2, or 3 Spinal Muscular Atrophy (SMA) confirmed by genetic testing AND 1. Prescribed by or in consultation with a neurologist specializing in neuromuscular disorders 2. Submission of a baseline, age appropriate exam to establish baseline motor function and ability 3. Patient is not currently taking SMN2-targeting antisense oligonucleotide or SMN2 splicing modifier AND patient has not had gene therapy treatment for SMA (or being considered for treatment with any other gene therapy for SMA) 4. Patient is not requiring invasive ventilation or tracheostomy 5. The requesting physician attests to providing clinical outcome information within the Audaire Health™ provider portal as requested by BCBSM Initial approval: 1 year Continuation of treatment requires submission of repeat motor ability assessment and documentation of response to therapy defined as a clinically significant improvement in SMA-associated motor milestones and motor function (for example, progression, stabilization, or decreased functional motor decline) compared to predicted natural history and progression	✓	✓	✓	✓	✓	✓	✓	✓
exemestane (Aromasin)	Coverage for $0 copayment will be provided when: 1. The member is a woman at least 35 years of age 2. The medication is being used for prevention of primary breast cancer 3. Members classified as high risk 4. Does not have a history of breast cancer 5. Member is currently post-menopausal 6. Member is not taking any estrogen containing products	✓	✓	✓	✓	✓		✓	✓

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Exkivity	Coverage requires the following: 1. Treatment of 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 2. Age ≥ 18 years old Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓
Exservan	Coverage requires the following: 1. Diagnosis of Amyotrophic Lateral Sclerosis (ALS) 2. Trial of generic riluzole tablets OR 2. Difficulty swallowing Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Fabior	Coverage requires the following: Trial and failure, contraindication, or intolerance to both generic adapalene (Differin) and generic tretinoin (Retin-A, Avita) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		✓	**NC**

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Fanapt	Coverage requires the following: Trial and failure, contraindication, or intolerance to two preferred or generic second generation antipsychotics (examples include: aripiprazole, clozapine, risperidone, quetiapine, olanzapine, ziprasidone) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓
Farydak	Coverage requires the following: 1. Diagnosis of multiple myeloma 2. Will be used in combination with bortezomib and dexamethasone 3. Has received at least 2 prior regimens, including bortezomib and an immunomodulatory agent (e.g. lenalidomide (Revlimid), or thalidomide (Thalomid)) Initial approval: 1 year. Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Fasenra pen	Coverage requires the following: 1. Diagnosis of severe uncontrolled eosinophilic asthma 2. Age ≥ 12 years old 3. Patient is currently receiving and will continue to receive standard of care regimen 4. Severe eosinophilic asthma identified by: a. Blood eosinophils greater than or equal to 150 cells/microliter at at initiation of treatment AND b. Failure to maintain adequate control after at least a 3 month trial of daily oralcorticosteroids or high dose inhaled corticosteroids in combination with: i. LABA (long acting inhaled β2 agonist) OR ii. Leukotriene modifier OR iii. LAMA (long acting muscarininc antagonist) in adults and children ≥ 12 years old 5. Cannot be used in combination with other biologic agents indicated for uncontrolled eosinophilic asthma Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
febuxostat (Uloric)	Coverage requires trial and treatment failure with allopurinol (Zyloprim)	✓	✓	✓				✓	✓
fenoprofen calcium 200 mg, 400 mg (Nalfon, Fenortho)	Coverage requires the following: 1. Age ≥ 18 years old 2. Treatment of mild to moderate pain	✓	✓	**NC**	✓	✓	✓	✓	**NC**

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
fenoprofen calcium 600 mg (Nalfon)	Coverage requires the following: 1. Age ≥ 18 years old 2. Treatment of mild to moderate pain	✓	✓	✓	✓	✓	✓	✓	✓
fentanyl citrate buccal lollipop (Actiq)	Coverage requires the following: 1. Medication is being used for the treatment of breakthrough cancer pain 2. Member is tolerant to high dose opioids 3. Currently receiving a long acting opioid 4. Treatment failure or intolerance to oral immediate release opioids (examples include, but not limited to: morphine, oxycodone, or hydrocodone containing products)	✓	✓	✓	✓	✓	✓	✓	✓
Fentora; fentanyl citrate buccal tablet	Coverage requires the following: 1. Medication is being used for the treatment of breakthrough cancer pain 2. Member is tolerant to high dose opioids 3. Currently receiving a long acting opioid 4. Treatment failure or intolerance to oral immediate release opioids (examples include, but not limited to: morphine, oxycodone, or hydrocodone containing products) 5. Treatment failure or intolerance to generic Actiq	✓	✓	**NC**	✓	✓	✓	✓	**NC**

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
fesoterodine (Toviaz)	Coverage requires the following: 1. Diagnosis of overactive bladder 2. Age ≥ 18 years old 3. Trial and failure, contraindication, or intolerance to at least two preferred generic overactive bladder therapies OR 1. Diagnosis of neurogenic detrusor overactivity (NDO) 2. Age ≥ 6 years old with weight > 25 kg 3. Trial and failure, contraindication, or intolerance to two generic anticholinergic agents for the treatment of NDO Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓			✓	**NC**
Fetzima	Coverage requires trial and failure of at least three antidepressant agents	✓	✓	**NC**	✓	✓		✓	**NC**
Finacea foam	Coverage requires the following: 1. Trial and failure, contraindication, or intolerance to generic topical metronidazole 2. Trial and failure, contraindication, or intolerance to generic oral tetracycline, generic doxycycline or generic minocycline Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓			✓	**NC**

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Fintepla	Coverage requires the following: 1. Treatment of seizures associated with Dravet syndrome 2. Age ≥ 2 years old 3. Trial and treatment failure of two of the following: valproic acid, clobazam, topiramate OR 1. Treatment of seizures associated with Lennox-Gastaut syndrome 2. Age ≥ 2 years old 3. Trial and treatment failure of 2 generic alternatives for the treatment of seizures Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Firdapse	Coverage requires the following: 1. Treatment of Lambert-Eaton myasthenic syndrome 2. Age > 18 years old 3. Prescribed by a neurologist Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Flector, Diclofenac Epolamine 1.3% patch	Coverage requires the following: 1. Diagnosis of acute pain due to minor strains, sprains or contusions 2. Trial of or intolerance to generic oral diclofenac and at least two other oral, traditional NSAIDs Initial approval: 3 months Renewal requires that current criteria are met, and that the medication is providing clinical benefit Please note: Coverage will not be provided in the presence of concurrent therapy with oral NSAIDs	✓	✓	**NC**	✓	✓	✓	✓	**NC**
Fleqsuvy	Coverage requires the following: 1. For the treatment of spasticity resulting from multiple sclerosis (MS) OR for individuals with other spinal cord diseases or injuries 2. Treatment failure of or intolerance to generic baclofen tablets OR 2. Member is unable to swallow tablets Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓		✓	✓	**NC**

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Fluoroplex	Coverage requires the following: 1. Age ≥ 18 years old 2. Diagnosis of actinic keratosis 3. Trial and treatment failure or intolerance to cryotherapy or phototherapy 4. Trial and failure or intolerance to a generic or preferred topical fluorouracil Initial approval: 1 month Renewal requires recurrence and/or new lesions	✓	✓	✓	✓	✓	✓	✓	✓
Follistim AQ	Coverage requires the following: 1. The treatment is being provided by a board -certified infertility specialist 2. It is being prescribed to treat infertility in accordance with generally accepted medical practice 3. Requires a previous trial of Gonal-f or Gonal-f RFF 4. The members benefit provides for coverage for infertility medications Coverage is provided in accordance with your medical fertility benefit	✓	✓	✓	✓			✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Forteo	Coverage requires the following: 1. History of fragility fracture 2. Will not be used in combination with bisphosphonates, another anabolic bone-modifying agent or denosumab OR 1. Diagnosis of osteoporosis 2. Treatment with a bisphosphonate has been ineffective after at least a 12-month treatment period based on objective documentation (such as reduction in T score or fracture) UNLESS one of the following: a. Treatment with bisphosphonates (both oral and intravenous) are not tolerated or contraindicated b. History of fracture(s) c. T-score less than -3.0 3. Will not be used in combination with bisphosphonates, another anabolic bone-modifying agent or denosumab Initial approval: 2 years Use of Forteo for more than 2 years should only be considered if high risk for fracture remains or has returned	✓	✓	✓	✓	✓	✓	✓	✓
Fosamax Plus D	Coverage requires trial and treatment failure or intolerance to two of the following: 1. Actonel (risedronate) 2. Boniva (ibandronate) 3. Fosamax (alendronate) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓			✓	**NC**

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Fotivda	Coverage requires the following: 1. Age ≥ 18 years old 2. Diagnosis of relapsed or refractory advanced renal cell carcinoma (RCC) 3. Received at least 2 prior systemic therapies Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓
frovatriptan (Frova)	Coverage requires trial of 2 of the following generic triptans: Imitrex, Maxalt, Amerge, or Zomig/ZMT Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓
Fulphila	Coverage requires trial and failure or intolerance to Neulasta and Ziextenzo	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Galafold	Coverage requires the following: 1. Diagnosis of Fabry's disease confirmed by genetic testing showing an amenable mutation in the GLA gene a. In addition for males: serum assay of enzyme α-galactosidase showing decreased activity in plasma and/or leukocytes 2. Age ≥ 18 years old 3. Prescribed by or in consultation with a geneticist or metabolic specialist 4. Initiation of therapy should begin as follows: a. Males with classic disease: at time of diagnosis b. Females and males with atypical disease: once patient is showing symptoms of Fabry's disease Galafold will not be approved for use in combination or with any other molecular chaperone or enzyme replacement therapy for Fabry's disease	✓	✓	✓	✓	✓	✓	✓	✓
Gammagard, Gammaked, Gamunex-C	Requires appropriate diagnosis for coverage, subcutaneous administration and other criteria may apply depending on diagnosis. Dosing must be based on ideal body weight (IBW) unless the patient's BMI is greater than 30. If the patient's BMI is greater than 30 or if actual body weight is 20-30% greater than IBW, adjusted body weight must be used. Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Ganirelix Acetate (generic only)	Coverage requires the following: 1. It is being prescribed to treat infertility in accordance with generally accepted medical practice 2. The members benefit provides for coverage for infertility medications 3. Will not be covered if being used as part of assisted reproductive treatment (ART)			**NC**				✓	**NC**

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Gattex	Coverage requires the following: 1. Diagnosis of Short Bowel Syndrome (SBS) 2. Dependent on parenteral support ≥ 12 months Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit, defined as a reduction in ≥ 20% of weekly parenteral nutrition volume or intravenous fluid volume	✓	✓	✓	✓	✓	✓	✓	✓
Gavreto	Coverage requires the following: 1. Age ≥ 18 years old 2. Treatment of metastatic RET fusion-positive non-small cell lung cancer (NSCLC) as detected by an FDA-approved test OR 1. Age ≥ 12 years old 2. Treatment of advanced or metastatic RET-mutant medullary thyroid cancer (MTC) that requires systemic therapy OR 1. Age ≥ 12 years old 2. Treatment of advanced or metastatic RET fusion-positive thyroid cancer that requires systemic therapy and who are radioactive iodine-refractory (if radioactive iodine is appropriate) Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Gelnique	Coverage requires treatment failure or intolerance to at least 2 generic OAB (Overactive Bladder) therapies Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓			✓	**NC**
Gilotrif	Coverage requires the following: 1. Diagnosis of metastatic non-small cell lung cancer (NSCLC) whose tumors have non-resistant epidermal growth factor receptor (EGFR) mutations as detected by an FDA-approved test OR 2. Diagnosis of metastatic squamous NSCLC that has progressed following platinum-based chemotherapy Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Glassia	Coverage requires the following: 1. Age ≥ 18 years old 2. Must be a nonsmoker 3. Member must have pre-treatment serum levels of alpha-1 antitrypsin (AAT) that are less than 11 micromol/L measured by ELISA (less than 80 mg/dlL measured by radial immunodiffusion or less than 57 mg/dL measured by nephelometry) consistent with phenotypes PiZZ, PiZ (null), or Pi (null, null) of AAT a. Phenotype/genotype testing may be requested for additional support of alpha-1 antitrypsin deficiency diagnosis 4. Member must have symptoms with their emphysema 5. Member must have deteriorating lung function, as demonstrated by a decline in the FEV1 (35-60% of predictive value) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Gonal-f, Gonal-f RFF	Coverage requires the following: 1. The treatment is being provided by a board-certified infertility specialist 2. It is being prescribed to treat infertility in accordance with generally accepted medical practice 3. The members benefit provides for coverage for infertility medications Coverage is provided in accordance with your medical fertility benefit			✓				✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Gralise	Coverage requires the following: Diagnosis of post-herpetic neuralgia (PHN) AND 1. ≤ 65 years of age 2. Trial of generic Neurontin (gabapentin) 3. Trial of generic tricyclic antidepressant (ex: amitriptyline, desipramine, imipramine) OR 1. ≥ 65 years of age 2. Trial of generic Neurontin (gabapentin)	✓	✓	**NC**		✓		✓	**NC**
Grastek	Coverage requires the following: 1. Diagnosis of grass pollen-induced allergic rhinitis, confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for Timothy grass or cross-reactive grass pollens 2. Trial of one agent from each of the following classes: a. Intranasal corticosteroid b. Oral or intranasal antihistamine Initial approval: 3 years Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓			✓	**NC**

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Growth Hormone (adults) **Preferred** Genotropin Norditropin **Non-preferred** Humatrope Omnitrope Saizen Zomacton Nutropin Nutropin AQ	Coverage requires the following: Written by an endocrinologist, gastroenterologist, or infectious disease specialist AND 1. Documentation of at least one known cause for pituitary disease or condition affecting pituitary function (i.e. pituitary tumor, traumatic brain injury, surgical damage, hypothalamic disease, irradiation, trauma, history of childhood growth hormone deficiency, or infiltrative disease), with one of the following (A, B, C, or D): A. Failed at least one clinically validated, clearly documented growth hormone stimulation test i. IGF-1 level below age and BMI-corrected lower limit of reference labs normal range ii. For suspected growth hormone deficiency due to traumatic brain injury the following must also be met: a. Adherence to screening recommendations for growth hormone deficiency as defined by the Glasgow Coma Scale (GCS) b. GH stimulation test must be administered at least one-year post brain injury iii. For history of childhood growth hormone deficiency, GH stimulation test to be done after growth hormone has been discontinued for at least one month **(criteria continued next page)**	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Growth Hormone (adults) (continued)	OR B. Failed at least one clearly documented, clinically validated growth hormone stimulation test i. IGF -1 level below age and BMI-corrected lower limit of reference labs normal range ii. Documentation of two additional pituitary hormone deficiencies clearly of pituitary origin (other than growth hormone) requiring hormone replacement OR C. Documentation of three pituitary hormone deficiencies clearly of pituitary origin (other than growth hormone) requiring hormone replacement i. IGF-1 level below age and BMI-corrected lower limit of reference labs normal range OR D. Failed at least two clearly documented, clinically validated GH stimulation tests i. IGF-1 level below age and BMI-corrected lower limit of reference lab's normal range OR 1. Diagnosis of AIDS wasting cachexia 2. Unexplained weight loss > 10% of baseline 3. Concomitant anti-viral therapy for the duration of treatment OR 1. Diagnosis of short bowel syndrome 2. Receiving specialized nutritional support, which may include dietary adjustments, enteral feedings, parenteral nutrition, fluid and micronutrient supplements Authorization period for short bowel syndrome: 4 weeks of treatment Coverage for a non-preferred medication requires treatment failure to ALL preferred medications (Genotropin and Norditropin)	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Growth Hormone (pediatrics) **Preferred** Genotropin Norditropin **Non-preferred** Humatrope Omnitrope Saizen Skytrofa Zomacton Nutropin Nutropin AQ	Coverage requires the following: Written by pediatric endocrinologist, pediatric nephrologist, or trauma/burn surgeon AND 1. Diagnosis of Growth Hormone Deficiency with ONE of the following: a. 2 subnormal growth hormone stimulation tests, or b. 1 subnormal growth hormone stimulation test AND IGF-1 and IGFBP3 levels below normal for children of the same age and gender, or c. Documentation of a hypothalamic pituitary defect (such as a major congenital malformation, tumor, surgery, irradiation, or trauma) AND a deficiency in at least one additional pituitary hormone AND 2. Initial height measurements < 5th percentile for age and gender 3. Abnormal growth velocity for at least 6 months 4. Open epiphyses OR 1. Diagnosis of Growth Hormone Deficiency due to congenital hypopituitarism in a newborn 2. Documentation of hypoglycemia with associated with growth hormone levels <5 mcg/L AND a. Documentation of deficiency of at least one additional pituitary hormone, or b. Imaging to support a pituitary defect (such as ectopic posterior pituitary and pituitary hypoplasia with abnormal stalk OR 1. Diagnosis of Turners Syndrome, SHOX deficiency, or Noonan Syndrome 2. Initial height measurements < 5th percentile for age and gender 3. Abnormal growth velocity for at least 6 months 4. Open epiphyses **(criteria continued next page)**	✓	✓	✓	✓	✓	✓	✓	✓

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Growth Hormone (pediatrics) (continued)	OR 1. Chronic Renal Insufficiency 2. Initial height measurements < 5th percentile for age and gender 3. Abnormal growth velocity for at least 6 months 4. Open epiphyses 5. If post-transplant – persistent growth failure without spontaneous catch up one year post-transplant and in whom steroid-free immunosuppression is not feasible OR 1. Small for Gestational Age (SGA) 2. Birth weight and/or length at least 2 standard deviations below the mean for gestational age 3. Fails to manifest catch-up growth by 2 years of age 4. Open epiphyses Authorization period: Approved until 18th birthday OR 1. Diagnosis of Prader-Willi Syndrome OR 1. Pediatric Burn 2. Burns over at least 40% of total body surface area Initial approval: 1 year Coverage for a non-preferred medication requires treatment failure to ALL preferred medications (Genotropin and Norditropin)	✓	✓	✓	✓	✓	✓	✓	✓

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Haegarda	Coverage requires the following: 1. Diagnosis of hereditary angioedema (HAE) 2. Diagnosis confirmed by genetic testing or with all the following laboratory findings: i. Normal C1q levels (normal range = 5.0-8.6 mg/dL) ii. C4 level below the limits of the laboratory's normal reference range (normal range = 16-58 mg/dL) iii. C1INH (antigenic or function) below the limits of the laboratory's normal reference range (normal range ≥ 41%) 3. History of at least 2 HAE attacks per month OR a history of attacks that are considered severe with swelling of the face, throat or gastrointestinal tract 4. Prescribed by an immunologist, allergist or hematologist Renewal requires improvement in HAE demonstrated by a 50% reduction in the number of attacks OR that the severity of HAE attacks was reduced by 50% or more	✓	✓	✓	✓	✓	✓	✓	✓
Harvoni /Ledipasvir +Sofosbuvir	Coverage requires the following: 1. Age 3 years or older 2. Diagnosis of chronic hepatitis C genotype 1,4,5 or 6 3. If treatment experienced, documentation of previous treatment experience for Hepatitis C 4. Trial of preferred medication: Zepatier for genotypes 1 and 4 OR Epclusa for genotypes 1,4,5 and 6 in adult patients 5. If cirrhosis is present: documentation of decompensated or compensated cirrhosis Drug will be reviewed on a case by case basis utilizing AASLD guidelines and FDA approved package labeling and trial and failure of Epclusa or Zepatier	✓	✓	**NC**	✓	✓	✓	✓	**NC**

