2017 Prior Authorization Criteria
Effective: 05/01/2017
Updated 05/2017

ACTHAR GEL

Products Affected

- H.p. Acthar

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Covered for ONE of the following indications: (1) West syndrome, (2) Acute exacerbations of multiple sclerosis (MS) for patients receiving concurrent immunomodulator therapy (e.g., interferon beta 1a, glatiramer acetate, dimethyl fumarate, fingolimod, teriflunomide), (3) Rheumatic disorders, (4) Collagen diseases, (5) Dermatologic diseases, (6) Allergic states, (7) Ophthalmic diseases, (8) Respiratory diseases, (9) Transfusion reaction due to serum protein reaction, (10) Proteinuria in nephrotic syndrome and inadequate response or contraindication to two therapies from any of the following different classes: corticosteroids (e.g., cortisone or dexamethasone), calcineurin inhibitors (e.g., cyclosporine or tacrolimus, per DRUGDEX), (11) Diagnosis for adrenal insufficiency with trial/failure or contraindication to cosyntropin, (12) Gout and intolerance or contraindication to at least two first-line gout therapies (e.g., allopurinol, probenecid, colchicine), (13) Pediatric acquired epileptic aphasia. IN ADDITION: For covered indications (2) through (9), limited/unsatisfactory response or intolerance (i.e. severe anaphylaxis) to two corticosteroids (i.e. IV methylprednisolone, IV dexamethasone, or high dose oral steroids) must be documented.
Age Restrictions	N/A
Prescriber Restrictions	Neurologist for infantile spasm
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

ACTIMMUNE

Products Affected

- Actimmune

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

ADAGEN

Products Affected

- Adagen

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Contraindicated when used as preparatory or support therapy for bone marrow transplantation, severe thrombocytopenia.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

ADEMPAS

Products Affected

- Adempas

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrent use with organic nitrates (i.e. isosorbide mononitrate, isosorbide dinitrate, nitroglycerin) or PDE inhibitors (i.e. sildenafil, Adcirca, dipyridamole, theophylline). Pregnancy.
Required Medical Information	For Persistent/recurrent Chronic Thromboembolic Pulmonary Hypertension (CTEPH) (WHO Group 4) after surgical treatment or inoperable CTEPH AND patient has a mean pulmonary artery pressure greater than 25 mm Hg at rest or greater than 30 mm Hg with exertion, documented by right-heart catheterization or echocardiography AND Patient has a documented thromboembolic occlusion of the pulmonary vasculature. For Pulmonary Arterial Hypertension (PAH) (WHO Group 1) and WHO functional class II to IV symptoms AND patient has mean pulmonary artery pressure greater than 25 mm Hg at rest or greater than 30 mm Hg with exertion, documented by right-heart catheterization or echocardiography.
Age Restrictions	N/A
Prescriber Restrictions	Pulmonologist or cardiologist
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

AFINITOR

Products Affected

- Afinitor
- Afinitor Disperz

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

ALDURAZYME

Products Affected

- Aldurazyme

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Mucopolysaccharidosis, Type I (Hurler and Hurler-Scheie forms) and Scheie form with moderate to severe symptoms.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	Not covered for mildly affected patients with the Scheie form.

ALECENSA

Products Affected

- Alecensa

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

ALIMTA

Products Affected

- Alimta

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

ALPHA1-PROTEINASE INHIBITORS

Products Affected

- Prolastin-c
- Zemaira

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Not covered for patients with the PiMZ or PiMS phenotypes of alpha 1 - antitrypsin deficiency as they appear to be at small risk for panacinar emphysema.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	Zemaira: inadequate response or inability to tolerate Prolastin-C

AMPYRA

Products Affected

- Ampyra

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patients with history of seizures. Patients with moderate to severe renal impairment (physicians should be notified of potential risk for increased seizures in patients with mild renal impairment: CrCl between 51 and 80ml/min).
Required Medical Information	Renal function labs. Results of two Timed 25 Foot-Walk Test. Patient is ambulatory and able to complete a Timed 25-Foot Walk Test.
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Initial: 6 months. Re-authorization every 6 months w/ evidence of improvement.
Other Criteria	Evidence of improvement is defined as in walking speed while on Ampyra as compared to baseline.

ANDROGEL

Products Affected

- Androgel
- Androgel Pump
- Testosterone TRANSDERMAL GEL 1%, 25MG/2.5GM

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Testosterone levels within normal range (range for the lab doing the testing). Female patients. Men with carcinoma of the breast or suspected carcinoma of the prostate. Use for muscle building purposes.
Required Medical Information	For members initiating testosterone replacement therapy: Testosterone levels (total or free). Require either ONE low total testosterone level OR ONE low free testosterone level. (normal ranges as provided by office or clinic performing labs). Note: Members that are already stabilized on therapy will not be required to provide labs and can be approved as continuation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

ANTIDEPRESSANTS

Products Affected

- Brintellix
- Desvenlafaxine Er
- Emsam
- Fetzima
- Fetzima Titration Pack
- Pristiq TB24 25MG
- Trintellix

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only. Documentation of an adequate therapeutic trial (maximum tolerated dose for 6-12 weeks) or inability to tolerate or contraindication to any two of the following: bupropion, bupropion ER, bupropion SR, bupropion XL, citalopram, desipramine, escitalopram, fluoxetine, fluvoxamine, mirtazapine, mirtazapine ODT, nefazodone, paroxetine, sertraline, trazodone, venlafaxine or venlafaxine ER.

ANTIHISTAMINES-AGE EDIT

Products Affected

- Clemastine Fumarate TABS 2.68MG
- Cyproheptadine Hcl TABS
- Diphenhydramine Hcl INJ 50MG/ML
- Phenadoz
- Phenergan RECTAL SUPP
- Promethazine Hcl ORAL TABS
- Promethazine Hcl RECTAL SUPP
- Promethegan

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

ANTIPARKINSON AGENTS-AGE EDIT

Products Affected

- Benztropine Mesylate INJ
- Benztropine Mesylate ORAL TABS
- Trihexyphenidyl Hcl

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	Inadequate response or inability to tolerate one of the following: amantadine, pramipexole, or ropinirole.

ANTISPASMOTICS-AGE EDIT

Products Affected

- Chlordiazepoxide Hcl/clidinium Bromide
- Dicyclomine Hcl CAPS
- Dicyclomine Hcl SOLN
- Dicyclomine Hcl TABS

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

APOKYN

Products Affected

- Apokyn INJ 30MG/3ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Off label use for erectile dysfunction as treatment for ED are CMS exclusions. Contraindicated when used concomitantly with 5HT3 receptor antagonists such as ondansetron or granisetron.
Required Medical Information	For Parkinson's disease: medical history that documents patient experiences motor fluctuations despite an optimized oral drug regimen which includes levodopa.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	Requests for Parkinson's disease are covered following an appropriate trial of a levodopa-containing regimen.

APTIOM

Products Affected

- Aptiom

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrent use with oxcarbazepine
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

ARANESP

Products Affected

- Aranesp Albumin Free

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Uncontrolled hypertension
Required Medical Information	For initiation of therapy: adequate iron stores have been demonstrated by means of bone marrow iron or serum ferritin levels or serum iron saturation studies within the prior 12 months (Note: for persons with iron deficiency, erythropoietin analog therapy may be initiated simultaneous with iron replacement), and the following criteria is met: hemoglobin (Hgb) is approaching or has fallen below 10 g/dl (CKD not on dialysis-adult, cancer), 11 g/dL (CKD on dialysis), 12 g/dL (pediatric CKD) or hematocrit of 30% OR patient will be starting myelosuppressive therapy and will have an anticipated hemoglobin drop associated with their therapy. For continuation of therapy: documentation of the below: for persons with anemia due to myelosuppressive anticancer chemotherapy: Hgb target of 12 g/dl For persons with chronic renal failure and end-stage renal disease (ESRD): Hgb target 10-11 g/dl. Continued use of the therapy is not covered if the hemoglobin rises less than 1 g/dl (hematocrit rise less than 3%) compared to pretreatment baseline by 12 weeks of treatment and whose hemoglobin level remains less than 10 g/dL (or the hematocrit is less than 30%).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 weeks
Other Criteria	Excluded from patients with Hgb at or above 10 g/dL (CKD not on dialysis-adult, cancer), 11 g/dL (CKD on dialysis), 12 g/dL (pediatric CKD).