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Harvoni oral pellets	Coverage requires the following: 1. Age 3 years or older 2. Diagnosis of chronic hepatitis C genotype 1,4,5 or 6 3. If treatment experienced, documentation of previous treatment experience for Hepatitis C 4. Trial of preferred medication: Zepatier for genotypes 1 and 4 OR Epclusa for genotypes 1,4,5 and 6 in adult patients 5. If cirrhosis is present: documentation of decompensated or compensated cirrhosis Drug will be reviewed on a case by case basis utilizing AASLD guidelines and FDA approved package labeling and trial and failure of Epclusa or Zepatier	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Hemlibra	Coverage requires the following: 1. For prophylaxis of bleeding episodes in patients diagnosed with congenital hemophilia A with inhibitors a. Prescribed and dispensed by a specialist that works in a hemophilia treatment center b. Documentation of a historical or current high titer for factor VIII inhibitors measuring > 5 Bethesda Units per milliliter (BU/mL) c. Will not be used in combination with Immune Tolerance Induction (ITI) d. Medication is dispensed by a treatment center associated with hemophilia that provides high quality hemophilia care with outcome based results (ie: hemophilia treatment centers) OR 2. For prophylaxis of spontaneous bleeding episodes in patients diagnosed with congenital hemophilia A without inhibitors a. Prescribed and dispensed by a specialist that works in a hemophilia treatment center b. Documentation of severe hemophilia A with factor VIII level <1% OR moderate hemophilia A with factor VIII level between 1%-5% c. Documentation of optimally dosed prophylactic factor VIII product is ineffective for the prevention of spontaneous bleeding events (such as: continuing to have bleeding events or arthroscopic changes within a target joint) d. Documentation of the number of bleeds experienced within the past 12 months e. Medication is dispensed by a treatment center associated with hemophilia that provides high quality hemophilia care with outcome based results (ie: hemophilia treatment centers) Initial approval: 1 year Continuation of coverage will be provided when treatment has been proven successful through a decrease in the number of bleeds and absence of anti-drug antibodies that impact the clearance or efficacy of Hemlibra	✓	✓	✓	✓	✓		✓	✓

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Hetlioz	Coverage requires the following: 1. Age ≥ 18 years old 2. Diagnosis of Non-24-hour sleep-wake disorder in patients who are totally blind and unable to perceive light 3. Trial and failure, contraindication, or intolerance to over-the-counter melatonin AND Rozerem (ramelteon) OR 1. Age ≥ 16 years old 2. Diagnosis of nighttime sleep disturbances in Smith-Magenis Syndrome (SMS) confirmed by genetic testing showing deletion of chromosome 17p11.2 OR mutation in the retinoic acid-induced 1 (RAI1) gene 3. Trial and failure, contraindication, or intolerance to over-the-counter melatonin AND acebutolol 4. For adults only- Trial and failure, contraindication, or intolerance to Rozerem (ramelteon) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Hetlioz LQ	Coverage requires the following: 1. Age 3 to 15 years old 2. Diagnosis of nighttime sleep disturbances in Smith-Magenis Syndrome (SMS) confirmed by genetic testing showing deletion of chromosome 17p11.2 OR mutation in the retinoic acid-induced 1 (RAI1) gene a. Trial and failure, contraindication, or intolerance to over-the-counter melatonin AND acebutolol Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Hizentra	Requires appropriate diagnosis for coverage, subcutaneous administration and other criteria may apply depending on diagnosis. Dosing must be based on ideal body weight (IBW) unless the patient's BMI is greater than 30. If the patient's BMI is greater than 30 or if actual body weight is 20-30% greater than IBW, adjusted body weight must be used. Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Horizant	Coverage requires the following: 1. Diagnosis of Restless Leg Syndrome (RLS) 2. Trial and treatment failure of generic Mirapex (pramipexole) 3. Trial and treatment failure of generic Requip/XL (ropinirole) 4. Trial and treatment failure of generic Neurontin (gabapentin) OR 1. Diagnosis of post-herpetic neuralgia (PHN) 2. ≤ 65 years of age 3. Trial of generic Neurontin (gabapentin) 4. Trial of generic tricyclic antidepressant (ex: amitriptyline, desipramine, imipramine) OR 1. Diagnosis of post-herpetic neuralgia (PHN) 2. ≥ 65 years of age 3. Trial of generic Neurontin (gabapentin)	✓	✓	**NC**		✓		✓	**NC**

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Humira	Coverage requires the following: 1. Diagnosis of Psoriatic Arthritis 2. Age ≥ 18 years old OR 1. Diagnosis of Rheumatoid Arthritis 2. Age ≥ 18 years old 3. Trial and treatment failure of one Disease Modifying Anti-Rheumatic Drug (DMARD) after a minimum 3-month trial (examples include methotrexate, hydroxychloroquine, leflunomide, sulfasalazine) OR 1. Diagnosis of Juvenile Idiopathic Arthritis (JIA) 2. Age ≥ 2 years old 3. Trial and treatment failure of one Disease Modifying Anti-Rheumatic Drug (DMARD) after a minimum 3-month trial (examples include methotrexate, leflunomide) OR 1. Diagnosis of Ankylosing Spondylitis 2. Age ≥ 18 years old OR 1. Diagnosis of Psoriasis 2. Age ≥ 18 years old 3. Trial and treatment failure of one topical steroid **(criteria continued next page)**	✓	✓	✓	✓			✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Humira (continued)	OR 1. Diagnosis of moderately to severely active Crohn's Disease 2. Age ≥ 6 years old 3. Treatment with an adequate course of conventional therapy (such as steroids for at least 7 days (examples include prednisone, methylprednisolone, or budesonide) or immunomodulators for at least 2 months (examples include methotrexate, azathioprine, or sulfasalazine)) OR 1. Diagnosis of moderately to severely active Ulcerative Colitis 2. Age ≥ 5 years old 3. Treatment with an adequate course of conventional therapy (such as steroids for at least 7 days (examples include prednisone, methylprednisolone, or budesonide) or immunomodulators for at least 2 months (examples include azathioprine, or cyclosporine)) OR 1. Diagnosis of Hidradenitis Suppurativa 2. Age ≥ 12 years old 3. Previous 3-month trial of oral antibiotics OR 1. Diagnosis of Noninfectious Uveitis 2. Age ≥ 2 years old 3. Trial of an oral corticosteroid 4. Trial of an oral immunomodulatory agent (examples include methotrexate, azathioprine, cyclosporine) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
hydrocodone bitartrate (Hysingla ER)	Coverage requires the following: 1. Diagnosis of moderate to severe chronic pain requiring around the clock opioid analgesia for an extended period of time 2. Trial and failure or intolerance to three generic long-acting opioids (examples include, but not limited to: buprenorphine transdermal patch, tramadol, morphine, fentanyl, and methadone) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit Note: Coverage will not be provided if the patient is on more than one long acting opioid concurrently	✓	✓	**NC**	✓	✓	✓	✓	**NC**
hydrocodone bitartrate (Zohydro ER)	Coverage requires the following: 1. Diagnosis of moderate to severe chronic pain requiring around the clock opioid analgesia for an extended period of time 2. Trial and failure or intolerance to three generic long-acting opioids (examples include, but not limited to: buprenorphine transdermal patch, tramadol, morphine, fentanyl, and methadone) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit. Note: Coverage will not be provided if the patient is on more than one long acting opioid concurrently	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
hydromorphone (Exalgo)	Coverage requires the following: 1. Diagnosis of moderate to severe chronic pain requiring around the clock opioid analgesia for an extended period of time 2. Trial and failure or intolerance to three generic long-acting opioids (examples include, but not limited to: buprenorphine transdermal patch, tramadol, morphine, fentanyl, and methadone) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit Note: Coverage will not be provided if the patient is on more than one long acting opioid concurrently.	✓	✓	**NC**				✓	**NC**
HyQvia	Requires appropriate diagnosis for coverage, subcutaneous administration and other criteria may apply depending on diagnosis. Dosing must be based on ideal body weight (IBW) unless the patient's BMI is greater than 30. If the patient's BMI is greater than 30 or if actual body weight is 20-30% greater than IBW, adjusted body weight must be used Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Ibrance	Coverage requires the following: 1. Diagnosis of HR-positive, HER-2 negative advanced or metastatic breast cancer (in combination with an aromatase inhibitor) OR 2. Diagnosis of HR-positive, HER-2 negative advanced or metastatic breast cancer (in combination with fulvestrant) in patients with disease progression following endocrine therapy Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓
Ibsrela	Coverage requires the following: 1. Trial and treatment failure or intolerance to lactulose or polyethylene glycol 2. Trial and treatment failure or intolerance to Linzess Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓			✓	**NC**
ibuprofen-famotidine (Duexis)	Coverage requires the following: 1. Diagnosis of osteoarthritis or rheumatoid arthritis 2. Trial and treatment failure or intolerance to the generic individual agents (ibuprofen 800mg and famotidine) taken in combination 3. Trial and treatment failure or intolerance to at least two other generic oral NSAIDs	**NC**	**NC**	✓				**NC**	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
icatibant (Firazyr)	Coverage requires the following: 1. Treatment of acute attacks of hereditary angioedema (HAE) 2. Diagnosis confirmed by genetic testing or with all the following laboratory findings: i. Normal C1q levels (normal range = 5.0-8.6 mg/dL) ii. C4 level below the limits of the laboratory's normal reference range (normal range = 16-58 mg/dL) iii. C1INH (antigenic or function) below the limits of the laboratory's normal reference range (normal range ≥ 41%) 3. Prescribed by an immunologist, allergist or hematologist	✓	✓	✓	✓	✓	✓	✓	✓
Iclusig	Coverage requires the following: 1. Age ≥18 years old 2. Diagnosis of Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ALL) for whom no other tyrosine kinase inhibitor therapy is indicated or who are T315I-positive OR 2. Treatment of chronic phase, accelerated phase, or blast phase chronic myeloid leukemia (CML) for whom no other tyrosine kinase inhibitor therapy is indicated or who are T315I-positive OR 2. Treatment of chronic phase (CP) chronic myeloid leukemia (CML) with resistance or intolerance to at least two prior kinase inhibitors Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Idhifa	Coverage requires the following: 1. Treatment of relapsed or refractory acute myeloid leukemia (AML) 2. Isocitrate dehydrogenase-2 (IDH2) mutation Initial approval: 1 year. Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓
Imbruvica	Coverage requires treatment of FDA approved indications Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Imcivree	Coverage requires the following: 1. Age ≥ 6 years old 2. Diagnosis of proopiomelanocortin (POMC), proprotein convertase subtilisin/kexin type 1 (PCSK1), or leptin receptor (LEPR) deficiency confirmed by genetic testing 3. Genetic testing must demonstrate that the variants in POMC, PCSK1, or LEPR genes are interpreted as pathogenic, likely pathogenic, or of uncertain significance 4. Current weight and BMI (within 30 days) must be submitted to the plan for review 5. Patient has obesity defined as: a. Adults patients: BMI ≥ 30 kg/m2 b. Pediatric patients: BMI ≥ 95th percentile for children and teens of the same age and sex Initial approval: 4 months Continued coverage will be reviewed annually and may be provided if the member has maintained at least a 5% reduction in baseline body weight OR at least a 5% reduction in baseline BMI for patients with continued growth potential	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
imiquimod (Zyclara)	Coverage requires the following: 1. Age ≥ 18 years old 2. Diagnosis of actinic keratosis 3. Trial and failure or intolerance to cryotherapy or phototherapy 4. Trial and treatment failure or intolerance to a generic or preferred topical fluorouracil 5. Trial and treatment failure or intolerance to generic imiquimod 5% OR 1. Age ≥ 12 years old 2. Diagnosis of genital or perianal warts Initial approval: 8 weeks Renewal requires recurrence and or new lesions	✓	✓	**NC**	✓	✓		✓	**NC**
Inbrija	Coverage requires the following: 1. Treatment of intermittent OFF episodes in patients with Parkinson's Disease 2. Currently experiencing "off" episodes while taking carbidopa/levodopa 3. Using in combination with carbidopa/levodopa Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Increlex	Coverage requires the following: 1. Medication to be prescribed by a pediatric endocrinologist 2. Diagnosis of one of the following: a. Severe primary IGF-1 deficiency or growth hormone gene deletion or b. Genetic mutation of growth hormone receptor (Laron Syndrome) 3. Current height measurement at less than 3rd percentile for age and sex 4. IGF-1 level greater than or equal to 3 standard deviations below normal 5. Normal or elevated growth hormone levels based on at least one growth hormone stimulation test 6. Open growth plates Renewal requires that current criteria are met, and that the medication is providing clinical benefit Continued authorization in children may be given for up to 12 months until any one of the following conditions occurs: 1. Growth velocity is less than 2.5 cm/year 2. Bone age in males exceeds 16 0/12 years of age. 3. Bone age in females exceeds 14 0/12 years of age	✓	✓	✓	✓	✓	✓	✓	✓
Ingrezza	Coverage requires the following: 1. Diagnosis of tardive dyskinesia 2. Age ≥ 18 years old 3. Prescribed by a psychiatrist or neurologist Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Inlyta	Coverage requires the following: 1. Diagnosis of advanced Renal Cell Carcinoma (RCC) AND 2. Used in combination with Bavencio (avelumab) as first-line treatment OR 2. Used in combination with Keytruda (pembrolizumab) as first-line treatment OR 2. After treatment failure of one prior therapy	✓	✓	✓	✓	✓	✓	✓	✓
Inqovi	Coverage requires the following: 1. Diagnosis of myelodysplastic syndromes 2. Age ≥ 18 years old Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓
Inrebic	Coverage requires the following: 1. Treatment of patients with intermediate-2 or high-risk primary or secondary myelofibrosis (MF). 2. Age ≥ 18 years old 3. Trial or treatment failure to Jakafi	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Inveltys	Coverage requires the following: 1. Using for the treatment of post-operative eye pain 2. Trial and treatment failure of one preferred or generic alternative for eye pain Initial approval: 1 month	✓	✓	**NC**	✓	✓		✓	**NC**
Iressa	Coverage requires the following: 1. Diagnosis of metastatic non-small cell lung cancer (NSCLC) 2. Epidermal growth factor (EGFR) exon 19 deletions or exon 21 (l858R) substitution mutations as detected by an FDA-approved test Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓
Isturisa	Coverage requires the following: 1. Diagnosis of Cushing's disease 2. Pituitary surgery is not an option 3. Treatment failure to one of the following ketoconazole, mitotane, or cabergoline	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
ivermectin 1% cream (Soolantra)	Coverage requires the following: 1. Trial and failure, contraindication, or intolerance to generic topical metronidazole 2. Trial and failure, contraindication, or intolerance to generic oral tetracycline, generic doxycycline or generic minocycline Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓			✓	**NC**
ivermectin (Stromectol)	Coverage requires treatment of FDA approved indications Ivermectin will be approved for a maximum of 1 month	✓	✓	✓	✓		✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Jakafi	Coverage requires the following: 1. Diagnosis of intermediate or high risk myelofibrosis 2. Prescribing physician is an oncologist/hematologist OR 1. Diagnosis of polycythemia vera 2. Trial of hydroxyurea 3. Prescribing physician is an oncologist or hematologist OR 1. Diagnosis of acute graft-versus-host disease (GVHD) 2. Trial and failure, contraindication, or intolerance to systemic glucocorticoids 3. Age ≥ 12 years old OR 1. Diagnosis of chronic graft-versus-host disease (cGVHD) 2. Trial and failure, or intolerance to one or two lines of systemic therapy 3. Age ≥ 12 years old Initial approval: 6 months Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Jatenzo	Coverage requires the following: 1. Diagnosis of male hypogonadism 2. Two signs and symptoms specific to testosterone deficiency 3. Trial and failure, contraindication or intolerance to one generic or preferred testosterone product (examples include generic Androgel, Androderm, and generic Depo-Testosterone) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		✓	**NC**
Jornay PM	Coverage requires the following: 1. Diagnosis of Attention Deficit Hyperactivity Disorder 2. Age ≥ 6 years old 3. Treatment failure or intolerance to both a generic methylphenidate and a generic amphetamine product, one of which must be a long-acting formulation Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		✓	**NC**
Juxtapid	Coverage requires the following: 1. Diagnosis of homozygous familial hypercholesterolemia (HoFH) 2. Receiving optimal adjunctive therapies including a low-fat diet and other lipid-lowering treatments 3. Trial and treatment failure of Repatha	✓	✓	**NC**	✓	✓	✓	✓	**NC**

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Jynarque	Coverage requires the following: 1. Age ≥ 18 years old 2. Diagnosis of autosomal dominant polycystic kidney disease (ADPKD) 3. Prescribed by, or in consultation with, a nephrologist Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Kalydeco	Coverage requires the following: 1. Diagnosis of Cystic Fibrosis (CF) 2. FDA approved gene mutation confirmed by genetic testing Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Karbinal ER	Coverage requires trial and treatment failure to generic carbinoxamine and two other generic antihistamines	✓	✓	**NC**	✓			✓	**NC**

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Kerendia	Coverage requires the following: 1. Age ≥ 18 years old 2. Diagnosis of chronic kidney disease associated with type 2 diabetes 3. Being used to reduce the risk of renal function decline, end-stage kidney disease, cardiovascular death, non-fatal myocardial infarction, and hospitalization for heart failure Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓
Ketoprofen 25mg	Coverage requires the following: 1. Diagnosis of osteoarthritis OR 1. Diagnosis of pain OR 1. Diagnosis of primary dysmenorrhea OR 1. Diagnosis of rheumatoid arthritis	✓	✓	✓	✓	✓	✓	✓	✓

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Keveyis	Coverage requires the following: 1. Diagnosis of primary hyperkalemic periodic paralysis, primary hypokalemic periodic paralysis and related variants as confirmed by a genetic test or positive family history 2. Trial and failure of lifestyle modifications such as diet (potassium intake alterations) and exercise modifications 3. Trial and treatment failure of acetazolamide	✓	✓	✓	✓	✓	✓	✓	✓
Kevzara	Coverage requires the following: 1. Diagnosis of Rheumatoid Arthritis 2. Age ≥ 18 years old 3. Trial and treatment failure with one Disease Modifying Anti-Rheumatic Drug (DMARD) after a minimum 3-month trial (examples include methotrexate, hydroxychloroquine, leflunomide, sulfasalazine) 4. Trial and treatment failure of two of the following: Enbrel, Humira, Rinvoq, or Xeljanz/XR 5. Trial and treatment failure of Actemra and Orencia Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Khedezla	Coverage requires trial and failure of at least three antidepressant agents	✓	✓	**NC**	✓	✓		✓	**NC**

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Kineret	Coverage requires the following: 1. Diagnosis of Rheumatoid Arthritis 2. Age ≥ 18 years old 3. Trial and treatment failure of one Disease Modifying Anti-Rheumatic Drug (DMARD) after a minimum 3-month trial (examples include methotrexate, hydroxychloroquine, leflunomide, sulfasalazine) 4. Trial and treatment failure of two of the following: Enbrel, Humira, Rinvoq, or Xeljanz/XR 5. Trial and treatment failure of Actemra and Orencia OR 1. Diagnosis of Cryopyrin-Associated Periodic Syndromes (CAPS) with phenotype: Neonatal-onset multisystem inflammatory disease (NOMID) 2. Laboratory evidence of a genetic mutation OR elevated inflammatory markers plus at least two of six typical CAPS manifestations: (urticaria-like rash, cold-triggered episodes, hearing loss, musculoskeletal symptoms, chronic aseptic meningitis, or skeletal abnormalities) OR 1. Diagnosis of Still's disease: including adult onset Still's disease (AOSD) and systemic juvenile idiopathic arthritis (sJIA) 2. Trial and treatment failure of one of the following therapies: methotrexate, leflunomide, prednisone, NSAIDs **(criteria continued next page)**	✓	✓	✓	✓			✓	✓

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Kineret (continued)	OR 1. Diagnosis of deficiency of interleukin-1 receptor antagonist (DIRA) 2. Laboratory evidence of homozygous genetic mutations of IL1RN OR 1. Diagnosis of recurrent pericarditis (RP) 2. Age ≥ 12 years old 3. Trial and treatment failure or intolerance to nonsteroidal anti-inflammatory drugs (NSAIDs) in combination with colchicine Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓
Kisqali	Coverage requires the diagnosis of HR-positive, HER-2 negative advanced or metastatic breast cancer and ONE of the following: a) Using in combination with an aromatase inhibitor as initial endocrine-based therapy OR b) Using in combination with fulvestrant as initial endocrine-based therapy in postmenopausal women or in men OR c) Using in combination with fulvestrant following disease progression on endocrine therapy in postmenopausal women or in men AND patient has had an intolerance or contraindication to Ibrance Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Kisqali Femara Co-pack	Coverage requires the following: 1. Treatment of FDA approved indications Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓
Klisyri	Coverage requires the following: 1. Age ≥ 18 years old 2. Diagnosis of actinic keratosis (AK) on the face or scalp 3. Trial and treatment failure or intolerance to cryotherapy or phototherapy 4. Trial and treatment failure or intolerance to a generic or preferred topical fluorouracil 5. Trial and treatment failure or intolerance to generic imiquimod 5% Initial approval: 1 month Renewal requires lesion recurrence and/or the presence of new lesions	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Korlym	Coverage requires the following: 1. Member is ≥ 18 years of age 2. Prescriber is an endocrinologist 3. Diagnosis of hypercortisolism as a result of endogenous Cushing's Syndrome 4. Diagnosis of type II diabetes mellitus (DM) or glucose intolerance secondary to hypercortisolism. 5. Surgical treatment has been ineffective or not a candidate for surgery 6. Treatment failure or intolerance to a steroidogenesis inhibitor (such as ketoconazole or mitotane). 7. Failure to achieve blood glucose control with maximally titrated therapy to manage hyperglycemia. Must include at least 3 months of treatment with insulin 8. Documentation of baseline 2 – hour glucose tolerance test if diagnosis is glucose intolerance. 9. HbA1c is required if diagnosis is type II DM Initial approval: 1 year Renewal requires ≥ 1% reduction in HbA1c from baseline or ≥ 25% improvement in glucose tolerance	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Koselugo	Coverage requires the following: 1. Age ≥ 2 years old 2. Diagnosis of Neurofibromatosis Type 1 (NF1) 3. Diagnosis made using either genetic testing or diagnostic criteria established by the National Institutes of Health (NIH) OR 3. Receiving treatment by or in consultation with a neurofibromatosis clinic Initial approval: 6 months Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓
Kynmobi	Coverage requires the following: 1. Treatment of intermittent OFF episodes in patients with Parkinson's Disease 2. Age ≥ 18 years old 3. Using in combination with carbidopa/levodopa	✓	✓	✓	✓	✓	✓	✓	✓
lacosamide (Vimpat)	Coverage requires the following: 1. Treatment of seizures in patients with epilepsy	✓	✓	✓	✓			✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Lanreotide SC injection	Coverage requires the following: 1. Diagnosis of one of the following: a. Acromegaly in patients who have had an inadequate response to surgery and/or for whom surgery is not an option, and supported by an elevated Insulin-like Growth Factor-1 (IGF-1) level b. Unresectable, well- or moderately-differentiated, locally advanced or metastatic gastroenteropancreatic neuroendocrine tumors Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓	✓	✓	**NC**
lapatinib (Tykerb)	Coverage is provided for the treatment of the FDA approved indications	✓	✓	✓	✓	✓	✓	✓	✓
Latuda	Coverage requires the following: Trial and failure, contraindication, or intolerance to two preferred or generic second generation antipsychotics (examples include: aripiprazole, clozapine, risperidone, quetiapine, olanzapine, ziprasidone) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Lenvima	Coverage requires the following: 1. Diagnosis of locally recurrent or metastatic, progressive differentiated thyroid cancer (DTC) a. Progression of disease after treatment with standard therapy OR 1. Diagnosis of advanced renal cell carcinoma a. Using as first-line treatment in combination with pembrolizumab OR b. Treatment failure to one prior anti-angiogenic therapy AND using in combination with everolimus OR 1. Diagnosis of unresectable hepatocellular carcinoma OR 1. Diagnosis of advanced endometrial carcinoma a. Progression of disease after prior systemic therapy b. Not a candidate for curative surgery or radiation c. Using in combination with pembrolizumab Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Levorphanol	Coverage requires the following: 1. When used for as needed pain: Treatment failure or intolerance to three generic immediate release opioids (examples include, but not limited to: tramadol, morphine, hydrocodone, and oxycodone containing products) OR 1. When used for chronic pain requiring around-the-clock analgesia: Treatment failure or intolerance to three generic long-acting opioids. Examples include but are not limited to: buprenorphine transdermal patch, tramadol extended release, morphine extended release, fentanyl, methadone. Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit Note: Coverage will not be provided if the patient is on more than one long acting opioid concurrently	✓	✓	✓	✓			✓	✓
Livalo	Coverage requires treatment failure or intolerance to at least two generic statins (examples include atorvastatin, rosuvastatin, simvastatin) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓		✓				✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Livmarli	Coverage requires the following: 1. Treatment of cholestatic pruritus in patients with a diagnosis Alagille syndrome (ALGS) confirmed by documentationof ONE of the following: a. Genetic testing shows presence of the JAG1 or NOTCH2 genetic mutation b. Liver biopsy shows bile duct scarcity c. Involvement of 3 of 7 of the main organ systems affected in ALGS: hepatic, ocular, skeletal, vascular, facial, cardiac, or renal involvement 2. Age ≥ 1 year old 3. No history of liver transplant or planned future transplant 4. No clinical evidence of decompensated cirrhosis 5. Trial and failure, contraindication, or intolerance to generic ursodiol Initial approval: 6 months Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Livtencity	Coverage requires the following: 1. Diagnosis of post-transplant cytomegalovirus (CMV) infection/disease 2. Age ≥ 12 years old and weight ≥ 35 kg 3. Trial and treatment failure of one of the following: ganciclovir, valganciclovir, cidofovir or foscarnet Initial approval: 3 months	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Lonsurf	Coverage requires the following: 1. Diagnosis of metastatic colorectal cancer 2. Previous treatment with a. fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy b. anti-VEGF biological therapy 3. Test results showing RAS wild type have received treatment with an anti-EGFR therapy OR 1. Diagnosis of metastatic gastric or gastroesophageal junction adenocarcinoma 2. Previous treatment with at least 2 lines of chemotherapy prior systemic therapies which included a fluoropyrimidine, a platinum, either a taxane or irinotecan, and a HER2/neu-targeted therapy (if appropriate) Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓
Lorbrena	Coverage requires the following: 1. Age ≥ 18 years old 2. Diagnosis of metastatic non-small cell lung cancer (NSCLC) whose tumors are anaplastic lymphoma kinase (ALK)-positive as detected by an FDA-approved test	✓	✓	✓	✓	✓	✓	✓	✓
Lotemax SM	Coverage requires the following: 1. Using for the treatment of post-operative eye pain and inflammation 2. Trial and treatment failure to one preferred or generic alternative for eye pain Initial approval: 1 month	✓	✓	**NC**	✓	✓		✓	**NC**

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Lumakras	Coverage requires the following: 1. Age ≥ 18 years old 2. Diagnosis of KRAS G12C-mutated locally advanced or metastatic non-small cell lung cancer (NSCLC), as determinedby an FDA-approved test 3. Received at least one prior systemic therapy Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓
Lupkynis	Coverage requires the following: 1. Age ≥ 18 years old 2. Treatment of active lupus nephritis (LN) in combination with a background immunosuppressive therapy regimen 3. Must have active disease of the kidney confirmed on biopsy 4. Previous treatment courses of the following have been ineffective unless contraindicated or not tolerated: cyclophosphamide plus glucocorticoids OR mycophenolate mofetil plus glucocorticoids 5. Trial and failure, contraindication, or intolerance to Benlysta Initial approval: 6 months Initial renewal requires that the member is experiencing clinical benefit (for example, a stabilization or improvement in glomerular filtration rate (GFR) or at least a 50% reduction in proteinuria) Renewal approval: 1 year Subsequent renewal requires that the member has not yet reached complete clinical response defined as proteinuria less than 0.5–0.7 g/24 hours	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Luzu, Luliconazole	Coverage requires the following: 1. Diagnosis of tinea pedis, tinea cruris or tinea corporis 2. Treatment failure of 2 topical over-the-counter antifungal agents 3. Treatment failure of two oral generic antifungal agents (fluconazole, itraconazole or terbinafine)	✓	✓	**NC**	✓			✓	**NC**
Lynparza	Coverage requires the treatment of FDA approved indications Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓
Lybalvi	Coverage requires the following: Trial and failure, contraindication, or intolerance to two second generation antipsychotics (examples include: aripiprazole, clozapine, risperidone, quetiapine, olanzapine, ziprasidone) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Lyvispah	Coverage requires the following: 1. Diagnosis of spasticity 2. Trial of baclofen tablets OR 2. Member is unable to swallow tablets Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓	✓	✓	**NC**
Mavenclad	Coverage requires trial and failure or intolerance to one generic or preferred medication for the treatment of multiple sclerosis (MS) such as Avonex, Bafiertam, Betaseron, Copaxone, Kiesimpta, or Vumerity Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓
Mavyret	Coverage requires the following: 1. Age ≥ 3 years old 2. Diagnosis of chronic hepatitis C genotype 1, 2, 3, 4, 5, or 6 3. If treatment experienced, documentation of previous treatment experience for Hepatitis C 4. Trial of the preferred medication: Epclusa or Zepatier 5. Patients with HCV genotype 1 who have previously been treated with regimens containing an NS5A (nonstructural protein 5A) inhibitor or an NS3/4A protease inhibitor, but not both 6. If cirrhosis is present: documentation of decompensated or compensated cirrhosis Drug will be reviewed on a case by case basis utilizing AASLD guidelines and FDA approved package labeling and trial and failure to Epclusa or Zepatier	✓	✓	✓	✓	✓	✓	✓	✓

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Mekinist	Coverage requires the following: 1. Diagnosis of melanoma 2. Presence of BRAF V600E or V600K mutation 3. Using as a single agent or in combination with Tafinlar (dabrafenib) OR 1. Diagnosis of metastatic non-small cell lung cancer or advanced or metastatic anaplastic thyroid cancer 2. Presence of BRAF V600 E mutation 3. Using in combination with Tafinlar (dabrafenib) OR 1. Age ≥ 6 years old 2. Diagnosis of unresectable or metastatic solid tumors who have progressed following prior treatment and have no satisfactory alternative treatment options 3. Presence of with BRAF V600E mutation 4. Using in combination with Tafinlar (dabrafenib) Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓
Mektovi	Coverage requires the following: 1. Diagnosis of unresectable or metastatic melanoma with a BRAF V600E or V600K mutation as detected by an FDA-approved test 2. Using in combination with Braftovi Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
meloxicam capsule (Vivlodex)	Coverage requires the following: 1. Age ≥ 18 years old 2. Diagnosis of osteoarthritis 3. Trial and failure of generic Mobic (meloxicam tablet) 4. Trial and failure of two other preferred oral NSAIDs Initial approval: 1 year	✓	✓	**NC**	✓	✓		✓	**NC**
Menopur	Coverage requires the following: 1. It is being prescribed to treat infertility in accordance with generally accepted medical practice 2. The members benefit provides for coverage for infertility medications 3. Will not be covered if being used as part of assisted reproductive treatment (ART)			**NC**				✓	**NC**
metformin hcl extended release (Fortamet)	Coverage requires the following: 1. Age ≥ 18 years old 2. Diagnosis of type 2 diabetes mellitus 3. Trial and treatment failure or intolerance to generic Glucophage XR (metformin extended release) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		✓	**NC**

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
methylergonovine (Methergine)	Coverage requires the following: 1. Management of uterine atony, hemorrhage, and subinvolution of the uterus following delivery of the placenta or control of uterine hemorrhage following delivery of the anterior shoulder in the second stage of labor OR 1. Being used for the prevention of migraine headaches 2. Member has persistent history of recurring debilitating headaches (4 or more headache days per month with migraine headache lasting for 4 hours per day or longer) 3. Trial and treatment failure after a minimum of 2 month trial, contraindication, or intolerance to three of the following: a. Anticonvulsants b. ACE inhibitors or angiotensin receptor blockers c. Beta blockers d. Calcium channel blockers e. Antidepressants f. Botulinum toxin 4. Trial and treatment failure after a minimum 2 month trial, contraindication, or intolerance to at least one calcitonin gene related peptide (CGRP) antagonist (such as: Aimovig, Ajovy, Emgality, or Vyepti) OR 1. Being used for the treatment of episodic or chronic cluster headache 2. Trial and failure, contraindication, or intolerance to at least three of the following: suboccipital steroid injection, verapamil, lithium, melatonin, frovatriptan, prednisone, or topiramate 3. Trial and failure, contraindication, or intolerance to Emgality Initial approval: 6 months Renewal requires that current criteria are met, and that the medication is providing clinical benefit For headache indications, member must have at least a 1 month drug holiday after 3-6 months of therapy has occurred prior to restarting methylergonovine	✓	✓	✓	✓			✓	✓

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
miglustat (Zavesca)	Coverage is provided for members 18 years of age or older for the treatment of Type 1 Gaucher's disease for whom enzyme replacement therapy is not a therapeutic option (eg, because of allergy, hypersensitivity, or poor venous access) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
mometasone furoate (Nasonex)	Coverage requires trial and failure or intolerance of 2 of the following intranasal steroids: 1. Generic fluticasone (Flonase) 2. Generic flunisolide (Nasalide) 3. Nasacort (over-the-counter) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓			**NC**	**NC**
Molnupiravir	Criteria requires the following: 1. Age ≥ 18 years old	✓	✓	✓	✓			✓	✓
Motegrity	Coverage requires the following: 1. Trial and treatment failure or intolerance to lactulose or polyethylene glycol 2. Trial and treatment failure or intolerance to Linzess Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Myalept	Coverage requires the following: 1. Replacement therapy to treat the complications of leptin deficiency, in addition to diet, in patients with congenital or acquired generalized lipodystrophy. 2. Optimally treated with insulin 3. Optimally treated with a statin (examples include atorvastatin, simvastatin)	✓	✓	✓	✓	✓	✓	✓	✓
Mycapssa	Coverage requires the following: 1. Diagnosis of acromegaly 2. Previously tried, responded to, and tolerated generic immediate-release octreotide or lanreotide Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓	✓	✓	**NC**
Myfembree	Coverage requires the following: 1. Management of heavy menstrual bleeding associated with uterine leiomyomas (fibroids) in premenopausal women 2. Age ≥ 18 years old 3. Trial of 2 hormone related therapies Myfembree will be approved for a maximum of two years	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Myrbetriq granules	Coverage requires the following: 1. Diagnosis of neurogenic detrusor overactivity (NDO) 2. Age ≥ 3 years old 3. Trial and treatment failure or intolerance to two generic anticholinergic agents for the treatment of NDO OR 3. Member cannot swallow tablets/capsules AND has tried and failed an anticholinergic medication available as a solution Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓
Myrbetriq tablets	Coverage requires the following: 1. Diagnosis of overactive bladder (OAB) 2. Age ≥ 18 years old 3. Trial and treatment failure or intolerance to two preferred therapies for OAB OR 1. Diagnosis of neurogenic detrusor overactivity (NDO) 2. Weight ≥ 35 kg 3. Trial and treatment failure or intolerance to two generic anticholinergic agents for the treatment of NDO Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Mytesi	Coverage is provided for the symptomatic relief of noninfectious diarrhea in patients with HIV/AIDS and on antiretroviral therapy	✓	✓	✓	✓	✓	✓	✓	✓
naftifine (Naftin)	Coverage requires the following: 1. Diagnosis of tinea pedis, tinea cruris or tinea corporis 2. Treatment failure to two topical over-the-counter antifungal agents 3. Treatment failure to two oral generic antifungal agents	✓	✓	**NC**	✓			✓	**NC**
Namzaric	Coverage requires the following: Already stable on memantine (Namenda) and donepezil (Aricept) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		✓	**NC**
Natesto	Coverage requires the following: 1. Diagnosis of male hypogonadism 2. Two signs and symptoms specific to testosterone deficiency 3. Trial and failure, contraindication or intolerance to one generic or preferred testosterone product (examples include generic Androgel, Androderm, and generic Depo-Testosterone) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓	✓	✓	**NC**

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Natpara	Coverage requires the following: 1. The prescribing physician is an endocrinologist 2. Using as an adjunct to calcium and Vitamin D to control hypocalcemia in patients with hypoparathyroidism 3. Currently on calcium and Vitamin D and hypocalcemia is not well controlled	✓	✓	✓	✓	✓	✓	✓	✓
Nerlynx	Coverage requires the following: 1. Diagnosis of early stage HER2 positive breast cancer 2. Previous treatment with trastuzumab (Herceptin)-based therapy OR 1. Diagnosis of advanced or metastatic HER2 positive breast cancer 2. Previous treatment with two or more anti-HER2 based regimens 3. Using in combination with capecitabine	✓	✓	✓	✓	✓	✓	✓	✓
Neupro	Coverage requires the following: 1. Diagnosis of Parkinson's disease 2. Treatment failure or intolerance to generic Mirapex (pramipexole) and generic Requip (ropinirole) OR 1. Diagnosis of Restless legs syndrome 2. Treatment failure or intolerance to generic Mirapex (pramipexole), generic Requip (ropinirole) and generic Neurontin (gabapentin)	✓	✓	**NC**				✓	**NC**
Nexium Suspension	Coverage requires failure of or intolerance to all generic alternatives: omeprazole (Prilosec), pantoprazole (Protonix), lansoprazole (Prevacid/Prevacid Solutab), and rabeprazole (Aciphex)	✓	✓	**NC**	✓	✓		**NC**	**NC**

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Nexletol	Coverage requires the following: 1. Diagnosis of established atherosclerotic cardiovascular disease or heterozygous familial hypercholesterolemia 2. Age ≥ 18 years old 3. Trial of ezetimibe AND 4. Trial with one high intensity statin at maximum tolerated dose OR 4. History of statin intolerance (skeletal muscle related symptoms) after a trial of two generic statins (examples include: Crestor, Lescol, Lipitor, Livalo, Mevacor, Pravachol, Zocor) OR 4. History of rhabdomyolysis after a trial of one statin (Examples include: Crestor, Lescol, Lipitor, Livalo, Mevacor, Pravachol, Zocor)	✓	✓	✓	✓			✓	✓
Nexlizet	Coverage requires the following: 1. Diagnosis of established artherosclerotic cardiovascular disease or heterozygous familial hypercholesterolemia 2. Age ≥ 18 years old AND 3. Trial with one high intensity statin at maximum tolerated dose OR 3. History of statin intolerance (skeletal muscle related symptoms) after a trial of two generic statins (examples include: Crestor, Lescol, Lipitor, Livalo, Mevacor, Pravachol, Zocor) OR 3. History of rhabdomyolysis after a trial of one statin (examples include: Crestor, Lescol, Lipitor, Livalo, Mevacor, Pravachol, Zocor)	✓	✓	✓	✓			✓	✓