ARCALYST

Products Affected

- Arcalyst

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

ARMODAFINIL

Products Affected

- Armodafinil

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of ONE of the following: (A) For excessive sleepiness or hypersomnolence associated with narcolepsy: documentation of diagnosis. (B) For excessive sleepiness associated with obstructive sleep apnea (OSA). (C) For excessive sleepiness associated with shift work disorder (SWSD): documentation of diagnosis and the patient must have a job that requires them to frequently rotate shifts or work at night, and be unable to adjust to their schedule.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

ARZERRA

Products Affected

- Arzerra

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

ATYPICAL ANTIPSYCHOTICS

Products Affected

- Fanapt
- Fanapt Titration Pack
- Fazaclo ORAL TBDP 12.5MG, 150MG, 200MG
- Latuda
- Rexulti
- Saphris
- Versacloz
- Vraylar

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only. Inadequate response or contraindication or inability to tolerate ONE of the following at the maximum tolerated therapeutic dose: clozapine, clozapine ODT, olanzapine, olanzapine ODT, quetiapine, quetiapine ER, risperidone, risperidone ODT, paliperidone, molindone or ziprasidone.

AVASTIN

Products Affected

- Avastin

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

BANZEL

Products Affected

- Banzel

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Banzel is not covered for members with the diagnosis of Familial Short QT syndrome.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

BELEODAQ

Products Affected

- Beleodaq

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of the plan contract year
Other Criteria	Applies to new starts only.

BENLYSTA

Products Affected

- Benlysta

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	A documented diagnosis of systemic lupus erythematosus (SLE) and an active, autoantibody-positive test who are receiving standard therapy comprising any of the following (alone or in combination): anti-malarials, corticosteroids, immunosuppressives (excluding intravenous cyclophosphamide), and non-steroidal anti-inflammatory drugs.

BLINCYTO

Products Affected

- Blincyto

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only. Drug is also subject to a Part B versus Part D coverage determination.

BOSULIF

Products Affected

- Bosulif

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only. For diagnosis of chronic or accelerated Philadelphia chromosome positive (Ph+) chronic myelogenous leukemia (CML): documentation of resistance or intolerance to prior therapy with nilotinib (Tasigna). For diagnosis of blast phase Philadelphia chromosome positive (Ph+) chronic myelogenous leukemia (CML): documentation of resistance or intolerance to prior therapy with Gleevec (imatinib) or Sprycel (dasatinib).

BRIVIACT

Products Affected

- Briviact

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only. Requests for adjunct therapy for partial-onset seizure disorder are covered with documentation that the patient is currently on an anticonvulsant such as: lamotrigine, phenytoin, divalproex, levetiracetam, gabapentin, carbamazepine, topiramate, zonisamide.

BUPHENYL

Products Affected

- Buphenyl TABS
- Sodium Phenylbutyrate POWD 3GM/TSP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Contraindicated for acute hyperammonemia emergency management.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	Cycle disorders, documentation of ONE of the following: (A) As adjunctive therapy in the chronic management of patients with urea cycle disorders involving deficiencies of carbamoyl phosphate synthetase (CPS), ornithine transcarbamoylase (OTC) or argininosuccinic acid synthetase (AAS). (B) In all patients with neonatal-onset deficiency (complete enzymatic deficiency, presenting within the first 28 days of life). (C) In patients with late-onset disease (partial enzymatic deficiency, presenting after the first month of life) who have a history of hyperammonemic encephalopathy.

BUTALBITAL-AGE EDIT

Products Affected

- Ascomp/codeine
- Butalbital Compound/codeine CAPS 325MG; 50MG; 40MG; 30MG
- Butalbital/acetaminophen/caffeine ORAL CAPS
- Butalbital/acetaminophen/caffeine TABS 325MG; 50MG; 40MG
- Butalbital/acetaminophen/caffeine/codeine
- Butalbital/aspirin/caffeine CAPS
- Butalbital/aspirin/caffeine/codeine
- Capacet
- Esgic CAPS
- Margesic
- Zebutal CAPS 325MG; 50MG; 40MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

CABOMETYX

Products Affected

- Cabometyx

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only. For advanced renal cell carcinoma, prior therapy with Sutent (sunitinib) and Inlyta (axitinib).

CAMPATH

Products Affected

- Campath

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

CAPRELSA

Products Affected

- Caprelsa

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Do not use in patients with congenital long QT syndrome.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or Endocrinologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

CARDIOVASCULAR-AGE EDIT

Products Affected

- Disopyramide Phosphate ORAL CAPS
- Ticlopidine Hcl

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

CEREZYME

Products Affected

- Cerezyme

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

CINRYZE

Products Affected

- Cinryze

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Member has a history of at least 2 HAE attacks per month AND has an inadequate response or inability to tolerate 17 alpha-alkylated androgens (e.g. danazol) AND diagnosis of HAE is documented based on ONE of the following: (A) Hereditary Type I (HAE-I): (1) Low levels of C1 inhibitor (less than 19 mg/dL or below the lower limit of normal as defined by the laboratory performing the test) and (2) C1, C3, and C1q are normal (as defined by the laboratory performing the test) and (3) Low C4 (less than 14mg/dL or below the lower limit of normal as defined by the laboratory performing the test) OR (B) HAE-II: (1) C1 inhibitor level may be normal or elevated but it is dysfunctional (low antigenic or functional C1 inhibitor level or mutation in the C1 inhibitor gene) and (2) C1, C3 and C1q are normal (as defined by the laboratory performing the test)
Age Restrictions	N/A
Prescriber Restrictions	Immunologist or Rheumatologist
Coverage Duration	Initial approval: 6 months. Extended approval: Annual review will be based on response to therapy
Other Criteria	N/A

COLY-MYCIN

Products Affected

- Colistimethate Sodium INJ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Administration via nebulizer
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Infectious disease
Coverage Duration	3 months
Other Criteria	Allow intravenous (IV) or intramuscular (IM) use only. CMS endorsed compendia do not support inhalation/nebulization of colistimethate.

COMETRIQ

Products Affected

- Cometriq

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

COPAXONE

Products Affected

- Copaxone INJ 20MG/ML, 40MG/ML
- Glatopa

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	The member has a diagnosis of a relapsing form of multiple sclerosis OR has experienced a first clinical episode and has MRI features consistent with multiple sclerosis.
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

CORLANOR

Products Affected

- Corlanor

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Acute decompensated heart failure. Blood pressure less than 90/50 mmHg. Sick sinus syndrome, sinoatrial block, or 3rd degree AV block, unless a functioning demand pacemaker is present. Resting heart rate less than 60 bpm prior to treatment. Severe hepatic impairment. Pacemaker dependence (heart rate maintained exclusively by the pacemaker). Concomitant use of strong cytochrome P450 3A4 (CYP3A4) inhibitors (Examples: azole antifungals (e.g., itraconazole), macrolide antibiotics (e.g., clarithromycin, telithromycin), HIV protease inhibitors (e.g., nelfinavir), and nefazodone).
Required Medical Information	Patient is clinically stable for at least 4 weeks on an optimized and stable clinical regimen which includes both of the following: (a) maximally tolerated doses of beta blockers or inability to tolerate beta blockers (i.e. bisoprolol/bisoprolol-HCTZ, carvedilol, carvedilol CR, metoprolol succinate/metoprolol succinate-HCTZ, nevibolol) (b) ACE inhibitors or ARBs (or combinations with HCTZ) or inability to tolerate ACE inhibitor or ARB
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

COTELLIC

Products Affected

- Cotellic

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

CYCLOSPORINE

Products Affected

- Cyclosporine INJ
- Cyclosporine ORAL CAPS
- Cyclosporine Modified
- Gengraf
- Sandimmune SOLN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	Drug is also subject to a Part B versus Part D coverage determination.

CYRAMZA

Products Affected

- Cyramza

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

CYSTAGON

Products Affected

- Cystagon

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

DARZALEX

Products Affected

- Darzalex

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of previous treatment history.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

DEFERASIROX

Products Affected

- Exjade

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	CrCl less than 40 mL/minute or serum creatinine more than 2 times the age-appropriate ULN, high-risk myelodysplastic syndromes, advanced malignancies, platelet counts less than 50,000/mL.
Required Medical Information	Documentation of ONE of the following diagnoses: (1) Chronic iron overload caused by blood transfusions (transfusional hemosiderosis) or (2) Chronic iron overload in nontransfusion-dependent thalassemia syndromes and all of the following: (a) liver iron concentration (LIC) of at least 5 mg of iron per gram of liver dry weight (mg Fe/g dw) and (b) serum ferritin greater than 300 mcg/L.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

DIABETES-AGE EDIT

Products Affected

- Glyburide ORAL TABS
- Glyburide Micronized
- Glyburide/metformin Hcl

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	Patient has a trial or failure or a documented contraindication to glipizide and glimepiride.

DIGOXIN-AGE EDIT

Products Affected

- Digox TABS 250MCG
- Digoxin INJ 0.25MG/ML
- Digoxin ORAL SOLN
- Digoxin TABS 250MCG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

DRONABINOL

Products Affected

- Dronabinol

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	CINV-6 months, PONV-1 month, anorexia in AIDS-plan year
Other Criteria	For the diagnosis of nausea and vomiting associated with cancer chemotherapy, the following must be met: 1. The patient is receiving cancer chemotherapy AND 2. The patient has failed one 5HT-3 receptor antagonist such as ondansetron or granisetron. There are no additional requirements for anorexia associated with weight loss in patients with AIDS. Drug is also subject to a Part B versus Part D coverage determination.