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Nicotrol, Nicotrol NS	Coverage for $0 copayment will require trial and failure of 2 preferred agents such as generic bupropion extended release (Zyban), nicotine patch, nicotrine gum, nicotine lozenge	✓	✓	✓	✓	✓		✓	✓
nilutamide (Nilandron)	Coverage requires the following: 1. Treatment of metastatic prostate cancer in combination with surgical castration 2. Trial and failure, contraindication, or intolerance to flutamide (Eulexin) and bicalutamide (Casodex) Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓			✓	✓
Ninlaro	Coverage requires the following: 1. Diagnosis of multiple myeloma 2. Using in combination with lenalidomide and dexamethasone 3. Have received at least one prior therapy	✓	✓	✓	✓	✓	✓	✓	✓
nitisinone (Orfadin)	Coverage requires the following: 1. Diagnosis of hereditary tyrosinemia type 1 2. Using along with dietary restriction of tyrosine and phenylalanine	✓	✓	✓	✓	✓	✓	✓	✓
Nityr	Coverage requires the following: 1. Diagnosis of hereditary tyrosinemia type 1 2. Using along with dietary restriction of tyrosine and phenylalanine	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Nocdurna	Coverage requires the following: 1. Diagnosis of nocturnal polyuria 2. Lifestyle changes have been tried (including limiting fluids, elevation of legs) 3. Treatment failure or intolerance to one generic medication for overactive bladder (OAB) 4. Trial of generic oral desmopressin Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		✓	**NC**
Noctiva	Coverage requires the following: 1. Diagnosis of nocturnal polyuria 2. Age ≥ 50 years old 3. Lifestyle changes have been tried (including limiting fluids such as water, alcohol and caffeine, elevation of legs) 4. Treatment failure or intolerance to one generic medication for over active bladder (OAB) (examples tolterodine, oxybutynin) 5. Trial of generic oral desmopressin	✓	✓	**NC**	✓	✓		✓	**NC**
Nourianz	Coverage requires the following: 1. Treatment of intermittent OFF episodes in patients with Parkinson's Disease 2. Currently experiencing "off" episodes while taking carbidopa/levodopa 3. Using in combination with carbidopa/levodopa Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Nubeqa	Coverage requires the following: 1. Treatment of nonmetastatic castration-resistant prostate cancer	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Nucala	Coverage requires the following: 1. Diagnosis of severe uncontrolled eosinophilic asthma 2. Age ≥ 6 years old 3. Patient is currently receiving, and will continue to receive standard of care regimen 4. Severe eosinophilic asthma identified by: a. Blood eosinophils greater than or equal to 150 cells/microliter at initiation of treatment AND b. Failure to maintain adequate control after at least a 3 month trial of daily oral corticosteroids or high dose inhaled corticosteroids in combination with: i. LABA (long acting inhaled β2 agonist) OR ii. or leukotriene modifier OR iii. LAMA (long acting muscarininc antagonist) in adults and children ≥ 12 years old 5. Cannot be used in combination with other biologic agents indicated for uncontrolled eosinophilic asthma OR 1. Diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA) 2. Age ≥18 years old 3. Consult with an allergist/immunologist prior to initiation of Nucala therapy 4. History or presence of asthma 5. Presence of at least 2 of the following criteria that are typical of EGPA: histopathological evidence of eosinophilic vasculitis, perivascular eosinophilic infiltration, or eosinophil-rich granulomatous inflammation, neuropathy, pulmonary infiltrates, allergic rhinitis and nasal polyps, cardiomyopathy, glomerulonephritis, alveolar hemorrhage, palpable purpura, or antineutrophil cytoplasmic antibody (ANCA) positivity **(criteria continued next page)**	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Nucala (continued)	6. Cannot be used in combination with other biologic agents indicated for EGPA OR 1. Diagnosis of hypereosinophilic syndrome (HES) 2. Age ≥ 12 years old 3. At least 2 HES flares within the past 12 months (defined as HES-related worsening of clinical symptoms or blood eosinophil counts requiring an escalation in therapy 4. Stable on HES therapy for at least 4 weeks (examples include: oral corticosteroids, immunosuppressive or cytotoxic therapy) 5. Eosinophil counts of 1,000 cells/microL or higher at initiation of therapy 6. Member does not have eosinophilia of unknown clinical significance, non-hematologic secondary HES (drug hypersensitivity, parasitic helminth infection, HIV infection, non-hematologic malignancy), or F1P1L1-PDGFRa kinase-positive HES 7. Cannot be used in combination with other biologic agents indicated for HES OR 1. Diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP) 2. Age > 18 years old 3. Patient is currently receiving, and will continue to receive standard of care regimen 4. CRSwNP is recurring despite previous treatment with intranasal corticosteroids 5. Cannot be used in combination with other biologic agents indicated for CRSwNP Approval length: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Nucynta	Coverage requires the following: 1. Diagnosis of acute pain 2. Treatment failure or intolerance to three generic immediate release opioids (examples include, but not limited to: tramadol, morphine, hydrocodone, and oxycodone containing products) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Nucynta ER	Coverage requires the following: 1. Diagnosis of moderate to severe chronic pain requiring around the clock opioid analgesia for an extended period of time 2. Trial and failure or intolerance to three generic long-acting opioids (examples include, but not limited to: buprenorphine transdermal patch, tramadol, morphine, fentanyl, and methadone) 3. Trial and failure or intolerance to Xtampza ER OR 1. Diagnosis of Diabetic Peripheral Neuropathy (DPN) AND 2. If the member is equal to or greater than 65 years of age: Trial and failure of generic gabapentin (Neurontin) AND generic duloxetine (Cymbalta) OR 3. If the member is less than 65 years of age: Trial and failure of generic gabapentin (Neurontin) and generic duloxetine (Cymbalta) and a tricyclic antidepressant such as amitriptyline, desipramine, nortriptyline or imipramine Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit Note: Coverage will not be provided if the patient is on more than one long acting opioid concurrently	✓	✓	✓	✓	✓	✓	✓	✓
Nuedexta	Coverage requires the following: 1. Diagnosis of pseudobulbar affect (PBA) 2. Presence of an underlying neurological condition causing symptoms of PBA (ex. Multiple Sclerosis, amyotrophic lateral sclerosis, Parkinson's Disease, stroke, traumatic brain injury)	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Nuplazid	Coverage requires the following: 1. Diagnosis of Parkinson's disease psychosis 2. Prescribed by a neurologist or psychiatrist Initial approval: 1 year Renewal requires clinically significant improvement in psychosis symptoms	✓	✓	✓	✓	✓	✓	✓	✓
Nurtec ODT	Coverage requires the following: 1. For acute treatment of migraine 2. Age ≥ 18 years old 3. Treatment failure or contraindication with 2 generic triptan medications OR 1. For preventive treatment of migraine headaches 2. Age ≥ 18 years old 3. Member has history of ≥ 4 headache days per month 4. Trial of two medications from two different classes for the prevention of migraines Initial approval: 1 year Renewal for acute treatment of migraine requires that current criteria are met, and that the medication is providing clinical benefit Renewal for preventative treatment of migraine headaches requires at least a 50% or greater reduction in monthly migraine days (MMDs) from baseline	✓	✓	✓	✓	✓	✓	✓	✓

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Nyvepria	Coverage requires trial and failure or intolerance to Neulasta and Ziextenzo	✓	✓	✓	✓	✓	✓	✓	✓
Ocaliva	Coverage requires the following: 1. Diagnosis of primary biliary cholangtis (PBC) confirmed by 2 of the 3 following American Association for the Study of Liver Diseases criteria: a positive test for antimitochondrial antibodies, elevated serum levels of alkaline phosphatase (ALP), histologic evidence of PBC based on liver biopsy 2. If cirrhosis is present: documentation of no evidence of portal hypertension 3. Inadequate response to ursodeoxycholic acid (UDCA) such as Actigall (ursodiol) after at least one year at a dose of 13-15mg/kg/day or inability to tolerate UDCA 4. Treatment plan must include UDCA unless unable to tolerate it Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Odactra	Coverage requires the following: 1. Diagnosis of house dust mite (HDM)-induced allergic rhinitis confirmed by a positive skin test or in vitro testing for IgE antibodies to house dust mites 2. Trial of one agent from each of the following classes: a. Intranasal corticosteroid b. Oral or intranasal antihistamine Initial approval: 3 years Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓	✓	✓	**NC**

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Odomzo	Coverage requires the following: 1. Diagnosis of locally advanced basal cell carcinoma 2. Carcinoma occurred again following surgery or radiation therapy OR member is not able to receive treatment with surgery or radiation therapy	✓	✓	✓	✓	✓	✓	✓	✓
Ofev	Coverage requires the following: 1. Treatment of idiopathic pulmonary fibrosis (IPF) OR 1. Treatment of declining pulmonary function in patients with systemic sclerosis-associated interstitial lung disease OR 1. Treatment of chronic fibrosing interstitial lung diseases (ILDs) with a progressive phenotype Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Olumiant	Coverage requires the following: 1. Diagnosis of Rheumatoid Arthritis 2. Age ≥ 18 years old 3. Trial and treatment failure of one Disease Modifying Anti-Rheumatic Drug (DMARD) after a minimum 3-month trial (examples include methotrexate, hydroxychloroquine, leflunomide, sulfasalazine) 4. Trial and treatment failure of two of the following: Enbrel, Humira, Rinvoq, or Xeljanz/XR 5. Trial and treatment failure of Actemra and Orencia Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Omnaris	Coverage requires trial and failure or intolerance of 2 of the following intranasal steroids: 1. Generic fluticasone (Flonase) 2. Generic flunisolide (Nasalide) 3. Nasacort (over-the-counter) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓			**NC**	**NC**

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Ongentys	Coverage requires the following: 1. Age ≥ 18 years old 2. For treatment of patients with Parkinson's disease (PD) experiencing "OFF" episodes 3. Taking with carbidopa/levodopa 4. Trial and failure or contraindication to generic COMT-inhibitor such as generic Comtan (entacapone) or generic Tasmar (tolcapone)	✓	✓	✓	✓	✓		✓	✓
Onureg	Coverage requires the following: Maintenance treatment of acute myeloid leukemia (AML) in adults who achieved first complete remission (CR) or complete remission with incomplete blood count recovery (Cri) following intensive induction chemotherapy and are not able to complete intensive curative therapy Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓
Onzetra Xsail	Coverage requires the following: 1. Treatment failure or intolerance to generic Imitrex (sumatriptan) nasal spray and one other generic triptan (examples include: generic Maxalt (rizatriptan), generic Amerge (naratriptan), generic Zomig/ZMT(zolmitriptan)) OR 1. Age 12-17 years old 2. Treatment failure or intolerance to generic Maxalt (rizatriptan) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		✓	**NC**

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Opsumit	Coverage is provided for the treatment of pulmonary arterial hypertension (WHO Group 1)	✓	✓	✓	✓	✓	✓	✓	✓
Opzelura	Coverage requires the following: 1. Diagnosis of atopic dermatitis (AD) 2. Age ≥ 12 years old 3. Trial and treatment failure with one topical steroid 4. Trial and treatment failure with generic Protopic (pimecrolimus) or generic Elidel (tacrolimus) 5. Trial and treatment failure with Eucrisa 6. Cannot be used in combination with therapeutic biologics, other JAK inhibitors or potent immunosuppressants such as azathioprine or cyclosporine Initial approval: 3 months Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Oralair	Coverage requires the following: 1. Diagnosis of grass pollen-induced allergic rhinitis, confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for any of the 5 grass species contained in this product 2. Trial of one agent from each of the following classes: a. Intranasal corticosteroid b. Oral or intranasal antihistamine Initial approval: 3 years Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓			✓	**NC**

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Oracea, doxycycline IR DR	Coverage requires the following: Trial and treatment failure or intolerance to generic doxycycline monohydrate (Monodox) or generic doxycycline hyclate immediate release (Vibramycin) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		✓	**NC**

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Orencia SC	Coverage requires the following: 1. Diagnosis of Rheumatoid Arthritis 2. Age ≥ 18 years old 3. Trial and treatment failure of one Disease Modifying Anti-Rheumatic Drug (DMARD) after a minimum 3-month trial (examples include methotrexate, hydroxychloroquine, leflunomide, sulfasalazine) 4. Trial and treatment failure of two of the following: Enbrel, Humira, Rinvoq, or Xeljanz/XR OR 1. Diagnosis of Juvenile Idiopathic Arthritis (JIA) 2. Age ≥ 2 years old 3. Trial and treatment failure of one DMARD after a minimum 3-month trial (examples include methotrexate, leflunomide) 4. Trial and treatment failure of two of the following: Enbrel, Humira, or Xeljanz OR 1. Diagnosis of Psoriatic Arthritis 2. Age ≥ 18 years old 3. Trial and treatment failure of two of the following: Enbrel, Humira, Otezla, Stelara, Rinvoq, Skyrizi, Tremfya or Xeljanz/XR Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Orenitram	Coverage requires the following: 1. Diagnosis of pulmonary arterial hypertension (WHO Group 1) 2. Trial and treatment failure of sildenafil or tadalafil AND ambrisentan or bosentan	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Orgovyx	Coverage requires the following: 1. Age ≥ 18 years old 2. Diagnosis of advanced prostate cancer 3. Trial and failure, contraindication, OR intolerance to Firmagon (covered under medical benefit) Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓
Oriahnn	Coverage requires the following: 1. Management of heavy menstrual bleeding associated with uterine leiomyomas (fibroids) in premenopausal women 2. Age ≥18 years old 3. Trial of two hormone related therapies 4. Trial of Myfembree Oriahnn will be approved for a maximum of two years	✓	✓	✓	✓	✓	✓	✓	✓
Orilissa	Coverage requires the following: 1. Treatment of pain associated with endometriosis 2. Trial of two hormone related therapies 3. Age ≥ 18 years old. 150mg: Approval length 2 years 200mg: Approval length 6 months	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Orkambi	Coverage requires the following: 1. Diagnosis of cystic fibrosis (CF) in patients with two copies of the F508del mutation confirmed by genetic test. 2. Age ≥ 2 years old 3. Prescribed by pulmonologist in a Cystic Fibrosis center Initial approval: 6 months Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Orladeyo	Coverage requires the following: 1. Age ≥ 12 years old 2. Diagnosis of hereditary angioedema (HAE) 3. Diagnosis confirmed by genetic testing or with all the following laboratory findings: i. Normal C1q levels (normal range = 5.0-8.6 mg/dL) ii. C4 level below the limits of the laboratory's normal reference range (normal range = 16-58 mg/dL) iii. C1INH (antigenic or function) below the limits of the laboratory's normal referencerange (normal range ≥ 41%) 4. History of at least 2 HAE attacks per month OR a history of attacks that are considered severe with swelling of the face, throat or gastrointestinal tract 5. Prescribed by an immunologist, allergist or hematologist 6. Trial and failure, contraindication, OR intolerance to Haegarda AND Takhzyro (if appropriate per age) 7. Not to be used in combination with other products indicated for HAE prophylaxis Initial approval: 1 year Renewal requires improvement in HAE demonstrated by a 50% reduction in the number of attacks OR the severity of HAE attacks was reduced by 50% or more	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Otezla	Coverage requires the following: 1. Diagnosis of Psoriatic Arthritis 2. Age ≥ 18 years old OR 1. Diagnosis of Psoriasis 2. Age ≥ 18 years old 3. Trial and treatment failure of one topical steroid OR 1. Diagnosis of oral ulcers associated with Behcet disease 2. Age ≥ 18 years old 3. Trial and treatment failure to one topical steroid for oral ulcers such as triamcinolone paste Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Otrexup	Coverage requires the following: 1. Diagnosis of rheumatoid arthritis, polyarticular juvenile idiopathic arthritis, or psoriasis 2. Trial and treatment failure of oral methotrexate 3. Trial and treatment failure of injectable methotrexate	✓	✓	**NC**	✓	✓	✓	✓	**NC**

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Ovidrel	Coverage requires the following: 1. The treatment is being provided by a board-certified infertility specialist 2. It is being prescribed to treat infertility in accordance with generally accepted medical practice 3. The members benefit provides for coverage for infertility medications Coverage is provided in accordance with your medical fertility benefit			✓				✓	✓
oxandrolone (Oxandrin)	Coverage requires the following: 1. Relief of bone pain accompanying osteoporosis OR 2. Offset protein catabolism associated with prolonged administration of corticosteroids OR 3. Adjunctive therapy to promote weight gain after weight loss following extensive surgery, chronic infections or severe trauma or in some patients who fail to gain or maintain normal weight	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Oxbryta	Coverage requires the following: 1. Diagnosis of sickle cell disease 2. Age ≥ 4 years old 3. Hemoglobin ≤ 10.5 g/dl 4. Not receiving long-term red blood cell transfusion therapy 5. Trial and failure after a minimum 6 month trial, contraindication, OR intolerance to hydroxyurea OR 5. If requesting tablets for suspension, member cannot swallow tablets/capsules AND has tried and failed after aminimum 6-month trial, a contraindication, or intolerance to Siklos (hydroxyurea) Initial approval: 1 year Renewal requires improved sickle cell disease control (including, but not limited to: improvement in hemoglobin, symptoms improvement, or reduction in vaso-occlusive crises, and not receiving regular transfusion therapy)	✓	✓	✓	✓	✓	✓	✓	✓
Oxervate	Coverage requires the following: Diagnosis of neurotrophic keratitis that has progressed to stage 2 or 3 Approval: 8 weeks	✓	✓	✓	✓	✓	✓	✓	✓
oxiconazole (Oxistat)	Coverage requires the following: 1. Diagnosis of tinea pedis, tinea cruris or tinea corporis 2. Treatment failure to two topical over-the-counter antifungal agents 3. Treatment failure to two oral generic antifungal agents	✓	✓	**NC**	✓			✓	**NC**

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Oxtellar XR	Coverage requires the following: 1. Treatment of seizures in patients with epilepsy 2. Treatment failure or intolerance to at least 3 generic alternatives, one of which must be generic oxcarbazepine (Trileptal)	✓	✓	**NC**	✓	✓		✓	**NC**
oxymorphone HCl ER (Opana ER)	Coverage requires the following: 1. Diagnosis of moderate to severe chronic pain requiring around the clock opioid analgesia for an extended period of time 2. Trial and failure or intolerance to three generic long-acting opioids (examples include, but not limited to: buprenorphine transdermal patch, tramadol, morphine, fentanyl, and methadone) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit Note: Coverage will not be provided if the patient is on more than one long acting opioid concurrently	✓	✓	✓	✓	✓		✓	✓
Ozobax	Coverage requires the following: 1. Diagnosis of spasticity 2. Trial of baclofen tablets OR 1. Member is unable to swallow tablets Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓	✓	✓	**NC**

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Palforzia	Coverage for maintenance treatment requires the following: 1. FDA approved indication 2. Completion of all dose levels of up-dosing before starting maintenance OR 1. Stable on maintenance dose Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Palynziq	Coverage requires the following: 1. Diagnosis of phenylketonuria 2. Age ≥ 18 years old 3. Following a phenylalanine-restricted diet 4. Phenylalanine concentration ≥ 600 umol/liter 5. Trial and failure of Kuvan (Requires prior authorization) Initial approval: 1 year Renewal requires current phenylalanine concentration < 600 µmol/L or at least a 20% reduction from baseline	✓	✓	✓	✓	✓	✓	✓	✓
Pancreaze	Coverage requires trial and treatment failure of Creon and Zenpep Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓			✓	**NC**