EGRIFTA

Products Affected

- Egrifta

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Egrifta is not covered for weight loss management, patients with active malignancy or patients who are pregnant, and in patients with disruption of the hypothalamic-pituitary axis due to hypophysectomy, hypopituitarism, pituitary tumor/surgery, head irradiation or head trauma.
Required Medical Information	For HIV-infected patients with lipodystrophy, documentation of active antiretroviral therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

ELITEK

Products Affected

- Elitek

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Glucose-6-phosphate dehydrogenase (G6PD) deficiency.
Required Medical Information	For the treatment of uric acid levels in patient with diagnosis of leukemia, lymphoma or solid tumor malignancies AND are receiving chemotherapy that is expected to cause tumor lysis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	5 days
Other Criteria	Applies to new starts only.

EMPLICITI

Products Affected

- Empliciti

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of previous treatment history.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or hematologist.
Coverage Duration	Through end of plan contract year.
Other Criteria	Applies to new starts only. For multiple myeloma: must be used in combination with lenalidomide and dexamethasone.

ENBREL

Products Affected

- Enbrel
- Enbrel Sureclick

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrent therapy with any other biologic disease modifying anti-rheumatic drug (DMARD), e.g. tumor necrosis factor antagonists
Required Medical Information	Documentation for evaluation of active or latent Tuberculosis (TB)
Age Restrictions	N/A
Prescriber Restrictions	Dermatologist or Rheumatologist
Coverage Duration	Through end of plan contract year.
Other Criteria	Documentation of ONE of the following: (1) For moderate to severe Rheumatoid Arthritis, Ankylosing Spondylitis, Psoriatic Arthritis or Juvenile Idiopathic Arthritis: Inadequate response or inability to tolerate ONE of the following: methotrexate, Hydroxychloroquine, Leflunomide, Azathioprine, Sulfasalazine OR (2) For moderate to severe Plaque Psoriasis: inadequate response or inability to tolerate ONE of the following drugs: Topical Calcipotriene, Topical Anthralin, Topical Steroids, Topical immunomodulators (Elidel, Protopic), Topical retinoids

ENTRESTO

Products Affected

- Entresto

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	History of angioedema related to previous ACE inhibitor or ARB therapy. Concomitant use of ACE inhibitors. Concomitant use of aliskiren (Tekturna) in patients with diabetes.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

EPCLUSA

Products Affected

- Epclusa

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Confirmation of hepatitis C genotype. Previous hepatitis C treatment history (if any). Other medications that will be used with current AASLD/IDSA protocol (if any). Presence or absence of cirrhosis
Age Restrictions	N/A
Prescriber Restrictions	Infectious disease, gastroenterologist, hepatologist
Coverage Duration	Duration will be applied consistent with current AASLD/IDSA guidance.
Other Criteria	(A) For Genotypes 1 and 4, patient must have documented failure/contraindication/intolerance to Harvoni (ledipasvir and sofosbuvir) OR Zepatier (elbasvir and grazoprevir), if appropriate based on current AASLD/IDSA guidance. For Genotype 5 and 6, patient must have documented failure/contraindication/intolerance to Harvoni (ledipasvir and sofosbuvir), if appropriate based on current AASLD/IDSA guidance, AND (B) Criteria will be applied consistent with current AASLD/IDSA guidance.

ERAXIS

Products Affected

- Eraxis

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 weeks
Other Criteria	The patient will need to have tried and failed fluconazole and oral voriconazole.

ERBITUX

Products Affected

- Erbitux

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

ERGOLOID-AGE EDIT

Products Affected

- Ergoloid Mesylates TABS

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	For treatment of Alzeihmer's/Dementia: inadequate response or inability to tolerate one of the following: galantamine, rivastigmine, or donepezil.

ERIVEDGE

Products Affected

- Erivedge

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

ERWINAZE

Products Affected

- Erwinaze

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

ESBRIET

Products Affected

- Esbriet

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Confirmation of diagnosis of Idiopathic Pulmonary Fibrosis (IPF)
Age Restrictions	N/A
Prescriber Restrictions	Pulmonologist
Coverage Duration	Through end of plan contract year
Other Criteria	For diagnosis of IPF: inadequate response or inability to tolerate nintedanib (Ofev) or documentation demonstrating that a trial may be inappropriate.

ESTROGEN-AGE EDIT

Products Affected

- Amabelz
- Estradiol ORAL TABS
- Estradiol TRANSDERMAL PTTW
- Estradiol TRANSDERMAL PTWK
- Estradiol/norethindrone Acetate
- Fyavolv
- Jevantique Lo
- Jinteli
- Lopreeza
- Menest
- Mimvey
- Mimvey Lo
- Norethindrone Acetate/ethinyl Estradiol ORAL TABS 2.5MCG; 0.5MG, 5MCG; 1MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

EXONDYS 51

Products Affected

- Exondys 51

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a pediatric or adult neurologist or an internist who is experienced in treating DMD.
Coverage Duration	Through end of plan contract year
Other Criteria	Patient has ambulatory capacity and has been stable on corticosteroid therapy at least 6 months.

FABRAZYME

Products Affected

- Fabrazyme

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

FARYDAK

Products Affected

- Farydak

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or hematologist.
Coverage Duration	Through end of plan contract year.
Other Criteria	Applies to new starts only.

FASLODEX

Products Affected

- Faslodex INJ 250MG/5ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Pregnancy
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

FENTANYL ORAL

Products Affected

- Fentanyl Citrate Oral Transmucosal

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	The drug is not indicated in the management of acute or post-operative pain. This medication must not be used in opioid non-tolerant patients. The patient must not have any of the following contraindications: Not covered for patients with pain not associated with cancer.
Required Medical Information	For the management of breakthrough cancer pain in patients with malignancies already receiving and tolerant to opioid therapy for their underlying cancer pain.
Age Restrictions	N/A
Prescriber Restrictions	Oncologists and pain specialists who are experienced in the use of Schedule II opioids to treat cancer pain.
Coverage Duration	Through end of plan contract year
Other Criteria	Diagnosis of breakthrough cancer pain in opioid-tolerant patients AND concomitant use of long acting opioid therapy, such as ONE of these-controlled-release morphine or extended-release morphine or controlled-release oxycodone or extended-release oxymorphone or fentanyl transdermal or methadone.

FERRIPROX

Products Affected

- Ferriprox

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

FIRAZYR

Products Affected

- Firazyr

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Member has a history of at least 2 HAE attacks per month AND has an inadequate response or inability to tolerate 17 alpha-alkylated androgens (e.g. danazol) AND diagnosis of HAE is documented based on ONE of the following: (A) Hereditary Type I (HAE-I): (1) Low levels of C1 inhibitor (less than 19 mg/dL or below the lower limit of normal as defined by the laboratory performing the test) and (2) C1, C3, and C1q are normal (as defined by the laboratory performing the test) and (3) Low C4 (less than 14mg/dL or below the lower limit of normal as defined by the laboratory performing the test) OR (B) HAE-II: (1) C1 inhibitor level may be normal or elevated but it is dysfunctional (low antigenic or functional C1 inhibitor level or mutation in the C1 inhibitor gene) and (2) C1, C3 and C1q are normal (as defined by the laboratory performing the test)
Age Restrictions	N/A
Prescriber Restrictions	Immunologist or Rheumatologist
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

FIRMAGON

Products Affected

- Firmagon

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Not covered for pregnant women or women of child-bearing age.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

FORTEO

Products Affected

- Forteo INJ 600MCG/2.4ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Fracture history. Documentation of high risk for fracture for postmenopausal women, high risk defined with the presence of two of the following: low BMD scores (T-score less than or equal to -2.5 at the spine or hip or both), age greater than 70, or positive family history for osteoporosis in a 1st degree relative. Start date of therapy (max cumulative therapy duration of 2 years of therapy per lifetime).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	2 years from initiation of therapy
Other Criteria	Documentation of ONE of the following: (A) For postmenopausal women with osteoporosis at high risk for fracture and men with primary or hypogonadal osteoporosis: (1) trial and failure/contraindication to an oral bisphosphonate (e.g. alendronate). (B) For patients with glucocorticoid induced osteoporosis: (1) trial and failure/contraindication to an oral bisphosphonate (e.g. alendronate) or (2) baseline T-score ≤ -1.0

FYCOMPA

Products Affected

- Fycompa

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

GAMASTAN

Products Affected

- Gamastan S/d

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

GATTEX

Products Affected

- Gattex

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of the following: Patient has had a colonoscopy (or alternate imaging) of the entire colon with no evidence of neoplastic disease including polyps (or if polyps, they were removed within 6 months prior to starting treatment with Gattex) AND patient has had an initial laboratory assessment (bilirubin, alkaline phosphatase, lipase and amylase) within 6 months prior to starting treatment with Gattex to identify abnormal test levels.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	Patient has been dependent on parenteral nutrition/intravenous support for at least 12 months AND requires parenteral nutrition at least three times per week.