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Paxlovid	Criteria requires the following: 1. Age ≥ 12 years old	✓	✓	✓	✓			✓	✓
Pemazyre	Coverage requires the following: 1. Age ≥ 18 years old 2. For the treatment of previously treated, unresectable locally advanced or metastatic cholangiocarcinoma 3. Presence of fibroblast growth factor receptor 2 fusion or other rearrangement (as detected by an FDA-approved test) Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓
Pertyze	Coverage requires trial and treatment failure of Creon and Zenpep Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓			✓	**NC**
Pexeva	Coverage requires trial and failure of at least three antidepressant agents, one of which must be generic paroxetine (Paxil)	✓	✓	✓	✓			✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
phenoxy-benzamine HCl (Dibenzyline)	Coverage is provided for the treatment of hypertension and sweating episodes due to pheochromocytoma: Age ≥ 18 years old **Preoperative treatment:** for members who have experienced treatment failure of or intolerance to a preferred selective alpha1-adrenergic receptor blocker (such as Cardura (doxazosin)) in combination with a preferred calcium channel blocker (such as Norvasc (amlodipine)) Approval duration: up to 14 days **Non-preoperative treatment:** for members who have experienced treatment failure of or intolerance to TWO selective alpha1-adrenergic receptor blockers (such as Cardura (doxazosin)) where both are used in combination with a preferred calcium channel blocker (such as Norvasc (amlodipine)) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
pirfenidone (Esbriet)	Coverage is provided for the treatment of idiopathic pulmonary fibrosis (IPF) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Piqray	Coverage requires the following: 1. Treatment of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2) negative, advanced or metastatic breast cancer in males and postmenopausal females 2. Used in combination with fulvestrant 3. PIK3CA-mutation confirmed by FDA approved test 4. Progression of cancer after an endocrine-based regimen such as anastrozole (Arimidex), exemestane (Aromasin), and letrozole (Femara) Initial approval: 1 year Continuation of treatment requires a lack of disease progression OR for Piqray 250 mg tablet strength: 1. Diagnosis of PIK3CA ‑ Related Overgrowth Spectrum (PROS) confirmed by detection of a PIK3CA mutation or based on clinical features suspected of PROS Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Pomalyst	Coverage requires the following: 1. Diagnosis of Multiple myeloma 2. Used in combination with dexamethasone 3. Received at least 2 prior therapies including an immunomodulatory agent (ex. Thalidomide, lenalidomide) and a proteasome inhibitor (ex. Bortezomib) 4. Disease progression within 60 days of completion of last therapy OR 1. Diagnosis of AIDS-related Kaposi Sarcoma after failure of highly active antiretroviral therapy (HAART) 2. Used in combination with HAART OR 1. Diagnosis of Kaposi Sarcoma in patients who are HIV-negative Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Pregnyl	Coverage requires the following: 1. The treatment is being provided by a board-certified infertility specialist 2. It is being prescribed to treat infertility in accordance with generally accepted medical practice. 3. The member's benefit provides for coverage for infertility medications 4. Coverage may be provided in accordance with your medical fertility benefit For the diagnosis of: 1. Hypogonadotrophic hypogonadism secondary to a pituitary deficiency in males OR 2. Prepubertal cryptorchidism not caused by anatomic obstruction	✓	✓	✓	✓	✓	✓	✓	✓
Procysbi	Coverage requires the following: 1. Treatment of nephropathic cystinosis 2. Has had a positive response to oral cysteamine (Cystagon) but has experienced intolerable side effects	✓	✓	**NC**	✓	✓	✓	✓	**NC**

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Promacta	Coverage requires the following: 1. Diagnosis of chronic immune thrombocytopenia (ITP) and persistent thrombocytopenia (platelet count < 100,000 mcL) for ≥ 3 months and requires all of the following: a. Age ≥ 1 year of age b. Inadequate response or patient must not be a candidate for corticosteroids, immunoglobulins or splenectomy c. Current platelet count is < 20,000 mcL or <30,000 mcL and has symptoms of active bleeding d. Dose is < 75 mg/day OR 2. Diagnosis of thrombocytopenia with chronic hepatitis C and requires all of the following: a. ≥18 years of age b. Platelets <75,000 mcL OR 3. Diagnosis of severe aplastic anemia and requires all of the following: a. ≥ 2 years of age b. Current platelets ≤ 30,000/mcL c. Insufficient response to antithymocyte globulin based immunosuppressive therapy OR c. Using in combination with standard immunosuppressive therapy as first line treatment Initial approval: 3 months Renewal of therapy requires ALL the following to be met: 1. Recent platelet count between 50,000 and 200,000/mcL OR for platelet counts outside this range, dosage has been adjusted accordingly to FDA labeled recommendations 2. Dose does not exceed recommended maximum for indication	✓	✓	✓	✓	✓	✓	✓	✓

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Pulmozyme	Coverage requires a diagnosis of cystic fibrosis	✓	✓	✓	✓	✓	✓	✓	✓
pyrimethamine (Daraprim)	Coverage is provided for the treatment of toxoplasmosis when used conjointly with a sulfonamide	✓	✓	✓	✓	✓	✓	✓	✓
Pyrukynd	Coverage requires the following: 1. Diagnosis of hemolytic anemia with pyruvate kinase (PK) deficiency 2. Age ≥ 18 years old 3. Must have clinical manifestations of disease, including, but not limited to, decreased hemoglobin (Hgb), increased reticulocytes, bilirubin, and/or lactate dehydrogenase (LDH) levels AND either one of the following: i.Serum assay showing a decrease of pyruvate kinase activity OR ii.Genetic testing showing at least 2 variant alleles in the pyruvate kinase liver and red blood cell (PKLR) gene Initial approval: 6 months Renewal requires improvement in pyruvate kinase (PK) deficiency, including, but not limited to, improvement in Hgb, hemolysis laboratory results, and transfusion requirements	✓	✓	✓	✓	✓	✓	✓	✓
Qbrexza	Coverage requires the following: 1. Treatment of primary axillary hyperhidrosis 2. Age ≥ 9 years of age 3. Trial of Drysol Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓			✓	**NC**

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Qelbree	Coverage requires the following: 1. Diagnosis of attention deficit hyperactivity disorder (ADHD) 2. Age ≥ 6 years old 3. Trial and treatment failure or intolerance to one generic methylphenidate product and one generic amphetamine product 4. Trial and treatment failure or intolerance to generic Strattera (atomoxetine) OR 4. Member cannot swallow tablets/capsules and has tried and failed one agent that can be opened and sprinkled on applesauce, such as extended release methylphenidate (Metadate CD) or generic amphetamine-dextroamphetamine (Adderall XR) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓
Qinlock	Coverage requires the following: 1. Age ≥ 18 years old 2. For the treatment of advanced gastrointestinal stromal tumor (GIST) 3. Received prior treatment with 3 or more kinase inhibitors, including imatinib Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Qnasl	Coverage requires trial and failure or intolerance of 2 of the following intranasal steroids: 1. Generic fluticasone (Flonase) 2. Generic flunisolide (Nasalide) 3. Nasacort (over-the-counter) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓			**NC**	**NC**
Qsymia	Coverage requires the following: 1. 18 years and older 2. BMI ≥ 30, or ≥ 27 with one weight related comorbid condition 3. Current weight (within 30 days) must be submitted to the plan for review 4. Concurrent lifestyle modification program 5. Not to be used in combination with other weight loss products OR 1. 12 to 17 years of age 2. BMI ≥ 95th percentile, standardized for age and sex 3. Current weight (within 30 days) must be submitted to the plan for review 4. Concurrent lifestyle modification program 5. Not to be used in combination with other weight loss products Initial approval: 1 year Continued coverage will be reviewed annually and may be provided if the member has maintained at least a 5% weight loss from baseline	✓	✓	**NC**	✓	✓	✓	✓	**NC**

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Quillichew ER	Coverage requires the following: 1. The member is ≥ 6 years of age and diagnosed with ADHD or ADD 2. And has tried and failed both a generic methylphenidate and a generic amphetamine product, one of which must be a generic long acting formulation OR 2. Member cannot swallow tablets/capsules and has tried and failed one of the agents that can be opened and sprinkled on applesauce, extended release methylphenidate (Metadate CD), generic amphetamine-dextroamphetamine (Adderall XR) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓	✓	✓	**NC**
Quillivant XR	Coverage requires the following: 1. The member is ≥ 6 years of age and diagnosed with ADHD or ADD 2. And has tried and failed both a generic methylphenidate and a generic amphetamine product, one of which must be a generic long acting formulation OR 2. Member cannot swallow tablets/capsules and has tried and failed one of the agents that can be opened and sprinkled on applesauce, extended release methylphenidate (Metadate CD), generic amphetamine-dextroamphetamine (Adderall XR) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		✓	**NC**

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Qulipta	Coverage requires the following: 1. For preventive treatment of migraine headaches 2. Age ≥ 18 years old 3. Member has history of ≥ 4 headache days per month 4. Trial of two medications from two different classes for the prevention of migraines Initial approval: 1 year Renewal requires at least a 50% or greater reduction in monthly migraine days (MMDs) from baseline	✓	✓	**NC**	✓	✓	✓	✓	**NC**
Quviviq	Coverage requires treatment failure of 3 of the following: immediate-release zolpidem (Ambien), eszopiclone (Lunesta), zaleplon (Sonata), trazodone (Desyrel), or doxepin (Silenor) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**			✓	✓	**NC**
Ragwitek	Coverage requires the following: 1. Age ≥ 5 years old 2. Diagnosis of short ragweed pollen induced allergic rhinitis, confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for short ragweed pollen 3. Trial of one agent from each of the following classes: a. Intranasal corticosteroid b. Oral or intranasal antihistamine Initial approval: 3 years Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		✓	**NC**

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
raloxifene (Evista)	Coverage for $0 copayment will be provided when: 1. The member is a woman, at least 35 years of age and post-menopausal 2. The medication is being used for prevention of primary breast cancer in members classified as high risk 3. Cost share will not be waived for members with a history of breast cancer or venous thrombotic event (VTE)	✓	✓	✓	✓	✓		✓	✓
Rasuvo	Coverage requires the following: 1. Diagnosis of rheumatoid arthritis, polyarticular juvenile idiopathic arthritis, or psoriasis 2. Trial and treatment failure of oral methotrexate 3. Trial and treatment failure of injectable methotrexate	✓	✓	**NC**	✓	✓	✓	✓	**NC**
Ravicti	Coverage requires the following: 1. Diagnosis of urea cycle disorder 2. Trial and treatment failure of dietary protein restriction and/or amino acid supplementation 3. Trial and treatment failure of Buphenyl (sodium phenylbutyrate)	✓	✓	✓	✓	✓	✓	✓	✓
Rayos	Coverage requires the following: 1. Diagnosis of rheumatoid arthritis 2. Trial or intolerance of two systemically absorbed generic oral corticosteroids, one of which must be prednisone Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**		✓		✓	**NC**

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Rebif	Coverage requires trial and failure or intolerance to two generic or preferred medications for the treatment of multiple sclerosis (examples include: Avonex, Bafiertam, Betaseron, Copaxone, Kesimpta, and Vumerity) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓		✓			✓	
Recorlev	Coverage requires the following: 1. Treatment of endogenous hypercortisolemia in patients with Cushing's syndrome for whom surgery is not an option or has not been curative 2. Age ≥ 18 years old 3. Trial and treatment failure, contraindication, or intolerance to ketoconazole, mitotane, or cabergoline Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓	✓	✓	**NC**
RediTrex	Coverage requires the following: 1. Diagnosis of rheumatoid arthritis, polyarticular juvenile idiopathic arthritis, or psoriasis 2. Trial and treatment failure of oral methotrexate 3. Trial and treatment failure of injectable methotrexate	✓	✓	**NC**	✓	✓	✓	✓	**NC**

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Repatha	Coverage requires the following: 1. Diagnosis of primary hyperlipidemia, or prevention of cardiovascular events in patients with established cardiovascular disease a. Age ≥ 18 years old b. Trial and failure of one high intensity statin OR b. History of statin intolerance (skeletal muscle related symptoms) after a trial of two generic statins (Examples include: Crestor, Lescol, Lipitor, Livalo, Mevacor, Pravachol, Zocor) OR b. History of rhabdomyolysis after a trial of one statin (Examples include: Crestor, Lescol, Lipitor, Livalo, Mevacor, Pravachol, Zocor) OR 2. Diagnosis of homozygous familial hypercholesterolemia or heterozygoius familial hypercholesterolemia a. Age ≥ 10 years old b. Trial and treatment failure with one high intensity statin OR b. History of statin intolerance (skeletal muscle related symptoms) after a trial of two generic statins (Examples include: Crestor, Lescol, Lipitor, Livalo, Mevacor, Pravachol, Zocor) **(criteria continued next page)**	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Repatha (continued)	OR b. History of rhabdomyolysis after a trial of one statin (Examples include: Crestor, Lescol, Lipitor, Livalo, Mevacor, Pravachol, Zocor) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Retevmo	Coverage requires the following: 1. Age ≥ 18 years old 2. Diagnosis of Metastatic RET Fusion-Positive Non-Small Cell Lung Cancer OR 1. Age ≥ 12 years old 2. Diagnosis of RET-Mutant Medullary Thyroid Cancer OR 1. Age > 12 years old 2. Diagnosis of RET Fusion-Positive Thyroid Cancer Refractory to radioactive iodine (if radioactive iodine is appropriate) Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Revcovi	Coverage requires the following: 1. Diagnosis of adenosine deaminase (ADA) deficiency in patients with severe combined immunodeficiency disease (SCID) 2. Prescribed by or in consultation with an immunologist 3. Confirmation of diagnosis by serum assay showing a decrease of adenosine deaminase activity followed by genetic testing showing a mutation in the adenosine deaminase gene 4. Treatment failure of or not a suitable candidate for a bone marrow transplant Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Rexulti	Coverage requires the following: Trial and failure, contraindication, or intolerance to two preferred or generic second generation antipsychotics (examples include: aripiprazole, clozapine, risperidone, quetiapine, olanzapine, ziprasidone) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓			✓	**NC**

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Reyvow	Coverage requires the following: 1. Age ≥ 18 years old 2. For the acute treatment of migraines 3. Trial and treatment failure, contraindication, or intolerance to 2 generic triptan medications 4. Trial and treatment failure, contraindication, or intolerance to Ubrelvy and Nurtec ODT Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓
Rezurock	Coverage requires the following: 1. Age ≥ 12 years old 2. Diagnosis of chronic graft versus‐host disease (cGVHD) after failure of at least two prior lines of systemic therapy Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit Please note: For quantity requests greater than one tablet per day due to concomitant proton pump inhibitor therapy, use of a H2-receptor antagonist is recommended	✓	✓	✓	✓	✓	✓	✓	✓
Rhopressa	Coverage requires the following: 1. Trial of one generic medication, such as generic Xalatan, generic Lumigan, timolol Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Rinvoq	Coverage requires the following: 1. Diagnosis of Rheumatoid Arthritis 2. Age ≥ 18 years old 3. Trial and treatment failure of one Disease Modifying Anti-Rheumatic Drug (DMARD) after a minimum 3-month trial (examples include methotrexate, hydroxychloroquine, leflunomide, sulfasalazine) 4. Trial and treatment failure of one or more tumor necrosis factor (TNF) inhibitor(s) OR 1. Diagnosis of Psoriatic Arthritis 2. Age > 18 years old 3. Trial and treatment failure of one or more tumor necrosis factor (TNF) inhibitor(s) OR 1. Diagnosis of moderate to severe Atopic Dermatitis 2. Age ≥ 12 years old 3. Weight ≥ 40 kg 4. Trial and treatment failure of one of the following: high potency topical corticosteroid, tacrolimus, pimecrolimus, cyclosporine, methotrexate, azathioprine, or mycophenolate mofetil 5. Cannot be used in combination with other biologic agents indicated for severe atopic dermatitis **(criteria continued next page)**	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Rinvoq (continued)	OR 1. Diagnosis of Ulcerative Colitis 2. Age ≥ 18 years old 3. Treatment with an adequate course of conventional therapy (such as steroids for at least 7 days (examples include prednisone, methylprednisolone, or budesonide) or immunomodulators for at least 2 months (examples include azathioprine or cyclosporine)) 4. Trial and treatment failure of one or more tumor necrosis factor (TNF) inhibitor(s) OR 1. Diagnosis of ankylosing spondylitis 2. Age ≥ 18 years old 3. Trial and treatment failure of one or more tumor necrosis factor (TNF) inhibitor(s) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
risedronate DR (Atelvia)	Coverage requires trial and treatment failure or intolerance to two of the following: 1. Actonel (risedronate) 2. Boniva (ibandronate) 3. Fosamax (alendronate) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Rocklatan	Coverage requires the following: 1. Trial of one generic medication, such as generic Xalatan, generic Lumigan, timolol Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓		✓	✓
Rozlytrek	Coverage requires the following: 1. Treatment of metastatic non-small cell lung cancer in adults whose tumors are ROS1-positive 2. Age ≥ 18 years old OR 1. Treatment of solid tumors that have a neurotrophic tyrosine receptor kinase (NTRK) gene fusion without a known acquired resistance mutation 2. Age ≥ 12 years old 3. Tumor is metastatic or where surgical resection is not an option 4. Tumor has progressed following treatment or there is no alternative therapy	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Rubraca	Coverage requires the following: 1. For the maintenance treatment of adult patients with recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in a complete or partial response to platinum-based chemotherapy OR 1. Diagnosis of metastatic castration-resistant prostate cancer 2. Deleterious BRCA mutation as detected by FDA-approved test 3. Prior treatment with androgen receptor-directed therapy and a taxane-based chemotherapy Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓
Ruconest	Coverage requires the following: 1. Treatment of acute attacks of hereditary angioedema (HAE) 2. Diagnosis confirmed by genetic testing or with all the following laboratory findings: i. Normal C1q levels (normal range = 5.0-8.6 mg/dL) ii. C4 level below the limits of the laboratory's normal reference range (normal range = 16-58 mg/dL) iii. C1INH (antigenic or function) below the limits of the laboratory's normal reference range (normal range ≥ 41%) 3. Prescribed by an immunologist, allergist or hematologist	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
rufinamide tablet (Banzel)	Coverage requires the following: 1. Treatment of seizures associated with Lennox-Gastaut syndrome 2. Age ≥ 1 year old 3. Trial and failure, contraindication, OR intolerance to two generic alternatives for the treatment of Lennox-Gastaut Syndrome	✓	✓	✓	✓			✓	✓
Rukobia	Coverage requires the following: 1. Age ≥ 18 years 2. Treatment of human immunodeficiency virus type 1 (HIV-1) infection 3. Treatment failure to multiple HIV treatment regimens 4. Member is currently failing his/her antiretroviral regimen due to resistance or intolerance 5. Used in combination with other antiretroviral(s) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Rydapt	Coverage requires the following: 1. Diagnosis of acute myeloid leukemia (AML) that is FLT3 mutation-positive as detected by an FDA-approved test. 2. Using in combination with cytarabine and daunorubicin induction and cytarabine consolidation OR 1. Diagnosis of mast cell leukemia (MCL) OR 1. Diagnosis of aggressive systemic mastocytosis or systemic mastocytosis with associated hematological neoplasm (SM-AHN)	✓	✓	✓	✓	✓	✓	✓	✓
Rytary	Coverage requires trial and treatment failure of generic Sinemet CR Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		✓	**NC**
Sancuso	Coverage requires the following: 1. Using for prevention and/or treatment of nausea/vomiting associated with chemotherapy and/or radiation therapy 2. Treatment/failure with generic ondansetron (Zofran)/ODT and generic granisetron (Kytril) Initial approval: 1 year Renewal requires continuation of chemotherapy	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Sandostatin LAR / Depot	Coverage requires the following: 1. Diagnosis of one of the following: a. Acromegaly in patients who have had an inadequate response to surgery and/or for whom surgery is not an option, or being used to shrink tumor prior to surgery, and supported by an elevated Insulin-like Growth Factor-1 (IGF-1) level b. Symptomatic treatment of severe diarrhea or flushing episodes associated with the diagnosis of metastatic carcinoid tumor c. Treatment of diarrhea associated with the diagnosis of vasoactive intestinal peptide tumors 1. Previously tried, responded and tolerated generic immediate release octreotide Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
sapropterin (Kuvan)	Coverage requires the following: 1. Treatment of phenylketonuria (PKU) 2. Following a phenylalanine-restricted diet	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Savella	Coverage requires the following 1. Diagnosis of fibromyalgia 2. Treatment failure or intolerance to gabapentin 3. Treatment failure or intolerance to 3 of the following: a. Tricyclic antidepressant b. Selective serotonin reuptake inhibitor (SSRI) c. Serotonin norepinephrine reuptake inhibitor (SNRI) d. Cyclobenzaprine (Flexeril) e. Tramadol (Ultram)	✓	✓	✓				✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Saxenda	Coverage requires the following: 1. 18 years and older 2. BMI ≥ 30, or ≥ 27 with one weight related comorbid condition 3. Current weight (within 30 days) must be submitted to the plan for review 4. Concurrent lifestyle modification program 5. Not to be used in combination with other weight loss products OR 1. 12 to 17 years of age 2. BMI corresponding to 30 or greater for adults 3. Current weight (within 30 days) above 132 lb (60 kg) must be submitted to the plan for review 4. Concurrent lifestyle modification program 5. Not to be used in combination with other weight loss products Initial approval: 1 year For adults, continued coverage will be reviewed annually and may be provided if the member has maintained at least a 4% weight loss from baseline For pediatrics, continued coverage will be reviewed annually and may be provided if the member has maintained at least a 1% weight loss from baseline	✓	✓	**NC**	✓	✓	✓	✓	**NC**

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Scemblix	Coverage requires the following: 1. Treatment of philadelphia chromosome - positive chronic myeloid leukemia (Ph+ CML) in chronic phase (CP) 2. Previously treated with two or more tyrosine kinase inhibitors (TKIs) 3. Age ≥ 18 years old OR 1. Treatmentt of philadelphia chromosome - positive chronic myeloid leukemia (Ph+ CML) in chronic phase (CP) 2. Presence of T315I mutation 3. Age ≥ 18 years old Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓
Secuado	Coverage requires the following: Trial and failure, contraindication, or intolerance to two preferred or generic second generation antipsychotics (examples include: aripiprazole, clozapine, risperidone, quetiapine, olanzapine, ziprasidone) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓
Serostim	Coverage requires the following: 1. Diagnosis of AIDS wasting cachexia 2. Age ≥ 18 years old 3. Unexplained weight loss > 10% of baseline 4. Concomitant anti-viral therapy for the duration of treatment 5. Prescribed by an endocrinologist, gastroenterologist, or infectious disease specialist	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Signifor	Coverage requires the following: 1. Treatment of hypercortisolism as a result of endogenous Cushing's syndrome 2. Surgical treatment has not been effective or is not an option 3. Treatment failure or intolerance to ketoconazole or mitotane, unless contraindicated Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Signifor LAR	Coverage requires the following: 1. Diagnosis of one of the following: a. Acromegaly in patients who have had an inadequate response to surgery and/or for whom surgery is not a option, and supported by an elevated Insulin-like Growth Factor-1 (IGF-1) level b. Cushing's Disease for whom pituitary surgery is not an option or has not been curative and the following: i. Treatment failure to ketoconazole, mitotane or cabergoline, unless contraindicated or not tolerated ii. Treatment failure with Signifor, unless contraindicated or not tolerated Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓	✓	✓	**NC**

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Siklos	Coverage requires the following: 1. Diagnosis of sickle cell anemia 2. Age ≥ 2 years old 3. Unable to swallow capsules Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
sildenafil citrate suspension (Revatio)	Coverage is provided for the treatment of pulmonary arterial hypertension (WHO Group 1) when the member is unable to swallow tablets/capsules Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
sildenafil citrate tablet (Revatio)	Coverage is provided for the treatment of pulmonary arterial hypertension (WHO Group 1) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit			✓					✓
sildenafil (Viagra)	May be covered for the diagnosis of erectile dysfunction dependent on the plan's benefit with quantity limit restrictions	✓	✓	**NC**	✓	✓		✓	**NC**

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Simponi	Coverage requires the following: 1. Diagnosis of Ankylosing Spondylitis 2. Age ≥ 18 years old 3. Trial and treatment failure of four of the following: Humira, Enbrel, Xeljanz/XR, Taltz, or Rinvoq OR 1. Diagnosis of Rheumatoid Arthritis 2. Age ≥ 18 years old 3. Trial and treatment failure to one Disease Modifying Anti-Rheumatic Drug (DMARD) after a minimum 3-month trial (examples include methotrexate, hydroxychloroquine, leflunomide, sulfasalazine) 4. Trial and treatment failure of two of the following: Enbrel, Humira, Rinvoq, or Xeljanz/XR 5. Trial and treatment failure of Actemra and Orencia 6. Using in combination with methotrexate OR 1. Diagnosis of Psoriatic Arthritis 2. Age ≥ 18 years old 3. Trial and treatment failure of two of the following:Enbrel, Humira, Otezla, Stelara, Rinvoq, Skyrizi, Tremfya or Xeljanz/XR 4. Trial and treatment failure of Taltz and Orencia OR 1. Diagnosis of Ulcerative Colitis 2. Age ≥ 18 years old **(criteria continued next page)**	✓	✓	✓	✓	✓	✓	✓	✓

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Simponi (continued)	3. Treatment with an adequate course of conventional therapy (such as steroids for at least 7 days (examples include prednisone, methylprednisolone, or budesonide) or immunomodulators for at least 2 months (examples include azathioprine or cyclosporine)) Trial and treatment failure of Humira, Stelara, Xeljanz/XR, and Rinvoq Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit								
Sirturo	Coverage requires the following: 1. Age ≥ 5 years old and weighting at least 15 kg 2. Treatment of pulmonary multi-drug resistant tuberculosis (MDR-TB)	✓	✓	✓	✓	✓	✓	✓	✓
Sitavig	Coverage requires the following: Trial and failure of all of the following: 1. Generic oral acyclovir (Zovirax) 2. Generic valacyclovir (Valtrex)	✓	✓	**NC**	✓	✓		✓	**NC**

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Skyrizi	Coverage requires the following: 1. Diagnosis of Psoriasis 2. Age ≥ 18 years old 3. Trial and treatment failure of one topical steroid OR 1. Diagnosis of Psoriatic Arthritis 2. Age ≥ 18 years old Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Somatuline Depot	Coverage requires the following: 1. Diagnosis of one of the following: a. Acromegaly in patients who have had an inadequate response to surgery and/or for whom surgery is not an option, and supported by an elevated Insulin-like Growth Factor-1 (IGF-1) level b. Unresectable, well- or moderately-differentiated, locally advanced or metastatic gastroenteropancreatic neuroendocrine tumors c. Carcinoid syndrome Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Somavert	Coverage requires diagnosis of acromegaly in patients who have had an inadequate response to surgery and/or for whom surgery is not an option	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
sorafenib (Nexavar)	Coverage is provided for the treatment of the FDA approved indications	✓	✓	✓	✓	✓	✓	✓	✓
Sovaldi tablets	Coverage requires the following: If cirrhosis is present: documentation of decompensated or compensated cirrhosis AND one of the following: 1. Age 18 years or older 2. Diagnosis of chronic hepatitis C genotype 1, 2, 3, or 4 3. Trial of preferred medication: Epclusa or Zepatier 4. If treatment experienced, documentation of previous treatment experience for Hepatitis C OR 1. Age 3 years or older 2. Diagnosis of chronic hepatitis C genotype 2 or 3 3. Using in combination with ribavirin Drug will be reviewed on a case by case basis utilizing AASLD guidelines and FDA approved package labeling and trial and failure of Epclusa or Zepatier	✓	✓	**NC**	✓	✓	✓	✓	**NC**

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Sovaldi oral pellets	Coverage requires the following: If cirrhosis is present: documentation of decompensated or compensated cirrhosis AND one of the following: 1. Age 18 years or older 2. Diagnosis of chronic hepatitis C genotype 1, 2, 3, or 4 3. Trial of preferred medication: Epclusa or Zepatier 4. If treatment experienced, documentation of previous treatment experience for Hepatitis C OR 1. Age 3 years or older 2. Diagnosis of chronic hepatitis C genotype 2 or 3 3. Using in combination with ribavirin Drug will be reviewed on a case by case basis utilizing AASLD guidelines and FDA approved package labeling and trial and failure of Epclusa or Zepatier	✓	✓	✓	✓	✓	✓	✓	✓
Spritam	Coverage requires the following: 1. Treatment of seizure disorder/epilepsy 2. Member is unable to swallow tablets or capsules 3. Trial of 3 generic or preferred alternatives, one of which must be generic levetiracetam (Keppra) solution	✓	✓	**NC**	✓	✓		✓	**NC**
Sprycel	Coverage is provided for the treatment of the FDA approved indications	✓	✓	✓	✓	✓	✓	✓	✓

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Staxyn	May be covered for the diagnosis of erectile dysfunction dependent on the plan's benefit with quantity limit restrictions	✓	✓	**NC**	✓	✓		✓	**NC**
Stelara	Coverage requires the following: 1. Diagnosis of Psoriasis 2. Age ≥ 6 years old 3. Trial and treatment failure of one topical steroid OR 1. Diagnosis of Psoriatic Arthritis 2. Age ≥ 18 years old OR 1. Diagnosis of Crohn's Disease 2. Age ≥ 18 years old 3. Treatment with an adequate course of conventional therapy (such as steroids for at least 7 days (examples include prednisone, methylprednisolone, or budesonide) or immunomodulators for at least 2 months (examples include methotrexate, azathioprine, or sulfasalazine)) OR 1. Diagnosis of Ulcerative Colitis 2. Age ≥ 18 years old 3. Treatment with an adequate course of conventional therapy (such as steroids for at least 7 days (examples include prednisone, methylprednisolone, or budesonide) or immunomodulators for at least 2 months (examples include azathioprine or cyclosporine)) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Stendra	May be covered for the diagnosis of erectile dysfunction dependent on the plan's benefit with quantity limit restrictions	✓	✓	**NC**	✓	✓		✓	**NC**

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Stivarga	Coverage requires the following: 1. Diagnosis of metastatic or unresectable gastrointestinal stromal tumors and disease progression or intolerance to treatment with imatinib and sunitinib OR 2. Diagnosis of metastatic colorectal cancer (mCRC) and prior treatment with fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy, an anti- VEGF therapy, and, if RAS wild type, an anti-EGFR therapy OR 3. Treatment of hepatocellular cancer in patients who have previously been treated with sorafenib Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓
Strensiq	Coverage requires the following: 1. Diagnosis of perinatal/infantile and juvenile-onset hypophosphatasia. 2. < 18 years old at onset of symptoms 3. Diagnosis must be made by or in consultation with a geneticist, metabolic specialist, endocrinologist or bone and mineral specialist 4. Diagnosis confirmed by one or two pathogenic variants in the ALPL gene + 5. Must have documentation of active disease manifestations such as: skeletal malformations/fractures, respiratory difficulties, dental manifestations, kidney damage, or seizures Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Subsys	Coverage requires the following: 1. edication is being used for the treatment of breakthrough cancer pain 2. Member is tolerant to high dose opioids 3. Currently receiving a long acting opioid 4. Treatment failure or intolerance to oral immediate release narcotics (examples include, but not limited to: morphine, oxycodone, or hydrocodone containing products) 5. Treatment failure or intolerance to generic Actiq	✓	✓	**NC**	✓	✓	✓	✓	**NC**
Sucraid	Coverage is provided for the treatment of congenital sucrase-isomaltase deficiency	✓	✓	✓	✓			✓	✓
Sumatriptan succinate/ naproxen sodium (Treximet)	Coverage requires the following: 1. Treatment failure or intolerance to generic sumatriptan (Imitrex) and naproxen used in combination 2. Treatment failure or intolerance to a second generic triptan (Maxalt, Amerge, Zomig/ZMT) OR 1. Age 12-17 years old 2. Treatment failure or intolerance to generic Maxalt (rizatriptan) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		✓	**NC**

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
sunitinib (Sutent)	Coverage requires the following: 1. Treatment of advanced renal cell carcinoma (RCC) OR 1. Treatment of gastrointestinal stromal tumor (GIST) 2. Disease progression or intolerance to imatinib (Gleevec) OR 1. Treatment of progressive, well-differentiated pancreatic neuroendocrine tumors in patients with unresectable locally advanced or metastatic disease OR 1. Adjuvant treatment of adult patients at high risk of recurrent RCC following nephrectomy	✓	✓	✓	✓	✓	✓	✓	✓
Sunosi	Coverage requires the following: 1. Age ≥ 18 years old 2. Diagnosis of excessive daytime sleepiness associated with narcolepsy or obstructive sleep apnea (OSA) 3. For a diagnosis of OSA: Nonpharmacologic treatment has been initiated (ex. CPAP) 4. Trial and treatment failure of modafinil or armodafinil 5. Trial and treatment failure of one generic or preferred treatment such as methylphenidate or dextroamphetamine Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Symdeko	Coverage requires the following: 1. Age ≥ 6 years old 2. Diagnosis of cystic fibrosis (CF) 3. Presence of two copies of the F508del mutation OR at least one mutation in the CFTR gene that is responsive to Symdeko as confirmed by genetic test Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Sympazan	Coverage requires the following: 1. Diagnosis of Lennox-Gastaut syndrome 2. Trial of generic clobazam tablets AND generic clobazam solution OR 2. Documentation that the member is unable to swallow tablets/capsules/solution Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓	✓	✓	**NC**
Synribo	Coverage requires the following: Treatment of adult patients with chronic or accelerated phase chronic myeloid leukemia (CML) with resistance and/or intolerance to two or more tyrosine kinase inhibitors Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Tabrecta	Coverage requires the following: 1. Age ≥ 18 years old 2. Diagnosis of metastatic non-small cell lung cancer (NSCLC) 3. Tumor has a mutation that leads to mesenchymal-epithelial transition (MET) exon 14 skipping Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓
tadalafil (Adcirca)	Coverage requires the following: 1. Diagnosis of pulmonary arterial hypertension (WHO Group 1) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
tadalafil (Cialis 2.5mg, 5mg)	Coverage for daily dosing requires the following: 1. Diagnosis of Benign Prostatic Hyperplasia (BPH) 2. Trial and failure or intolerance of an alpha-blocker 3. Trial and treatment failure of a 5-alpha reductase inhibitor May be covered for the diagnosis of erectile dysfunction dependent on the plan's benefit with quantity limit restrictions	✓	✓	**NC**	✓			✓	**NC**
tadalafil (Cialis)	May be covered for the diagnosis of erectile dysfunction dependent on the plan's benefit with quantity limit restrictions	✓	✓	**NC**	✓	✓		✓	**NC**

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Tafinlar	Coverage requires the following: 1. Diagnosis of melanoma 2. Presence of BRAF V600E or V600K mutation 3. Using as a single agent or in combination with Mekinist (trametinib) OR 1. Diagnosis of metastatic non-small cell lung cancer or advanced or metastatic anaplastic thyroid cancer 2. Presence of BRAF V600 E mutation 3. Using in combination with Mekinist (trametinib) OR 1. Age ≥ 6 years old 2. Diagnosis of unresectable or metastatic solid tumors who have progressed following prior treatment and have no satisfactory alternative treatment options 3. Presence of with BRAF V600E mutation 4. Using in combination with Mekinist (trametinib) Initial approval: 1 year Continuation of treatment requires a lack of disease progression or unacceptable toxicity	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Tagrisso	Coverage requires the following: 1. Diagnosis of metastatic epidermal growth factor (EGFR) T790M mutation-positive non-small cell lung cancer (NSCLC) as detected by an FDA-approved test 2. Progression on or after EGFR tyrosine kinase inhibitor (TKI) therapy OR 1. Diagnosis of metastatic NSCLC 2. Presence of EGFR exon 19 deletions or exon 21 L858R mutation OR 1. Adjuvant treatment of non-small cell lung cancer (NSCLC) after tumor resection 2. Presence of EGFR exon 19 deletion or exon 21 L858R mutation Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Takhzyro	Coverage requires the following: 1. Diagnosis of hereditary angioedema (HAE) 2. Diagnosis confirmed by genetic testing or with all the following laboratory findings: i. Normal C1q levels (normal range = 5.0-8.6 mg/dL) ii. C4 level below the limits of the laboratory's normal reference range (normal range = 16-58 mg/dL) iii. C1INH (antigenic or function) below the limits of the laboratory's normal reference range (normal range ≥41%) 3. History of at least 2 HAE attacks per month OR a history of attacks that are considered severe with swelling of the face, throat or gastrointestinal tract 4. Prescribed by an immunologist, allergist or hematologist Initial approval: 1 year Renewal requires improvement in HAE demonstrated by a 50% reduction in the number of attacks OR the severity of HAE attacks was reducted by 50% or more	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Taltz	Coverage requires the following: 1. Diagnosis of Psoriasis 2. Age ≥ 6 years old 3. Trial and treatment failure of one topical steroid 4. Trial and treatment failure of one of the following: Enbrel, Humira, Otezla, Skyrizi, Stelara, or Tremfya OR 1. Diagnosis of Psoriatic Arthritis 2. Age ≥ 18 years old 3. Trial and treatment failure of one of the following: Enbrel, Humira, Otezla, Stelara, Rinvoq, Skyrizi, Tremfya, or Xeljanz/XR OR 1. Diagnosis of active Non-Radiographic Axial Spondyloarthritis with objective signs of inflammation 2. Age ≥ 18 years old OR 1. Diagnosis of active Ankylosing Spondylitis 2. Age ≥ 18 years old 3. Trial and treatment failure of Enbrel, Humira, Xeljanz/XR, or Rinvoq Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Talzenna	Coverage requires the following: Diagnosis of BRCA mutated, as detected by an FDA approved test, HER2-negative locally advanced or metastatic breast cancer	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
tamoxifen	Coverage for $0 copayment will be provided when: 1. The member is a woman at least 35 years of age 2. The medication is being used for prevention of primary breast cancer in members classified as high risk 3. Does not have a history of breast cancer 4. Does not have a family or personal history of venous thromboembolic events (VTE)	✓	✓	✓	✓	✓		✓	✓
Tarpeyo	Coverage requires the following: 1. Intended to reduce proteinuria for the diagnosis of primary immunoglobulin A nephropathy (IgAN) at risk of rapid disease progression, generally a urine protein-to-creatinine ratio (UPCR) ≥1.5 g/g 2. Age ≥ 18 years old 3. Trial and failure, contraindication, or intolerance to generic methylprednisolone, prednisolone, or prednisone Initial approval: 9 months	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Tavneos	Coverage requires the following: 1. Adjunctive treatment of severe active anti-neutrophil cytoplasmic autoantibody (ANCA)-associated vasculitis (granulomatosis with polyangiitis [GPA] and microscopic polyangiitis [MPA]) in combination with standard therapy including glucocorticoids 2. Age ≥ 18 years old 3. Must be initiated in combination with a standard therapy regimen that includes either cyclophosphamide plus glucocorticoids or rituximab/rituximab biosimilar plus glucocorticoids Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Targretin gel	Coverage requires the following: 1. Diagnosis of Cutaneous T-cell lymphoma 2. Topical treatment of cutaneous lesions	✓	✓	✓	✓	✓	✓	✓	✓
Tasigna	Coverage is provided for the treatment of the FDA approved indications	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Tavalisse	Coverage requires the following: Diagnosis of chronic immune thrombocytopenia (IT) and persistent thrombocytopenia (platelet count < 100,000mcl) for ≥ 3 months and all of the following: 1. Age ≥ 18 years old 2. Prescribed by or in consultation with a hematologist 3. Trial and treatment failure or not a candidate for treatment with corticosteroids, immunoglobulins or splenectomy 4. Current platelet count is < 20,000 mcl or < 30,000 mcl and symptoms of active bleeding 5. Trial of Promacta Initial approval: 3 months Renewal requires a stable platelet count of at least 50,000/mcL	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Tazverik	Coverage requires the following: 1. Age ≥ 16 years old 2. Diagnosis of epithelioid sarcoma 3. Not eligible for complete resection OR 1. Age ≥ 18 years old 2. Diagnosis of relapsed or refractory follicular lymphoma with tumors that are positive for an EZH2 mutation as detected by an FDA-approved test 3. Recieved at least 2 prior therapies OR 1. Age ≥ 18 years old 2. Diagnosis of relapsed or refactory folliclar lymphoma 3. No satisfactory alternative treatment options	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Tegsedi	Coverage requires the following: 1. Age ≥ 18 years old 2. Diagnosis of peripheral nerve disease caused by hereditary transthyretin-mediated amyloidosis (hATTR) with aTTR gene mutation 3. Signs and symptoms of ocular or cerebral area involvement (such as intraocular amyloidosis or primary/leptomeningeal amyloidosis), if present, must not predominate over polyneuropathy symptomology associated with hATTR 4. Documentation of clinical signs and symptoms of peripheral neuropathy (such as: tingling or increased pain in the hands, feet and/or arms, loss of feeling in the hands and/or feet, numbness or tingling in the wrists, carpal tunnel syndrome, loss of ability to sense temperature, difficulty with fine motor skills, weakness in the legs, difficulty walking)AND/OR documentation of clinical signs and symptoms of autonomic neuropathy symptoms (such as: orthostasis, abnormal sweating, dysautonomia [constipation and/or diarrhea, nausea, vomiting, anorexia, early satiety]) 5. Must have a baseline polyneuropathy disability (PND) score ≤ IIIb and/or baseline FAP Stage 1 or 2 6. Must not have New York Heart Association (NYHA) heart failure classification > 2 7. Must not have undergone a prior liver transplant Tegsedi will not be approved for use in combination with any of the following : Onpattro, Vyndaqel, Vyndamax Initial approval: 1 year. Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Tepmetko	Coverage requires the following: 1. Age ≥ 18 years old 2. Diagnosis of metastatic non-small cell lung cancer (NSCLC) 3. Tumor has a mutation that leads to mesenchymal-epithelial transition (MET) exon 14 skipping Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓
Testosterone, topical Androgel, generic Androgel, Androderm	Coverage requires the following: 1. Diagnosis of male hypogonadism 2. Two signs and symptoms specific to testosterone deficiency Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓
Testosterone, topical generic Axiron, generic Fortesta generic Testim, Testosterone 10mg (2%) Testosterone 30mg Testosterone 50mg (1%) generic Vogelxo	Coverage requires the following: 1. Diagnosis of male hypogonadism 2. Two signs and symptoms specific to testosterone deficiency Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓			✓	**NC**