GAZYVA

Products Affected

- Gazyva

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	HBsAGg and anti-HBc. If positive, a physician with expertise in managing hepatitis B has been consulted regarding monitoring and consideration for HBV antiviral therapy.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

GILENYA

Products Affected

- Gilenya

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patients who in the last 6 months experienced myocardial infarction, unstable angina, stroke, TIA, decompensated heart failure requiring hospitalization or Class III/IV heart failure. History or presence of Mobitz Type II second-degree or third-degree atrioventricular (AV) block or sick sinus syndrome, unless patient has a functioning pacemaker. Baseline QTc interval greater than or equal to 500 ms. Treatment with Class Ia or Class III anti-arrhythmic drugs.
Required Medical Information	Diagnosis of definite or probable relapsing-remitting MS, secondary progressive MS with relapses, or progressive relapsing MS. History of a clinical demyelinating event AND MRI-detected brain lesions consistent with MS.
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

GILOTRIF

Products Affected

- Gilotrif

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

GLEEVEC

Products Affected

- Gleevec ORAL TABS
- Imatinib Mesylate

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only. For brand Gleevec: inadequate response or inability to tolerate generic imatinib.

HALAVEN

Products Affected

- Halaven

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

HARVONI

Products Affected

- Harvoni

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Confirmation of hepatitis C genotype. Previous hepatitis C treatment history (if any). Other medications that will be used with current AASLD/IDSA protocol (if any). Presence or absence of cirrhosis.
Age Restrictions	N/A
Prescriber Restrictions	Infectious disease, gastroenterologist, hepatologist
Coverage Duration	Duration will be applied consistent with current AASLD/IDSA guidance.
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance.

HERCEPTIN

Products Affected

- Herceptin

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

HETLIOZ

Products Affected

- Hetlioz

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For non-24- hour sleep-wake disorder (“non-24”): Member is documented to be totally blind and has no light perception AND other sleep disorders have been ruled out or treated appropriately (i.e. sleep apnea).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

HUMIRA

Products Affected

- Humira
- Humira Pediatric Crohns Disease Starter Pack
- Humira Pen
- Humira Pen-crohns Diseasestarter
- Humira Pen-psoriasis Starter

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Combination therapy with other biologic disease modifying anti-rheumatic drug (DMARD), e.g. tumor necrosis factor antagonists
Required Medical Information	Documentation of ONE of the following: (1) For moderate to severe Rheumatoid Arthritis, Ankylosing Spondylitis, moderate to severe Juvenile Idiopathic Arthritis (JIA) , or Psoriatic Arthritis: trial with ONE of the following: methotrexate, hydroxychloroquine, leflunomide, azathioprine, sulfasalazine OR (2) For moderate to severe Plaque Psoriasis: trial with ONE of the following topical agents: calcipotriene, anthralin, corticosteroids, immunomodulators (Elidel, Protopic), retinoids OR (3) For Crohn's Disease or Ulcerative Colitis: trial with a conventional treatment [e.g. (i) Corticosteroids: Budesonide (Entocort EC), Prednisone, Hydrocortisone, Methylprednisolone, (ii) Aminosalicylates: Sulfasalazine, Mesalamine (Asacol, Rowasa, Canasa, Pentasa), Olsalazine (Dipentum), balsalazide (Colazal), (iii) Immunomodulators: Azathioprine, 6-mercaptopurine] OR (4) Diagnosis of one of the following: (i) Hidradenitis Suppurativa or (ii) Uveitis
Age Restrictions	N/A
Prescriber Restrictions	Dermatologist, Gastroenterologist, Ophthalmologist or Rheumatologist
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

HYDROXYPROGESTERONE

Products Affected

- Hydroxyprogesterone Caproate INJ 1.25GM/5ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

HYDROXYZINE-AGE EDIT

Products Affected

- Hydroxyzine Hcl INJ
- Hydroxyzine Hcl ORAL TABS
- Hydroxyzine Hcl SYRP
- Hydroxyzine Pamoate ORAL CAPS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	(A) For alcohol withdrawal syndrome: inadequate response or inability to tolerate clorazepate or diazepam. (B) For nausea/vomiting: inadequate response or inability to tolerate ondansetron. (C) For Allergic Rhinitis: inadequate response or inability to tolerate one of the following: levocetirizine, desloratadine, azelastine (nasal), or fluticasone (nasal). (D) For pruritus: inadequate response or inability to tolerate one of the following: levocetirizine, desloratadine, or topical steroids.

IBRANCE

Products Affected

- Ibrance

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Pregnancy
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year.
Other Criteria	Applies to new starts only.

ICLUSIG

Products Affected

- Iclusig

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only. A documented diagnosis of one of the following: 1. Chronic phase, accelerated phase, or blast phase chronic myeloid leukemia (CML) AND Documented confirmation of the presence of the T315i mutation OR No other tyrosine kinase inhibitor (TKI) therapy is indicated (i.e., imatinib (Gleevec), nilotinib (Tasigna)). 2. Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ALL) AND Documented confirmation of the presence of the T315i mutation OR No other tyrosine kinase inhibitor (TKI) therapy is indicated (i.e., imatinib (Gleevec), nilotinib (Tasigna))

ILARIS

Products Affected

- Ilaris

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Treatment of Cryopyrin-Associated Periodic Syndromes (CAPS), including Familial Cold Auto inflammatory Syndrome (FCAS), or Muckle-Wells Syndrome (MWS) or systemic juvenile idiopathic arthritis (SJIA)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	For moderately to severely active polyarticular-course juvenile idiopathic arthritis: Require documentation of an inadequate response to methotrexate (MTX) alone unless MTX is contraindicated.

IMBRUVICA

Products Affected

- Imbruvica

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

INCRELEX

Products Affected

- Increlex

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Increlex is contraindicated for growth promotion in patients with closed epiphyses, for IV administration, in patients with active or suspected neoplasia. Increlex should be discontinued if neoplasia develops while on therapy.
Required Medical Information	Child meets the following conditions and criteria: (1) Severe primary IGF-1 deficiency OR Growth hormone gene deletion with developed neutralizing antibodies to growth hormone OR Genetic mutation of GH receptor (i.e. Laron Syndrome) (2) Child has severe growth retardation with height standard deviation score (SDS) more than 3 SDS below the mean for chronological age and sex (3) Child with IGF-1 level greater than or equal to 3 standard deviations below normal based on lab reference range for age and sex (4) Child with normal or elevated growth hormone (GH) levels based on at least one growth hormone stimulation test (5) Evidence of open epiphyses.
Age Restrictions	N/A
Prescriber Restrictions	Pediatric Endocrinologist or Endocrinologist
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

INLYTA

Products Affected

- Inlyta

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only. For renal cell carcinoma: Requests for new starts are covered following a trial and failure of one (1) prior systemic therapy. Examples include but are not limited to Nexavar, Sutent, Avastin, Votrient and Afinitor.

INSOMNIA AGENTS-AGE EDIT

Products Affected

- Zaleplon
- Zolpidem Tartrate ORAL TABS
- Zolpidem Tartrate Er

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

INTRAVENOUS IMMUNE GLOBULINS (IVIG)

Products Affected

- Flebogamma Dif
- Gammagard Liquid
- Gammagard S/d Iga Less Than 1mcg/ml
- Gammaked
- Gammaplex INJ 10GM/200ML, 2.5GM/50ML, 20GM/400ML, 5GM/100ML
- Gamunex-c
- Octagam

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of ONE of the following: (1) Diagnosis of any of the following - pemphigus vulgaris, pemphigus foliaceus, bullous pemphigoid, mucous membrane pemphigoid, epidermolysis bullosa acquisita, Autoimmune hemolytic anemia, Autoimmune neutropenia, Kawasaki disease, Parvovirus B19 infection and severe anemia, Chronic inflammatory demyeinating polyneuropathies, Dermatomyositis and polymyositis, Gullian-Barre syndrome, Lambert-Eaton myasthenic syndrome, Multifocal motor neuropathy, Multiple Sclerosis, Myasthenia Gravis, Stiffperson Syndrome, Systemic lupus erythematosus. (2) Bone marrow transplantation and hematopoietic stem cell transplant when IgG level is below normal. (3) Coagulopathy due to acquired inhibitor of clotting factor VIII. (4) Treatment of humoral allograft rejection. (5) Prophylaxis for CMV disease in cases of solid organ transplant when the recipient was seronegative for cytomegalovirus (CMV) before transplantation and the donor is seropositive.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	For Flebogamma, Gammagard, Gammaked: Inadequate response, or inability to tolerate Gammaplex and Gamunex-C. Drug is also subject to a Part B versus Part D coverage determination.

INTRON-A

Products Affected

- Intron A INJ 10MU/ML, 18MU, 50MU, 6000000UNIT/ML
- Intron A W/diluent

PA Criteria	Criteria Details
Covered Uses	All Medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Autoimmune hepatitis. Decompensated liver disease
Required Medical Information	Documentation of ONE of the following: (A) Hairy cell leukemia and AIDS-related Kaposi's Sarcoma: diagnosis confirmation. (B) Malignant melanoma: Adjuvant to surgical treatment in pts free of disease but at high risk for systemic recurrence within 56 days of surgery. (C) For initial treatment of clinically aggressive follicular non-Hodgkin lymphoma: used with anthracycline-containing chemo. (D) Condylomata acuminate: intralesional treatment involving external surfaces of the genital and perianal areas. (E) Chronic hep C: In pts with compensated liver disease with history of blood or blood product exposure and/or pts who are hep C virus (HCV)-antibody-positive. (F) Chronic hep B: In pts with compensated liver disease with serum HBsAg-positive for at least 6 mos and with HBV replication (serum HBeAg-positive) with elevated ALT. (G) Giant Cell Tumor of the Bone: (1) single agent or combined with denosumab or radiation therapy for localized disease or (2) single agent for metastatic disease. (H) CML: (1) Follow-up therapy in pts unable to tolerate imatinib, dasatinib, nilotinib, bosutinib, or ponatinib or (2) Post transplant treatment in pts with either molecular relapse (BCR-ABL1 transcript positive) following complete cytogenetic response or cytogenetic relapse or those who do not achieve complete cytogenetic response (I) Kidney Cancer: 1st-line therapy in combo with bevacizumab for relapse or for surgically unresectable stage IV disease with predominant clear cell histology. (J) NHL - Adult T-Cell Leukemia/Lymphoma: In combo with zidovudine for chronic, smoldering, or acute disease as (1) 1st-line therapy or (2) additional therapy following response to 1st-line therapy or (3) additional therapy for acute disease in nonresponders if not previously received. (K) NHL - Mycosis Fungoides (MF)/Sezary Syndrome (SS) (L) Soft Tissue Sarcoma - Desmoid Tumors (Aggressive Fibromatosis) (M) Systemic Light Chain Amyloidosis: Primary treatment in combo with dexamethasone.
Age Restrictions	N/A

Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

IRESSA

Products Affected

- Iressa

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

ISTODAX

Products Affected

- Istodax
- Istodax (overfill)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only. Diagnosis of Cutaneous T-cell Lymphoma OR Peripheral T-cell Lymphoma AND prior use of one systemic therapy such as one of the following, a retinoid (ex. Bexarotene (Targretin), all-trans retinoic acid (Vesanoid), acitretin (Soriatane). Diagnosis of Peripheral T-cell Lymphoma and prior use of one therapy such as one of the following, Beleodaq(belinostat) or Folotyn (pralatrexate).

ITRACONAZOLE

Products Affected

- Itraconazole CAPS
- Sporanox SOLN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of onychomycosis requires a positive laboratory test such as (potassium hydroxide-KOH preparation, fungal culture, or nail biopsy) to confirm the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Onychomycosis: Fingernail- 6 weeks, Toenail-12 weeks. Other indications: 3 months
Other Criteria	Documentation of ONE of the following: (A) For the diagnosis of oropharyngeal or esophageal candidiasis, the solution will be used. (B) For oropharyngeal or esophageal candidiasis, patient has failed fluconazole. (C) For treatment of aspergillosis, blastomycosis, febrile neutropenia, empiric therapy of febrile neutropenic (ETFN) patients with suspected fungal infections, histoplasmosis (treatment of histoplasmosis, including chronic cavitary pulmonary disease and disseminated, nonmeningeal histoplasmosis in non-immunocompromised or immunocompromised patients), and onychomycosis of the fingernails or toenails the oral capsule will be used. (D) For aspergillosis, patient has failed or is intolerant or refractory to amphotericin B.

IXEMPRA

Products Affected

- Ixempra Kit

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only. For the treatment of metastatic or locally advanced breast cancer in patients that have not responded to an anthracycline and taxane chemotherapy agent: Used in combination with capecitabine. If used as monotherapy in patients with metastatic or locally advanced breast cancer, patient must have tumor that is resistant or refractory to anthracyclines, taxanes and capecitabine.

JAKAFI

Products Affected

- Jakafi

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For myelofibrosis, any one of the following: either primary myelofibrosis, or post-polycythemia vera myelofibrosis or post-essential thrombocythemiayelofibrosis.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	Initial approval: 6 months. Extended approval through end of plan year.
Other Criteria	Applies to new starts only. For polycythemia vera: an inadequate response or intolerance to hydroxyurea.

JEVTANA

Products Affected

- Jevtana

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only. A documented diagnosis of hormone-refractory metastatic prostate cancer AND documented failure of a docetaxel-based chemotherapy AND used in combination with prednisone.

KADCYLA

Products Affected

- Kadcyla

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	HER2-protein expression test (require positive or equivocal HER2 over-expression test). Documentation of past therapies and outcomes. Patients must have received prior therapy for metastatic disease OR developed disease recurrence during or within six months of completing adjuvant therapy. Confirm treatment is for patients with HER2-positive, metastatic breast cancer who previously received trastuzumab (Herceptin) and a taxane, either separately or in combination.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

KALYDECO

Products Affected

- Kalydeco

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Kalydeco is not effective in patients with CF who are homozygous for the F508del mutation in the CFTR gene.
Required Medical Information	Treatment of cystic fibrosis (CF) in patients who have a mutation in the CFTR gene. Documentation of the presence of the one of the following specific mutations: R117H, G551D, G1244E, G1349D, G178R, G551S, S1251N, S1255P, S549N, or S549R.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

KEYTRUDA

Products Affected

- Keytruda

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year.
Other Criteria	Applies to new starts only.

KISQALI

Products Affected

- Kisqali

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year.
Other Criteria	Applies to new starts only.

KORLYM

Products Affected

- Korlym

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Pregnancy. Patients taking simvastatin, lovastatin, and CYP3A substrates with narrow therapeutic ranges, such as cyclosporine, dihydroergotamine, ergotamine, fentanyl, pimozide, quinidine, sirolimus, and tacrolimus. Concomitant treatment with systemic corticosteroids for serious medical conditions or illnesses. Women with a history of unexplained vaginal bleeding. Women with endometrial hyperplasia with atypia or endometrial carcinoma.
Required Medical Information	Diagnosis of Diabetes Mellitus Type 2 AND Endogenous Cushing Syndrome.
Age Restrictions	N/A
Prescriber Restrictions	Endocrinologist
Coverage Duration	Initial approval: 3 months. Extended approval: 1 year
Other Criteria	N/A

KUVAN

Products Affected

- Kuvan

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of hyperphenylalaninemia caused by tetrahydrobiopterin-(BH4-) responsive phenylketonuria AND dosing is within the range of 5 to 20 mg/kg/day. Initial extension will ONLY be granted for members who meet ALL of the following criteria: Documented response to therapy as defined by greater that or equal to 30% reduction in baseline Phe level AND Documented compliance with Kuvan AND Still under the appropriate care and re-evaluations of a specialist knowledgeable in the management of PKU. Extended Approval: 6 month intervals, based on documentation of ALL of the following: Maintenance of greater than or equal to 30% reduction in baseline Phe level AND Documented compliance with Kuvan AND Still under the appropriate care and re-evaluations of a specialist knowledgeable in the management of PKU.
Age Restrictions	N/A
Prescriber Restrictions	Genetic/Metabolic specialist
Coverage Duration	Initial Approval: 2 months. Extended Approval: 6 month intervals
Other Criteria	N/A

KYNAMRO

Products Affected

- Kynamro

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Documentation of moderate or severe hepatic impairment or active liver disease including unexplained persistent abnormal liver function tests.
Required Medical Information	Documentation that Kynamro will not be used as adjunct to LDL apheresis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	Documentation that Kynamro will be used in combination with at least one other lipid-lowering therapy to decrease blood lipids to reach treatment targets.

KYPROLIS

Products Affected

- Kyprolis

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or hematologist.
Coverage Duration	Through end of plan contract year.
Other Criteria	Applies to new starts only.

LARTRUVO

Products Affected

- Lartruvo

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only

LENVIMA

Products Affected

- Lenvima 10 Mg Daily Dose
- Lenvima 14 Mg Daily Dose
- Lenvima 18 Mg Daily Dose
- Lenvima 20 Mg Daily Dose
- Lenvima 24 Mg Daily Dose
- Lenvima 8 Mg Daily Dose

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year.
Other Criteria	Applies to new starts only.