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
tetrabenazine (Xenazine)	Coverage requires diagnosis of chorea associated with Huntington's disease Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Thiola EC	Coverage requires the following: 1. For the prevention of cystine stone formation in patients weighing ≥ 20 kilograms 2. Resistant to treatment with conservative measures of high fluid intake, sodium restriction, limited protein intake and urine alkalization Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Tibsovo	Coverage requires the treatment of FDA approved indications	✓	✓	✓	✓	✓	✓	✓	✓
Tiglutik	Coverage requires the following: 1. Diagnosis of Amyotrophic Lateral Sclerosis (ALS) 2. Trial of generic riluzole tablets OR 2. Difficulty swallowing Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
tiopronin (Thiola)	Coverage requires the following: 1. For the prevention of cystine stone formation in patients weighing ≥ 20 kilograms 2. Resistant to treatment with conservative measures of high fluid intake, sodium restriction, limited protein intake and urine alkalization Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓
Tivorbex	Coverage requires the following: 1. Age ≥ 17 years old 2. Diagnosis of acute pain 3. Trial and treatment failure of oral indomethacin 4. Trial and treatment failure of two other oral preferred NSAIDs Initial approval: 3 months	✓	✓	**NC**	✓	✓		✓	**NC**
Tlando	Coverage requires the following: 1. Diagnosis of male hypogonadism 2. Two signs and symptoms specific to testosterone deficiency 3. Trial and failure, contraindication, or intolerance to one generic or preferred testosterone product (examples include generic Androgel, Androderm, and generic Depo-Testosterone) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		✓	**NC**

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Tobi Podhaler	Coverage requires the following: 1. Member has cystic fibrosis and is infected with Pseudomonas aeruginosa 2. Trial and failure of generic Tobi (tobramycin) inhalation nebulization solution Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓	✓	✓	**NC**
tobramycin (Bethkis)	Coverage requires the following: 1. Member has cystic fibrosis and is infected with Pseudomonas aeruginosa 2. Trial of generic Tobi (tobramycin) inhalation nebulization solution Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓	✓	✓	**NC**
tolvaptan (Samsca)	Coverage requires the following: 1. Age ≥ 18 years old 2. Diagnosis of clinically significant hyponatremia 3. Hyponatremia is defined as serum sodium <125 mEq/L or less marked hyponatremia that is symptomatic and has resisted correction with fluid restriction 4. Therapy is initiated/re-initiated in a hospital Samsca will be approved for a maximum of 1 month	✓	✓	✓	✓	✓	✓	✓	✓

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
topiramate ER (Qudexy XR)	Coverage requires the following: 1. Treatment of seizure disorder/epilepsy 2. Treatment failure or intolerance to at least 3 generic alternatives, one of which must be generic topiramate (Topamax) OR 1. For preventative treatment of migraine headaches 2. Age ≥ 12 years old 3. Treatment failure or intolerance to 3 generic alternatives for the prevention of migraines, one of which must be generic topiramate (Topamax) OR 1. Diagnosis of Lennox-Gastaut Syndrome 2. Treatment failure or intolerance to at least 2 generic alternatives, one of which must be generic topiramate (Topamax) Initial approval: 1 year Renewal requires that current criteria are met and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓	✓	✓	**NC**
Tracleer (suspension)	Coverage requires the following: 1. Diagnosis of pulmonary arterial hypertension (WHO Group 1) 2. Trial and treatment failure of sildenafil or tadalafil AND ambrisentan or bosentan	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Tremfya	Coverage requires the following: 1. Diagnosis of Psoriasis 2. Age ≥ 18 years old 3. Trial and treatment failure of one topical steroid OR 1. Diagnosis of Psoriatic Arthritis 2. Age ≥ 18 years old Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
trientine hydrochloride (Syprine)	Coverage requires the following: 1. Diagnosis of Wilson's disease Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Trikafta	Coverage requires the following: 1. Diagnosis of cystic fibrosis 2. Age > 6 years old 3. Presence of at least one copy of the F508del mutation OR at least one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to Trikafta as confirmed by genetic test 4. Member is not using Trikafta in combination with an additional CFTR potentiator such as: Orkambi, Kalydeco, or Symdeko Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Trintellix	Coverage requires trial and failure, contraindication, or intolerance to two antidepressant agents	✓	✓	✓	✓			✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Trokendi XR	Coverage requires the following: 1. Treatment of seizure disorder/epilepsy 2. Treatment failure or intolerance to at least 3 generic alternatives, one of which must be generic topiramate (Topamax) OR 1. For preventative treatment of migraine headaches 2. Age ≥ 12 years old 3. Treatment failure or intolerance to 3 generic alternatives for the prevention of migraines, one of which must be generic topiramate (Topamax) OR 1. Diagnosis of Lennox-Gastaut Syndrome 2. Treatment failure or intolerance to at least 2 generic alternatives, one of which must be generic topiramate (Topamax) Initial approval: 1 year Renewal requires that current criteria are met and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓	✓	✓	**NC**
Truseltiq	Coverage requires the following: 1. Age ≥ 18 years old 2. Treatment of previously treated, unresectable locally advanced or metastatic cholangiocarcinoma with a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement as detected by an FDA-approved test Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Tukysa	Coverage requires the following: 1. Age ≥ 18 years old 2. Diagnosis of advanced unresectable or metastatic human epidermal growth factor receptor 2 (HER2)-positive breast cancer 3. Have received one or more prior anti-HER2-based regimens in the metastatic setting 4. Using in combination with trastuzumab and capecitabine Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓
Turalio	Coverage requires the following: 1. Treatment of adult patients with symptomatic tenosynovial giant cell tumor (TGCT) 2. Condition is associated with severe morbidity or functional limitations 3. Will not be amenable to improvement with surgery. Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Tymlos	Coverage requires the following: 1. History of fragility fracture 2. Will not be used in combination with bisphosphonates, another anabolic bone-modifying agent or denosumab OR 1. Diagnosis of osteoporosis 2. Treatment with a bisphosphonate has been ineffective after at least a 12-month treatment period based on objective documentation (such as reduction in T score or fracture) UNLESS one of the following: a. Treatment with bisphosphonates (both oral and intravenous) are not tolerated or contraindicated b. History of fracture(s) c. T-score less than -3.0 3. Will not be used in combination with bisphosphonates, another anabolic bone-modifying agent or denosumab Tymlos will be approved for a maximum of 2 years	✓	✓	✓	✓	✓	✓	✓	✓
Tyvaso	Coverage requires the following: 1. Treatment of pulmonary arterial hypertension (WHO Group 1) 2. Trial and treatment failure of sildenafil or tadalafil AND ambrisentan or bosentan OR 1. Treatment of pulmonary arterial hypertension associated with interstitial lung disease (PH-ILD; WHO Group 3) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Ubrelvy	Coverage requires the following: 1. For acute treatment of migraine 2. Age ≥ 18 years old 3. Treatment failure or contraindication with 2 generic triptan medications Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Uceris foam	Coverage requires the following: 1. Trial of a preferred corticosteroid enema or foam 2. Trial of generic rectal mesalamine Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓			✓	**NC**
Udenyca	Coverage requires trial and failure or intolerance to Neulasta and Ziextenzo	✓	✓	✓	✓	✓	✓	✓	✓
Uptravi	Coverage requires the following: 1. Diagnosis of pulmonary arterial hypertension (WHO Group 1) 2. Trial and treatment failure of sildenafil or tadalafil AND ambrisentan or bosentan	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Valchlor	Coverage requires the following: 1. Diagnosis of Stage 1A or 1B mycosis fungoides type cutaneous T cell lymphoma 2. Trial and failure of two skin directed therapies (examples include phototherapy, total skin electron beam therapy, topical retinoids, corticosteroids, carmustine) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
vardenafil (Levitra)	May be covered for the diagnosis of erectile dysfunction dependent on the plans benefit with quantity limit restrictions	✓	✓	**NC**	✓	✓		✓	**NC**
varenicline (Chantix)	Requires trial and failure of 2 preferred agents such as generic bupropion extended release (Zyban), nicotine patch, nicotine gum, nicotine lozenge for $0 copayment	✓	✓	✓	✓	✓		✓	✓
Varubi	Coverage is provided for the prevention of chemotherapy-induced nausea/vomiting (CINV) and after a trial of all of the following: 1. Generic 5HT3 antagonist (ex. generic Zofran, generic Kytril) 2. Preferred NK1 antagonist (ex. Emend) 3. Glucocorticoid (dexamethasone) Initial approval: 1 year Renewal requires continuation of chemotherapy	✓	✓	✓	✓			✓	✓

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Vecamyl	Coverage requires a trial with all of the following drug classes: 1. Diuretic 2. Beta-Blocker 3. Ace-inhibitor 4. Angiotensin II receptor blocker 5. Calcium channel blocker	✓	✓	**NC**	✓	✓	✓	✓	**NC**
Venclexta	Coverage requires the treatment of FDA approved indications Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓
Ventavis	Coverage requires the following: 1. Diagnosis of pulmonary arterial hypertension (WHO Group 1) 2. Trial and treatment failure of sildenafil or tadalafil AND ambrisentan or bosentan	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Verkazia	Coverage requires the following: 1. Diagnosis of vernal keratoconjunctivitis 2. Age ≥ 4 years old 3. Trial and failure, or intolerance to a dual acting, topical antihistamine/mast-cell stabilizer such as epinastine, ketotifen and olopatadine 4. Trial and failure or intolerance to ophthalmic corticosteroids such as dexamethasone eye drops, Generic FML liquifilm, FML, FML forte, loteprednol and generic Pred Forte 5. Trial and failure or intolerance to generic Restasis OR 1. Diagnosis of vernal keratoconjunctivitis with compromised corneal epithelium/ corneal ulcers 2. Age ≥ 4 years old 3. Trial and failure or intolerance to generic Restasis Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**			✓	✓	**NC**

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Verzenio	Coverage requires the following: 1. Diagnosis of HR-positive, HER-2 negative advanced or metastatic breast cancer and ONE of the following: a. Using in combination with an aromatase inhibitor as initial therapy in postmenopausal women and men OR b. Using in combination with fulvestrant following endocrine therapy OR c. If metastatic, using as monotherapy following endocrine therapy AND prior chemotherapy 2. Intolerance or contraindication to Ibrance OR 1. Diagnosis of early HR-positive, HER-2 negative, node-positive breast cancer at high risk of recurrence 2. Ki-67 score ≥ 20% 3. Using in combination with adjuvant endocrine therapy Initial approval: 1 year Continuation of coverage requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Verquvo	Coverage requires the following: 1. Age ≥ 18 years old 2. Diagnosis of chronic heart failure New York Heart Association (NYHA) Class II-IV 3. Left ventricular ejection fraction (LVEF) of less than 45% 4. History of ONE of the following: i. Previous hospitalization for heart failure within prior 6 months OR ii. Outpatient intravenous (IV) diuretic treatment for heart failure within prior 3 months 5. Taken in combination with the following unless contraindicated or not tolerated: i. Metoprolol succinate, carvedilol, or bisoprolol AND ii. An ACE-inhibitor (ACE, such as lisinopril), angiotensin receptor blocker (ARB, such as losartan), or angiotensin receptor-neprilysin inhibitor (ARNI, such as sacubitril/valsartan) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓
Vesicare LS	Coverage requires the following: 1. Treatment of neurogenic detrusor overactivity (NDO) 2. Age ≥ 2 years old 3. Trial and failure of two anticholinergic drugs for the treatment of NDO OR 3. Physician provides documentation that the member cannot swallow tablets/capsules and has tried and failed an anticholinergic medication available as a solution Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓		✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Viberzi	Coverage requires the following: 1. Diagnosis of irritable bowel syndrome with diarrhea (IBS-D) 2. Trial and treatment failure, contraindication, or intolerance to a tricyclic antidepressant Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓			✓	**NC**
vigabatrin powder (Sabril)	Coverage requires the following: 1. Diagnosis of infantile spasms OR 1. Treatment of seizure disorder/epilepsy as adjunctive therapy 2. Trial and failure, contraindication, OR intolerance to three generic alternatives for the treatment of seizures	✓	✓	✓	✓	✓		✓	✓
vigabatrin tablet (Sabril)	Coverage requires the following: 1. Treatment of seizure disorder/epilepsy as adjunctive therapy 2. Trial and treatment failure of three generic alternatives for seizure 3. Trial of Sabril powder OR 1. Diagnosis of infantile spasms	✓	✓	✓	✓	✓		✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Vijoice 50 mg, 125 mg tablet	Coverage requires the following: 1. Age ≥ 2 years old 2. Diagnosis of PIK3CA‑Related Overgrowth Spectrum (PROS) confirmed by detection of a PIK3CA mutation or based on clinical features suspected of PROS Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
vilazodone (Viibryd)	Coverage requires trial and failure of at least three antidepressant agents	✓	✓	✓	✓			✓	✓
Viokace	Coverage requires trial and treatment failure of Creon and Zenpep Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓			✓	**NC**
Vitrakvi	Coverage requires treatment of FDA approved indications Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓
Vizimpro	Coverage requires the following: Diagnosis of metastatic non-small cell lung cancer (NSCLC) with epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 L858R substitution mutations as detected by an FDA-approved test	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Vonjo	Coverage requires the following: 1. Diagnosis of intermediate or high-risk primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis with a platelet count < 50,000 mcl 2. Age ≥ 18 years old Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓
Vosevi	Coverage requires the following: 1. Age 18 years or older 2. For patients with chronic hepatitis C genotype 1, 2, 3, 4, 5, or 6 infection that have failed treatment regimen containing an NS5A (nonstructural protein 5A) inhibitor and have no liver damage or have liver damage and showing no symptoms from the damage 3. For patients with chronic hepatitis C genotype 1a or 3 that have previously failed sofosbuvir containing regimen without an NS5A inhibitor and have no liver damage or have liver damage and showing symptoms of the damage 4. Trial and failure to preferred medication: Epclusa or Zepatier 5. If treatment experienced, documentation of previous treatments for Hepatitis C 6. If cirrhosis is present: documentation of decompensated or compensated cirrhosis Drug will be reviewed based on a case by case basis utilizing AASLD guidelines and FDA approved package labeling with trial and failure of Epclusa or Zepatier	✓	✓	✓	✓	✓	✓	✓	✓
Votrient	Coverage is provided for the treatment of FDA approved indications	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Voxzogo	Coverage requires the following: 1. Diagnosis of achondroplasia 2. Age ≥ 5 years old 3. Presence of fibroblast growth factor receptor 3 (FGFR3) gene mutation confirming diagnosis 4. Open epiphyses 5. Recent growth velocity and height (growth velocity must be > 1.5 cm/year) Initial approval: 1 year Renewal requires the presence of open epiphyses, and an updated height and growth velocity to show that growth has been maintained or increased from baseline	✓	✓	✓	✓	✓	✓	✓	✓
Vraylar	Coverage requires the following: Trial and failure, contraindication, or intolerance to two preferred or generic second generation antipsychotics (examples include: aripiprazole, clozapine, risperidone, quetiapine, olanzapine, ziprasidone) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓
Vyleesi	Coverage requires the following: 1. Premenopausal female ≥ 18 years old 2. Diagnosis of acquired, generalized hypoactive sexual desire disorder (HSDD) that has been ongoing for more than 6 months 3. Other causes (such as relationship difficulty, substance abuse, medication side effects) of HSDD must be ruled out Initial approval: 8 weeks Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓	✓	✓	**NC**

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Vyndamax	Coverage requires the following: 1. Treatment of the cardiomyopathy of wild type or hereditary transthyretin-mediated amyloidosis (ATTR-CM) and confirmed by technetium labeled bone scintigraphy 2. Age ≥ 18 years old 3. Prescribed by or in consultation with a cardiologist 4. Documentation of clinical signs and symptoms of ATTR-CM Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Vyndaqel	Coverage requires the following: 1. Treatment of the cardiomyopathy of wild type or hereditary transthyretin-mediated amyloidosis (ATTR-CM) and confirmed by technetium labeled bone scintigraphy 2. Age ≥ 18 years old 3. Prescribed by or in consultation with a cardiologist 4. Documentation of clinical signs and symptoms of ATTR-CM Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Vyzulta	Coverage requires the following: 1. Diagnosis of elevated intraocular pressure 2. Trial of all preferred medications (generic Xalatan, generic Lumigan, generic Travatan Z) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓			✓	**NC**
Wakix	Coverage requires a diagnosis of narcolepsy AND: 1. Age ≥ 18 years old 2. Cataplexy OR 2. Excessive daytime sleepiness 3. Trial and failure, contraindication, or intolerance to at least one generic or preferred treatment such as methylphenidate or dextroamphetamine, AND modafinil or armodafinil, AND Sunosi Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Wegovy	Coverage requires the following: 1. Age ≥ 18 years old 2. BMI ≥ 30, or ≥ 27 with one weight related comorbid condition 3. Current weight (within 30 days) must be submitted to the plan for review 4. Concurrent lifestyle modification program 5. Not to be used in combination with other weight loss products Initial approval: 1 year Continued coverage will be reviewed annually and may be provided if the member has maintained at least a 5% weight loss from baseline	✓	✓	**NC**	✓	✓	✓	✓	**NC**
Welireg	Coverage requires the following: 1. Age ≥ 18 years old 2. Treatment of von Hippel‑Lindau (VHL) disease requiring therapy for associated renal cell carcinoma (RCC), central nervous system (CNS) hemangioblastomas, or pancreatic neuroendocrine tumors (pNET), not requiring immediate surgery Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Winlevi	Coverage requires the following: 1. Treatment of acne 2. Age ≥ 12 years old 3. Trial and failure contraindication, or intolerance to one oral agent (examples include: generic Monodox, generic Vibramycin, generic Minocin, generic Bactrim, or generic Aldactone) 4. Trial and failure contraindication, or intolerance to three topical agents (examples include: generic Benzaclin, generic Benzamycin, generic Retin-A, or generic Differin cream/gel) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓			✓	**NC**
Xalkori	Coverage requires the following: 1. Diagnosis of metastatic non-small cell lung cancer (NSCLC) whose tumors are anaplastic lymphoma kinase (ALK) or ROS1-positive as detected by an FDA-approved test OR 1. Diagnosis of relapsed or refractory, systemic anaplastic large cell lymphoma (ALCL) that is ALK-positive in pediatric patients 1 year of age and older and young adults Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Xcopri	Coverage requires the following: 1. Treatment of seizures in patients with epilepsy 2. Treatment failure or intolerance to at least 3 generic alternatives for the treatment of seizures	✓	✓	✓	✓			✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Xeljanz tablet	Coverage requires the following: 1. Diagnosis of Rheumatoid Arthritis 2. Age ≥ 18 years old 3. Trial and failure of one Disease-Modifying Anti-Rheumatic Drug (DMARD) after a minimum 3-month trial (examples include methotrexate, hydroxychloroquine, leflunomide, sulfasalazine) 4. Trial and treatment failure of one or more tumor necrosis factor (TNF) inhibitor(s) OR 1. Diagnosis of Psoriatic Arthritis 2. Age ≥ 18 years old 3. Trial and treatment failure of one or more tumor necrosis factor (TNF) inhibitor(s) OR 1. Diagnosis of Ulcerative Colitis 2. Age ≥ 18 years old 3. Treatment with an adequate course of conventional therapy (such as steroids for at least 7 days (examples include prednisone, methylprednisolone, or budesonide) or immunomodulators for at least 2 months (examples include azathioprine or cyclosporine)) 4. Trial and treatment failure of one or more tumor necrosis factor (TNF) inhibitor(s) OR 1. Diagnosis of Polyarticular Juvenile Idiopathic Arthritis (JIA) 2. Age ≥ 2 years old 3. Trial and treatment failure of one Disease-Modifying Anti-Rheumatic Drug (DMARD) after a minimum 3-month trial (examples include methotrexate, leflunomide) 4. Trial and treatment failure of one or more tumor necrosis factor (TNF) inhibitor(s) **(criteria continued next page)**	✓	✓	✓	✓	✓	✓	✓	✓