LETAIRIS

Products Affected

- Letairis

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Not covered for patients who are pregnant. Not covered for patients with idiopathic pulmonary fibrosis.
Required Medical Information	Diagnosis of Pulmonary Arterial Hypertension (PAH) (WHO Group 1) and WHO functional class II to IV symptoms AND patient has mean pulmonary artery pressure equal to or greater than 25 mm Hg at rest or greater than 30 mm Hg with exertion, documented by right-heart catheterization or echocardiography.
Age Restrictions	N/A
Prescriber Restrictions	Pulmonologist or cardiologist.
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

LEUKINE

Products Affected

- Leukine INJ 250MCG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D or Febrile neutropenia.
Exclusion Criteria	N/A
Required Medical Information	Primary prophylaxis in conjunction with chemotherapy: in previously untreated adult and pediatric members with non-myeloid malignancies receiving established myelosuppressive chemotherapy that is expected to result in a greater than 20% incidence of febrile neutropenia OR members receiving chemotherapy who are at increased risk for chemotherapy-induced infectious complications because of bone marrow compromise or comorbidity. Febrile neutropenia: Adjunctive use with antibiotics in high-risk, febrile, neutropenic members who have one or more prognostic factors that are predictive of clinical deterioration: Documented neutropenia with absolute neutrophil count (ANC) under 1000/m, or uncontrolled primary disease, or Pneumonia, or Hypotension, or Multi-organ dysfunction (sepsis syndrome): or Invasive fungal infection. Dose-intensive chemotherapy: Use in settings where clinical research demonstrates that dose-intensive therapy produces improvement in disease control, when these therapies are expected to produce significant rates of febrile neutropenia. This include: Dose dense treatment given at every 2 weeks for early-stage breast cancer, or CHOP regimen for non-Hodgkin's lymphoma. Acute myeloid leukemia: For administration shortly after the completion of induction or consolidation AML therapy, to achieve decreases in the duration of neutropenia. Acute lymphoblastic leukemia (ALL): For administration after completion of the first few days of chemotherapy of the initial induction or first post-remission course. Myelodysplastic Syndromes: Intermittent use only in member with myelodysplastic syndromes who has less than 15% blasts in their bone marrow, AND has severe neutropenia (ANC less then 500/mL) and recurrent infections.
Age Restrictions	N/A
Prescriber Restrictions	N/A

Coverage Duration	Initial approval: 3 months. Extended approval: Through end of plan contract year
Other Criteria	N/A

LEUPROLIDE

Products Affected

- Leuprolide Acetate INJ
- Lupron Depot (1-month)
- Lupron Depot (3-month)
- Lupron Depot (4-month)
- Lupron Depot (6-month)
- Lupron Depot-ped (1-month)
- Lupron Depot-ped (3-month)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Contraindicated in pregnancy
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only for patients with prostate cancer.

LIDODERM

Products Affected

- Lidocaine PTCH

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	Patient has a documented trial and failure of one month of generic gabapentin.

LONSURF

Products Affected

- Lonsurf

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year.
Other Criteria	Applies to new starts only.

LYNPARZA

Products Affected

- Lynparza

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	A deleterious or suspected deleterious germline BRCA mutated as detected by an FDA-approved test.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year.
Other Criteria	Applies to new starts only. A documented diagnosis of advanced ovarian cancer which has been treated with at least three prior lines of chemotherapy such as carboplatin, cyclophosphamide, cisplatin, bevacizumab, etc.

LYRICA

Products Affected

- Lyrica

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only. Documentation of ONE of the following: (A) For neuropathic pain associated with diabetic peripheral neuropathy: a documented trial, failure, or contraindication to duloxetine. (B) For postherpetic neuralgia: a documented trial, failure, or contraindication to gabapentin. (C) For partial seizures: a documented trial, failure, or contraindication to gabapentin. (D) For fibromyalgia: a documented trial, failure, or contraindication to duloxetine. (E) For neuropathic pain associated with spinal cord injury, no prerequisite therapy is required.

MARQIBO

Products Affected

- Marqibo

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Patients with demyelinating conditions including Charcot-Marie-Tooth syndrome
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or Hematologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

MEGESTROL-AGE EDIT

Products Affected

- Megestrol Acetate ORAL TABS
- Megestrol Acetate SUSP 40MG/ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

MEKINIST

Products Affected

- Mekinist

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	A documented BRAF V600E or V600K mutations as detected by an FDA-approved test
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or dermatologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only. Can be used in combination with Tafinlar. However, if Mekinist is being used as a single agent, it is not indicated for use in patients who have received prior BRAF inhibitor therapy (i.e. Zelboraf, Tafinlar).

MEPRON

Products Affected

- Atovaquone SUSP
- Mepron SUSP

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of a diagnosis of mild to moderate Pneumocystis jiroveci pneumonia (PCP) and intolerance to trimethoprim-sulfamethoxazole (TMP-SMZ).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	Treatment of more severe episodes of PCP with atovaquone has not been studied (alveolar-arterial oxygen diffusion gradient greater than 45 mmHg).

METHADONE

Products Affected

- Methadone Hcl CONC
- Methadone Hcl INJ
- Methadone Hcl ORAL SOLN
- Methadone Hcl ORAL TABS
- Methadone Hcl TBSO
- Methadose TBSO

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of ALL of the following: (1) severe persistent chronic pain, (2) inadequate response or inability to tolerate two long-acting opioids AND (3) Prescriber is familiar with complexities of methadone's pharmacokinetic and pharmacodynamics properties
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

MODAFINIL

Products Affected

- Modafinil

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	(A) For excessive sleepiness or hypersomnolence associated with narcolepsy: documentation of diagnosis. (B) For excessive sleepiness associated with obstructive sleep apnea (OSA): documentation of use as an adjunct to standard treatment(s) for the underlying obstruction. (C) For excessive sleepiness associated with shift work disorder (SWSD): documentation of diagnosis and the patient must have a job that requires them to frequently rotate shifts or work at night, and be unable to adjust to their schedule. (D) For diagnosis of Steinert myotonic dystrophy syndrome: documentation of hypersomnia due to Steinert myotonic dystrophy syndrome.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

MOVANTIK

Products Affected

- Movantik

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Contraindicated in patients with known or suspected gastrointestinal (GI) obstruction OR patients receiving strong CYP3A4 inhibitors (e.g., clarithromycin, ketoconazole).
Required Medical Information	Documentation of opioid therapy
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	Inadequate response or inability to tolerate Amitiza

MOZOBIL

Products Affected

- Mozobil

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	Documentation of use in combination with a granulocyte-colony stimulating factor (G-CSF) (e.g. sargramostim (Leukine) or filgrastim (Neupogen)) to mobilize hematopoietic stem cells to the peripheral blood for collection and subsequent autologous transplantation in individuals who have ONE of the following conditions: (1) Non-Hodgkin's lymphoma OR (2) Multiple myeloma

MUSCLE RELAXANTS-AGE EDIT

Products Affected

- Chlorzoxazone TABS 500MG
- Cyclobenzaprine Hcl ORAL TABS

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

NAGLAZYME

Products Affected

- Naglazyme

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	The intravenous administration of Naglazyme is indicated for patients with Maroteaux-Lamy syndrome (Mucopolysaccharidosis VI). For renewal, patient has shown improvement in walking and stair climbing capacity.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial approval: 6 months. Extended approval: Annual review will be based on response to therapy
Other Criteria	N/A

NAMENDA

Products Affected

- Memantine Hcl
- Memantine Hcl Titration Pak
- Memantine Hydrochloride SOLN
- Namenda
- Namenda Titration Pak
- Namenda Xr
- Namenda Xr Titration Pack
- Namzaric

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	This prior authorization only applies to members under 45.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	Requests for Namenda tablets and solution: Inadequate response or inability to tolerate generic memantine

NATPARA

Products Affected

- Natpara

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	For diagnosis of hypoparathyroidism patient must be using in combination with calcium and vitamin D supplements AND had a trial and failure of calcitriol.

NEUMEGA

Products Affected

- Neumega

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation that the medication is being used following myelosuppressive chemotherapy in adult patients with non-myeloid malignancies who are at high risk for severe thrombocytopenia.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

NEUPOGEN

Products Affected

- Neupogen

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Confirm use is associated with one of the following: 1. Non-myeloid malignancies receiving a myelosuppressive chemotherapy regimen associated with a significant risk of severe neutropenia with fever 2. Induction or consolidation treatment for Acute myeloid leukemia (AML) 3. Bone marrow transplantation 4. Peripheral Blood Progenitor Cell (PBPC) Collection 5. Severe Chronic Neutropenia (SCN) with ANC less than 500/ml 6. Advanced HIV with ANC under 1000/ml to allow scheduled dosing of myelosuppressive anti-retroviral medications (e.g. zidovudine and ganciclovir).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

NEXAVAR

Products Affected

- Nexavar

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Approved for hepatocellular carcinoma (HCC) when it is unresectable. Approved for renal cell carcinoma that is advanced. Approved for locally recurrent or metastatic progressive differentiated thyroid carcinoma (DTC) that is refractory to iodine treatment.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

NINLARO

Products Affected

- Ninlaro

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	Through end of plan contract year.
Other Criteria	Applies to new starts only.

NITROFURANTOIN-AGE EDIT

Products Affected

- Nitrofurantoin SUSP
- Nitrofurantoin Macrocrystals
- Nitrofurantoin Monohydrate
- Nitrofurantoin Monohydrate/macrocrystals

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to greater than cumulative 90 days of therapy per year.

NORDITROPIN

Products Affected

- Norditropin Flexpro

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Growth Hormone Deficiency in Children and Adolescents: Patient has failed to respond to at least 2 standard GH stimulation tests. One abnormal GH test is sufficient for children with brain tumors and irradiation with documented multiple pituitary hormone deficiency (MPHD) AND Appropriate imaging (MRI or CT) of the brain to exclude tumor on hypothalamic-pituitary region One of the following criteria are met: Child has severe growth retardation with height standard deviation score (SDS) more than 3 SDS below the mean for chronological age and sex OR Child has moderate growth retardation with height SDS –2 and –3 SDS below the mean chronological age and sex and decreased growth rate (growth velocity measured over one year below 25th percentile for age and sex) OR Child exhibits severe deceleration in growth rate (growth velocity measured over 1 year –2 SDS below the mean for age and sex) OR Child has decreasing growth rate combined with a predisposing condition like previous cranial irradiation or tumor OR Child exhibits evidence of other pituitary hormone deficiencies or signs of congenital GHD (hypoglycemia, microphallus). GH Deficiency in Adults: Covered for adult GH deficiency who meet ALL the following criteria: Adult onset: Patients who have GH deficiency either alone or with multiple hormone deficiencies (hypopituitarism), as a result of EITHER disease of the pituitary or hypothalamus OR injury to either the pituitary or hypothalamus from surgery, radiation therapy, or trauma OR Childhood onset: Patients who were GH deficient during childhood who have GH deficiency confirmed as adult before therapy is started. AND Biochemical diagnosis of GH deficiency, by means of a negative response to two standard GH stim tests (maximum peak less then 5 ng/ml when measured by RIA or less than 2.5 ng/ml when measured by IRMA) AND Patients already receiving supplementation of other hormones as required AND Objective measurement of clinical features of GH deficiency.
Age Restrictions	N/A
Prescriber Restrictions	Endocrinologist or Pediatric Endocrinologist

Coverage Duration	Through end of plan contract year
Other Criteria	N/A

NORTHERA

Products Affected

- Northera

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Three months initially, then through end of plan contract year if still effective
Other Criteria	N/A

NOXAFIL

Products Affected

- Noxafil

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	Requests for new starts with invasive Aspergillus infection in immunosuppressed patients are covered when the infection is refractory to itraconazole or the patient is intolerant to itraconazole. Requests for new starts with invasive Candida infection in immunosuppressed patients or oropharyngeal candidiasis are covered when the infection is refractory or intolerant to fluconazole or itraconazole. Refractoriness is defined as progression of infection or failure to improve after a minimum of 7 days of prior therapeutic doses of effective antifungal therapy.

NULOJIX

Products Affected

- Nulojix

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Not covered in patients who are EBV seronegative or with unknown EBV serostatus.
Required Medical Information	Kidney transplant: Documentation of prophylaxis AND concurrent use with basiliximab induction, mycophenolate mofetil, and corticosteroids in adult Epstein-Barr virus seropositive kidney transplant recipients.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only. Drug is also subject to a Part B versus Part D coverage determination.

NUPLAZID

Products Affected

- Nuplazid

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Patient is taking Parkinson’s Disease medications(s).
Age Restrictions	N/A
Prescriber Restrictions	For Parkinson's disease psychosis: Prescribed by or after consultation with a neurologist or psychiatrist.
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

OCTREOTIDE

Products Affected

- Octreotide Acetate

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

ODOMZO

Products Affected

- Odomzo

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year.
Other Criteria	Applies to new starts only.

OFEV

Products Affected

- Ofev

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Confirmation of diagnosis of Idiopathic Pulmonary Fibrosis (IPF)
Age Restrictions	N/A
Prescriber Restrictions	Pulmonologist
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

OMNITROPE

Products Affected

- Omnitrope

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Growth Hormone Deficiency in Children and Adolescents: Patient has failed to respond to at least 2 standard GH stimulation tests. One abnormal GH test is sufficient for children with brain tumors and irradiation with documented multiple pituitary hormone deficiency (MPHD) AND Appropriate imaging (MRI or CT) of the brain to exclude tumor on hypothalamic-pituitary region One of the following criteria are met: Child has severe growth retardation with height standard deviation score (SDS) more than 3 SDS below the mean for chronological age and sex OR Child has moderate growth retardation with height SDS –2 and –3 SDS below the mean chronological age and sex and decreased growth rate (growth velocity measured over one year below 25th percentile for age and sex) OR Child exhibits severe deceleration in growth rate (growth velocity measured over 1 year –2 SDS below the mean for age and sex) OR Child has decreasing growth rate combined with a predisposing condition like previous cranial irradiation or tumor OR Child exhibits evidence of other pituitary hormone deficiencies or signs of congenital GHD (hypoglycemia, microphallus). GH Deficiency in Adults: Covered for adult GH deficiency who meet ALL the following criteria: Adult onset: Patients who have GH deficiency either alone or with multiple hormone deficiencies (hypopituitarism), as a result of EITHER disease of the pituitary or hypothalamus OR injury to either the pituitary or hypothalamus from surgery, radiation therapy, or trauma OR Childhood onset: Patients who were GH deficient during childhood who have GH deficiency confirmed as adult before therapy is started. AND Biochemical diagnosis of GH deficiency, by means of a negative response to two standard GH stim tests (maximum peak less then 5 ng/ml when measured by RIA or less than 2.5 ng/ml when measured by IRMA) AND Patients already receiving supplementation of other hormones as required AND Objective measurement of clinical features of GH deficiency.
Age Restrictions	N/A
Prescriber Restrictions	Endocrinologist or Pediatric Endocrinologist

Coverage Duration	Through end of plan contract year
Other Criteria	Inadequate response or inability to tolerate Norditropin

ONIVYDE

Products Affected

- Onivyde

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

OPDIVO

Products Affected

- Opdivo

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year.
Other Criteria	Applies to new starts only.

OPSUMIT

Products Affected

- Opsumit

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	(1) Pregnancy (2) Concurrent use with strong CYP3A4 inducers or inhibitors
Required Medical Information	Approved when all of the following inclusion criteria are met: (1) Documentation of a diagnosis of pulmonary arterial hypertension (PAH) WHO Group I with New York Heart Association (NYHA) Functional Class II- IV, (2) Diagnosis confirmed by catheterization (right-heart or Swan-Ganz) or echocardiography AND (3) Documentation of mean pulmonary artery pressure equal to or greater than 25 mm Hg at rest or greater than 30 mm Hg with exertion. RE-AUTHORIZATION CRITERIA: Documentation of stabilization or improvement as evaluated by a cardiologist or pulmonologist.
Age Restrictions	N/A
Prescriber Restrictions	Pulmonologist or cardiologist
Coverage Duration	6 month for initial authorization and 12 months for renewal authorizations
Other Criteria	N/A

ORFADIN

Products Affected

- Orfadin

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

ORKAMBI

Products Affected

- Orkambi

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation that the patient is homozygous for the F508del mutation in the CFTR gene.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a pediatric or adult pulmonologist
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

OTEZLA

Products Affected

- Otezla

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Dermatologist or Rheumatologist
Coverage Duration	Through end of plan contract year.
Other Criteria	Inadequate response or inability to tolerate adalimumab (Humira) AND etanercept (Enbrel) or documentation demonstrating that a trial may be inappropriate

OXANDROLONE

Products Affected

- Oxandrolone ORAL TABS

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	The indication of weight gain. Known or suspected carcinoma of the prostate or the male breast. Carcinoma of the breast in females with hypercalcemia. Pregnancy. Nephrosis. Hypercalcemia.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 month, renewals for return of symptoms
Other Criteria	N/A

PEG-INTRON

Products Affected

- Pegintron
- Peg-intron Redipen

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Contraindicated in patients with: Autoimmune hepatitis, Hepatic decompensation (Child-Pugh score greater than 6 [class B and C]) in cirrhotic patients before treatment, Hepatic decompensation with Child-Pugh score greater than or equal to 6 in cirrhotic CHC patients coinfected with HIV before treatment.
Required Medical Information	Confirmation of genotype, previous hepatitis C treatment history and response, other medications that will be used concurrently. For continuation of therapy: HCV RNA levels have declined greater than 2 log10 IU/ml at 12 weeks of therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	HCV: Initial 12 weeks, total duration 12 to 48 weeks based on genotype & drug regimen.
Other Criteria	Peg-Intron will not be covered for Chronic Hepatitis C Virus (HCV)genotype 1a or 1b. Initial approval will be granted when a documented failure/contraindication/intolerance to Harvoni for genotypes 4, 5, or 6. AND ONE of the following is met: (A)HCV infection, genotype 2 AND previous treatment with PEG/RBV or sofosbuvir/RBV has failed AND regardless of the presence/absence of cirrhosis AND concurrent therapy with Sovaldi and ribavirin: 12 weeks total OR (B) HCV infection, genotype 3, 4, 5 or 6 AND treatment naive OR previous treatment with PEG/RBV or sofosbuvir/RBV has failed AND regardless of the presence/absence of cirrhosis AND concurrent therapy with Sovaldi and ribavirin: 12 weeks total.