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Xeljanz tablet (continued)	OR 1.Diagnosis of ankylosing spondylitis 2. Age ≥ 18 years old 3. Trial and treatment failure of one or more tumor necrosis factor (TNF) inhibitor(s) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Xeljanz solution	Coverage requires the following: 1. Diagnosis of Polyarticular Juvenile Idiopathic Arthritis (JIA) 2. Age ≥ 2 years old 3. Trial and treatment failure to one Disease-Modifying Anti-Rheumatic Drug (DMARD) after a minimum 3-month trial (examples include methotrexate, leflunomide) 4. Trial and treatment failure of one or more tumor necrosis factor (TNF) inhibitor(s) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Xeljanz XR	Coverage requires the following: 1. Diagnosis of Rheumatoid Arthritis 2. Age ≥ 18 years old 3. Trial and failure of one Disease-Modifying Anti-Rheumatic Drug (DMARD) after a minimum 3-month trial (examples include methotrexate, hydroxychloroquine, leflunomide, sulfasalazine) 4. Trial and treatment failure of one or more tumor necrosis factor (TNF) inhibitor(s) OR 1. Diagnosis of Psoriatic Arthritis 2. Age ≥ 18 years old 3. Trial and treatment failure of one or more tumor necrosis factor (TNF) inhibitor(s) OR 1. Diagnosis of Ulcerative Colitis 2. Age ≥ 18 years old 3. Treatment with an adequate course of conventional therapy (such as steroids for at least 7 days (examples include prednisone, methylprednisolone, or budesonide) or immunomodulators for at least 2 months (examples include azathioprine or cyclosporine)) 4. Trial and treatment failure of one or more tumor necrosis factor (TNF) inhibitor(s) OR 1. Diagnosis of ankylosing spondylitis 2. Age ≥ 18 years old 3. Trial and treatment failure of one or more tumor necrosis factor (TNF) inhibitor(s) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Xelpros	Coverage requires the following: 1. Treatment of elevated intraocular pressure 2. Trial and treatment failure of two preferred medications such as generic Xalatan, Lumigan or Travatan Z Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		✓	**NC**
Xembify	Requires appropriate diagnosis for coverage, subcutaneous administration and other criteria may apply depending on diagnosis. Dosing must be based on ideal body weight (IBW) unless the patient's BMI is greater than 30. If the patient's BMI is greater than 30 or if actual body weight is 20-30% greater than IBW, adjusted body weight must be used. Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Xenical	Coverage requires the following: 1. 18 years and older 2. BMI ≥ 30 kg/m2 or ≥ 27 kg/m2 with one related comorbid condition 3. Current weight (within 30 days) must be submitted to the plan for review 4. Concurrent lifestyle modification program 5. Not to be used in combination with other weight loss products Initial approval: 1 year Continued coverage will be reviewed annually and may be provided if the member has maintained at least a 5% weight loss from baseline	✓	✓	**NC**	✓			✓	**NC**

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Xepi	Coverage requires the following: 1. Diagnosis of impetigo 2. Trial of generic Bactroban	✓	✓	**NC**	✓	✓		✓	**NC**
Xermelo	Coverage requires the following: 1. Diagnosis of carcinoid syndrome diarrhea 2. Age ≥ 18 years' old 3. Trial and treatment failure of somatostatin analog (SSA) (octreotide, lanreotide) 4. Using in combination with SSA	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Xifaxan 550mg	Coverage requires the following: 1. Diagnosis of irritable bowel syndrome with diarrhea (IBS-D) 2. Trial and treatment failure, contraindication, or intolerance to a tricyclic antidepressant OR 1. Diagnosis of small intestinal bacterial overgrowth (SIBO) as detected by an appropriate breath test 2. Trial and failure of TWO generic antibiotics Initial approval for IBS-D and SIBO: 1 month IBS-D and SIBO renewal: requires the presence of recurrent symptoms after the completion of the prior course of treatment (maximum of 2 renewals will be provided in accordance with FDA label for IBS-D) OR 1. Diagnosis of hepatic encephalopathy (HE) 2. Trial and failure of lactulose Initial approval for HE: 1 year HE renewal: requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓			✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Xolair	Coverage requires the following: 1. Diagnosis of uncontrolled moderate to severe allergic asthma 2. Age ≥ 6 years old 3. Positive skin test or in-vitro reactivity to a perennial aeroallergen 4. Failure to maintain adequate control after at least a 3 month trial of daily oral corticosteroids or high dose inhaled corticosteroids in combination with: a. LABA (long acting inhaled β2 agonist) OR b. Leukotriene modifier OR c. LAMA (long acting muscarininc antagonist) in adults and children ≥ 12 years old 5. IgE level > 30 but < 700 IU/ml for patients 12 years of age and older OR IgE level > 30 but < 1300 IU/ml for patients between the ages of 6 to < 12 years old 6. Cannot be used in combination with other biologic agents indicated for asthma 7. For self-administration of Xolair prefilled syringe: the patient has received the first 3 doses under the guidance of a health care provider OR 1. Diagnosis of chronic idiopathic urticaria 2. Documentation of diagnosis per the American Academy of Allergy Asthma and Immunology (AAAI) guidelines: a. Must have occurrence of almost daily hives and itching for at least 6 weeks 3. Age ≥ 12 years old **(criteria continued next page)**	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Xolair (continued)	4. Past trial and failure all of the following for at least 2 months: a. Trial and failure of a second-generation antihistamine at the maximal tolerated dose for at least 2 months b. Trial and failure one of the following at maximal dosing: i. Another second-generation antihistamine ii. H2 antagonist iii. Leukotriene receptor antagonist iv. First generation antihistamine given at bedtime v. Hydroxyzine vi. Doxepin 5. Other diagnoses have been ruled out 6. Cannot be used in combination with other biologic agents indicated for chronic idiopathic urticaria 7. For self-administration of Xolair prefilled syringe: the patient has received the first 3 doses under the guidance of a health care provider OR 1. Diagnosis of nasal polyps 2. Age ≥ 18 years old 3. Patient is currently receiving and will continue to receive standard of care regimen 4. Inadequate response to treatment with intranasal corticosteroids 5. Baseline serum total IgE level of 30 IU/mL to 1,500 IU/mL prior to initiating treatment with Xolair 6. Cannot be used in combination with other biologic agents indicated for nasal polyps 7. For self-administration of Xolair prefilled syringe: the patient has received the first 3 doses under the guidance of a health care provider Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Xolegel	Coverage requires the following: 1. Treatment of seborrheic dermatitis 2. Treatment failure or intolerance to three generic preferred topical agents, one of which must be ketoconazole	✓	✓	**NC**	✓			✓	**NC**
Xospata	Coverage requires the following: Treatment of relapsed or refractory acute myeloid leukemia (AML) in adult patients with an FMS-like tyrosine kinase 3 (FLT3) mutation as detected by an approved test	✓	✓	✓	✓	✓	✓	✓	✓
Xpovio	Coverage requires the following 1. Treatment of relapsed or refractory multiple myeloma 2. Used in combination with dexamethasone 3. Received ≥4 prior therapies and whose disease is refractory to ≥2 proteasome inhibitors, ≥2 immunomodulatory agents, and an anti-CD38 monoclonal antibody; OR 1. Treatment of relapsed or refactory diffuse large B-cell lymphoma 2. Recieved at least 2 prior systemic therapies OR 1. Treatment of multiple myeloma 2. Used in combination with Velcade (bortezomib) and dexamethasone 3. Received at least one prior therapy Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Xtampza ER	Coverage requires the following: 1. Diagnosis of moderate to severe chronic pain requiring around the clock opioid analgesia for an extended period of time Initial appoval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit Note: Coverage will not be provided if the patient is on more than one long acting opioid concurrently	✓	✓	✓	✓	✓		✓	✓
Xtandi	Coverage requires the following: 1. Treatment of castration-resistant prostate cancer OR 1. Treatment of metastatic castration-sensitive prostate cancer	✓	✓	✓	✓	✓	✓	✓	✓
Xuriden	Coverage requires the following: 1. Diagnosis of Hereditary Orotic Aciduria 2. Prescribed by or in consultation with an endocrinologist or geneticist Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Xyosted	Coverage requires the following: 1. Diagnosis of male hypogonadism 2. Two signs and symptoms specific to testosterone deficiency Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓	✓	✓	**NC**
Xyrem	Coverage requires a diagnosis of narcolepsy AND: 1. Age ≥ 7 years of age 2. Cataplexy 3. For adults only - Trial and failure, contraindication, or intolerance to Wakix OR 2. Excessive daytime sleepiness, AND 3. Trial and failure, contraindication, or intolerance to at least one generic or preferred treatment such as methylphenidate or dextroamphetamine 4. For adults only - Trial and failure, contraindication, or intolerance to modafinil or armodafinil, AND Sunosi, AND Wakix Xyrem will not be approved if patient is being treated with sedative hypnotic agents, other CNS depressants or using alcohol Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Xywav	Coverage requires the following: 1. Age ≥ 7 years old 2. Diagnosis of narcolepsy and cataplexy 3. For adults only - Trial and failure, contraindication, or intolerance to Wakix OR 1. Diagnosis of narcolepsy and excessive daytime sleepiness 2. Trial and failure, contraindication, or intolerance to at least one generic or preferred treatment such as methylphenidate or dextroamphetamine 3. For adults only - Trial and failure, contraindication, or intolerance to modafinil or armodafinil, AND Sunosi, AND Wakix OR 1. Age ≥ 18 years old 2. Diagnosis of idiopathic hypersomnia 3. Trial and failure, contraindication, or intolerance to at least one generic or preferred treatment such as methylphenidate or dextroamphetamine 4. For adults only - Trial and failure, contraindication, or intolerance to modafinil or armodafinil Xywav will not be approved if patient is being treated with sedative hypnotic agents, other central nervous system (CNS) depressants or using alcohol Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓	✓	✓	**NC**

✓ = Prior Approval/Step Therapy may apply
NC = Not Covered. You may be responsible for the full cost of the medication.
* For drugs covered under the commercial Blue Cross or BCN medical benefit, please see the **Blue Cross and BCN Utilization Management Medical Drug List**.

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Zejula	Coverage requires the treatment of FDA approved indications Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓
Zelboraf	Coverage requires the following: 1. Diagnosis of unresectable or metastatic melanoma with BRAF V600E mutation OR 2. Diagnosis of Erdheim-Chester Disease with BRAF V600 mutation Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓
Zelnorm	Coverage requires the following: 1. Treatment of adult women with irritable bowel syndrome with constipation 2. Age < 65 years old 3. Trial and treatment failure or intolerance to lactulose or polyethylene glycol 4. Trial and treatment failure or intolerance to Linzess Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓		✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Zembrace SymTouch	Coverage requires the following: Trial and failure of generic Imitrex (sumatriptan) injection and one other generic triptan (examples include: generic Maxalt (rizatriptan), generic Amerge (naratriptan), generic Zomig/ZMT(zolmitriptan)) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		✓	**NC**
Zepatier	Coverage requires the following: 1. Age ≥ 12 years old or weight ≥ 30 kilograms 2. Diagnosis of Chronic Hepatitis C genotype 1 or 4 3. For genotype 1a patients, test results for NS5a resistance-associated polymorphisms 4. If treatment experienced, documentation of previous treatment experience for Hepatitis C 5. If cirrhosis is present: documentation of decompensated or compensated cirrhosis Drug will be reviewed based on a case by case basis utilizing AASLD guidelines and FDA approved package labeling	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Zeposia	Coverage requires the following: 1. Diagnosis of ulcerative colitis 2. Age ≥ 18 years old 3. Treatment with an adequate course of conventional therapy (such as steroids for at least 7 days (examples include prednisone, methylprednisolone, or budesonide) or immunomodulators for at least 2 months (examples include azathioprine, or cyclosporine)) 4. Trial and treatment failure of two of the following: Humira, Stelara, Xeljanz/XR, or Rinvoq OR 1. Diagnosis of multiple sclerosis 2. Age ≥ 18 years old Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓	✓	✓	**NC**
Zercapli	Coverage requires that the member has been stable on generic sertraline tablets at a dose of 150 mg or 200 mg daily for at least 3 months Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓			✓	**NC**

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Zetonna	Coverage requires trial and failure or intolerance of 2 of the following intranasal steroids: 1. Generic fluticasone (Flonase) 2. Generic flunisolide (Nasalide) 3. Nasacort (over-the-counter) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		**NC**	**NC**
Zokinvy	Coverage requires the following: 1. Age ≥ 1 year old 2. Body surface area (BSA) ≥ 0.39 m^2 3. The requested dose is appropriate for the patient's current body surface area (BSA) 4. Diagnosis of Hutchinson-Gilford Progeria Syndrome (HGPS) confirmed by a mutation in the LMNA gene OR 4. Diagnosis of processing-deficient Progeroid Laminopathies with one of the following: i. Heterozygous LMNA gene mutation with progerin-like protein accumulation OR i. Homozygous or compound heterozygous ZMPSTE24 gene mutations Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Zolinza	Coverage is provided for the treatment of the FDA approved indications	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
zolpidem tartrate sublingual (Intermezzo)	Coverage requires treatment failure of 3 of the following: immediate-release zolpidem (Ambien), eszopiclone (Lunesta), zaleplon (Sonata), trazodone (Desyrel), or doxepin (Silenor) Coverage will not be approved for combination therapy with other sedative hypnotics Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	**NC**	✓	✓		✓	**NC**
Zomig nasal spray	Coverage requires the following: 1. Trial and treatment failure or intolerance to two generic triptans (generic Imitrex, generic Maxalt, generic Amerge or generic Zomig/ZMT tablets) OR 1. Age 12-17 years old 2. Trial and treatment failure or intolerance to generic Maxalt (rizatriptan) Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓				✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Zorvolex	Coverage requires the following: 1. Age ≥ 18 years old 2. Requires a diagnosis of acute pain or osteoarthritis 3. Trial of or intolerance to generic oral diclofenac and at least two other oral, traditional nonsteroidal anti-inflammatory drugs (NSAIDs) Initial approval for osteoarthritis: 1 year Initial approval for acute pain: 3 months	✓	✓	**NC**	✓	✓		✓	**NC**
Ztalmy	Coverage requires the following: 1. Diagnosis of seizures associated with cyclin‐dependent kinase‐like 5 (CDKL5) deficiency disorder 2. CDKL5 deficiency disorder confirmed by genetic testing showing mutations on the CDKL5 gene 3. Age ≥ 2 years old Initial approval: 1 year Renewal requires that current criteria are met, and that the medication is providing clinical benefit	✓	✓	✓	✓	✓	✓	✓	✓
Zydelig	Coverage requires the following: 1. Relapsed chronic lymphocytic leukemia (CLL), in combination with rituximab Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓

Drug name	Blue Cross and BCN coverage criteria	Prior Authorization and Step Therapy programs							
		Blue Cross						BCN	
		Custom Drug List	Clinical Drug List	Custom Select Drug List	Lite PA	Preferred Therapy	Off-Label/ High-Cost Specialty	Custom Drug List	Custom Select Drug List
Zykadia	Coverage requires the following: Diagnosis of anaplastic lymphoma kinase (ALK) positive, metastatic non-small cell lung cancer as detected by an FDA-approved test Initial approval: 1 year Continuation of treatment requires a lack of disease progression	✓	✓	✓	✓	✓	✓	✓	✓

We speak your language

If you, or someone you're helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Customer Service number on the back of your card.

Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de Servicio al cliente, que aparece en la parte trasera de su tarjeta.

إذا كنت أنت أو شخص آخر تساعده بحاجة لمساعدة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك دون أية تكلفة. للتحدث إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك.

如果您，或是您正在協助的對象，需要協助，您有權利免費以您的母語得到幫助和訊息。要洽詢一位翻譯員，請撥在您的卡背面的客戶服務電話。

ئەگەر ئێوە، یان کەسێک کە ئێوە یارمەتی دەدەن، پێویستی بە یارمەتی هەیە، مافی ئەوەتان هەیە بە زمانی خۆتان یارمەتی و زانیاری وەربگرن بەبێ هیچ تێچوونێک. بۆ قسەکردن لەگەڵ وەرگێڕ، پەیوەندی بە ژمارەی خزمەتگوزاری کڕیاران بکە کە لە پشتەوەی کارتەکەتدایە.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, cần trợ giúp, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số Dịch vụ Khách hàng ở mặt sau thẻ của quý vị.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e Shërbimit të Klientit në anën e pasme të kartës tuaj.

만약 귀하 또는 귀하가 돕고 있는 사람이 지원이 필요하다면, 귀하는 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 통역사와 대화하려면 귀하의 카드 뒷면에 있는 고객 서비스 번호로 전화하십시오.

যদি আপনার, বা আপনি সাহায্য করছেন এমন কারো, সাহায্য প্রয়োজন হয়, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য ও তথ্য পাওয়ার অধিকার আপনার রয়েছে। কোনো একজন দোভাষীর সাথে কথা বলতে, আপনার কার্ডের পেছনে দেওয়া গ্রাহক সহায়তা নম্বরে কল করুন।

Jeśli Ty lub osoba, której pomagasz, potrzebujecie pomocy, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer działu obsługi klienta, wskazanym na odwrocie Twojej karty.

Falls Sie oder jemand, dem Sie helfen, Unterstützung benötigt, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer des Kundendienstes auf der Rückseite Ihrer Karte an.

Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, rivolgiti al Servizio Assistenza al numero indicato sul retro della tua scheda.

ご本人様、またはお客様の身の回りの方で支援を必要とされる方でご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合はお持ちのカードの裏面に記載されたカスタマーサービスの電話番号までお電話ください。

Если вам или лицу, которому вы помогаете, нужна помощь, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону отдела обслуживания клиентов, указанному на обратной стороне вашей карты.

Ukoliko Vama ili nekome kome Vi pomažete treba pomoć, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, pozovite broj korisničke službe sa zadnje strane kartice.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa numero ng Customer Service sa likod ng iyong tarheta.

Important disclosure

Blue Cross Blue Shield of Michigan and Blue Care Network comply with Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross Blue Shield of Michigan and Blue Care Network provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information in other formats. If you need these services, call the Customer Service number on the back of your card. If you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or email with: Office of Civil Rights Coordinator, 600 E. Lafayette Blvd., MC 1302, Detroit, MI 48226, phone: 888-605-6461, TTY: 711, fax: 866-559-0578, email: CivilRights@bcbsm.com. If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health & Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail, phone, or email at: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, phone: 800-368-1019, TTD: 800-537-7697, email: OCRComplaint@hhs.gov. Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.