PERJETA

Products Affected

- Perjeta

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

PHENOBARBITAL-AGE EDIT

Products Affected

- Phenobarbital ELIX 20MG/5ML
- Phenobarbital ORAL TABS 100MG, 15MG, 16.2MG, 30MG, 32.4MG, 60MG, 64.8MG, 97.2MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only. For diagnosis of seizures: inadequate response or inability to tolerate one non-HRM alternative formulary drug (such as carbamazepine, lamotrigine, or topiramate).

POMALYST

Products Affected

- Pomalyst

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Pregnant patients.
Required Medical Information	For the treatment of patients with multiple myeloma who have received prior therapy with Revlimid (lenalidomide) and Velcade (bortezomib) and whose disease has progressed on or within 60 days of completion of the last therapy.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

PORTRAZZA

Products Affected

- Portrazza

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

PRALUENT

Products Affected

- Praluent

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

PROCRIT

Products Affected

- Procrit

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Uncontrolled hypertension. Pure red cell aplasia (PRCA) that begins after treatment with PROCRIT or other erythropoietin protein drugs.
Required Medical Information	For initiation of therapy: adequate iron stores have been demonstrated by means of bone marrow iron or serum ferritin levels or serum iron saturation studies within the prior 12 months (Note: for persons with iron deficiency, erythropoietin analog therapy may be initiated simultaneous with iron replacement), and the following criteria is met: hemoglobin (Hgb) is approaching or has fallen below 10 g/dl or hematocrit of 30% or less OR for patients who are undergoing elective, noncardiac, nonvascular surgery, perioperative hemoglobin is greater than 10 AND less than or equal to 13 g/dL OR patient will be starting myelosuppressive therapy and will have an anticipated hemoglobin drop associated with their therapy. For continuation of therapy: documentation of the following: for persons with anemia due to myelosuppressive anticancer chemotherapy - Hgb target of 12 g/dl For persons with chronic renal failure and end-stage renal disease (ESRD): Hgb target 10-11 g/dl For persons with other indications (e.g. ZVD HIV therapy): Hgb target of 12 g/dl For persons undergoing high risk surgery: Hgb target of 13 g/dl Continued use of the therapy is not covered if the hemoglobin rises less than 1 g/dl (hematocrit rise less than 3 %) compared to pretreatment baseline by 8 weeks of treatment and whose hemoglobin level remains less than 10 g/dL (or the hematocrit is less than 30%).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Surgery: 4 weeks, all other indications: 12 weeks
Other Criteria	N/A

PROMACTA

Products Affected

- Promacta

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	Requests for coverage for thrombocytopenia in chronic hepatitis C patients will be approved if the platelet count is less than 50 billion cells/L. Promacta should be withheld when platelet counts exceed 400,000/mcL or if there's no response within 4 weeks of treatment at the maximum dose (75mg/day). Not covered in the presence of clinical symptoms of liver injury or evidence of hepatic decompensation.

PULMONARY HYPERTENSION-OTHER

Products Affected

- Epoprostenol Sodium

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For Pulmonary arterial hypertension in WHO Group I and patient has NYHA functional class III or IV symptoms AND patient has mean pulmonary artery pressure greater than 25 mm Hg at rest or greater than 30 mm Hg with exertion, documented by right-heart catheterization or echocardiography.
Age Restrictions	N/A
Prescriber Restrictions	Pulmonologist or cardiologist
Coverage Duration	Through end of plan contract year
Other Criteria	Drug is also subject to a Part B versus Part D coverage determination.

PURIXAN

Products Affected

- Purixan

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only. Purixan will be used as part of a combination regimen for the treatment of ALL. Patient is unable to use the tablet formulation, for example, patient is unable to swallow tablets, pediatric patient, or unable to get needed dose with tablet formulation.

QUININE SULFATE

Products Affected

- Quinine Sulfate CAPS 324MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Treatment or prevention of leg cramps. Prevention of malaria or in patients with complicated P. falciparum. Prolonged QT interval. Glucose-6-phosphate dehydrogenase (G6PD) deficiency.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	7 days
Other Criteria	N/A

RAVICTI

Products Affected

- Ravicti

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

REBIF

Products Affected

- Rebif
- Rebif Rebidose
- Rebif Rebidose Titration Pack
- Rebif Titration Pack

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	The member has a diagnosis of a relapsing form of multiple sclerosis OR has experienced a first clinical episode and has MRI features consistent with multiple sclerosis.
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

REGRANEX

Products Affected

- Regranex

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Exclusion criteria: (1) Known neoplasm(s) at the site(s) of application. (2) Treatment of pressure ulcers and/or venous stasis ulcers. (3) Treatment of diabetic neuropathic ulcers that do not extend through the dermis into subcutaneous tissue (Stage I or II, IAET staging classification) or ischemic diabetic ulcers.
Required Medical Information	(A) Confirmed underlying diagnosis/status of diabetes either by history of current diabetic medical treatment or labs provided by the prescriber. (B) Documentation of a wound care plan. (C) Ulcer description meets the following criteria: (1) located on the lower extremity, (2) extends into the subcutaneous tissue or beyond, and (3) has adequate blood supply. RE-APPROVAL: documentation of a decrease in the ulcer size by the 10th week of therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 10 weeks. Reapproval: 10 weeks with documentation of response.
Other Criteria	N/A

RELISTOR

Products Affected

- Relistor

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Contraindicated in patients with known or suspected mechanical gastrointestinal obstruction.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	4 months
Other Criteria	Requests will be covered following a trial/failure or intolerance to lactulose AND polyethylene glycol.

REMICADE

Products Affected

- Remicade

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For the treatment of adult patients with moderate to severe chronic plaque psoriasis: PASI score of 10 or more and body surface area (BSA) involvement equal to or greater than 10% OR affecting crucial body areas such as the hands, feet, face, or genitals. For continuation of therapy, patient's condition must have improved or stabilized. For continuation therapy in plaque psoriasis, patient has shown a reduction in baseline PASI score and dose requested does not exceed the FDA maximum dose. For fistulizing Crohn's disease: Require diagnosis of fistulizing disease.
Age Restrictions	N/A
Prescriber Restrictions	Rheumatologist, Dermatologist or Gastroenterologist
Coverage Duration	Through end of plan contract year

Other Criteria	Required medical information: Documentation of ONE of the following diagnoses: (1) active, moderate to severe ankylosing spondylitis and an inadequate response or inability to tolerate at least one other treatment such as NSAIDs, or methotrexate (2) moderate to severe ulcerative colitis or Crohn's disease and an inadequate response or inability to tolerate at least one conventional treatment (e.g. corticosteroids, aminosalicylates, immunomodulators) (3) chronic, severe (i.e. extensive and/or disabling) plaque psoriasis for individuals who are candidates for systemic therapy and have had an inadequate response or are unable to tolerate other systemic therapies (4) Rheumatoid arthritis in combination with methotrexate or as monotherapy when the individual is intolerant of or has a contraindication to methotrexate (5) active psoriatic arthritis and inability to tolerate or inadequate response to at least one DMARD (6) Wegener's granulomatosis with evidence of severe active disease and inadequate response or inability to tolerate corticosteroids and immunosuppressant agents (7) Ulcerative Colitis in Children at least 6 years of age who have moderate to severe active UC and who have had an inadequate response to conventional therapies (8) Polyarticular juvenile idiopathic arthritis (JIA) in patients 4 years of age or older with evidence of active disease and who have had a documented failure or intolerance to a 3-month trial of any of the FDA-approved biologic DMARD

REMODULIN

Products Affected

- Remodulin

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For diagnosis of Pulmonary arterial hypertension: Patient is in WHO Group I AND has NYHA functional class II - IV symptoms AND patient has mean pulmonary artery pressure equal to or greater than 25 mm Hg at rest or greater than 30 mm Hg with exertion, documented by right-heart catheterization or echocardiography.
Age Restrictions	N/A
Prescriber Restrictions	Pulmonologist or cardiologist
Coverage Duration	Through end of plan contract year
Other Criteria	Drug is also subject to a Part B versus Part D coverage determination

REPATHA

Products Affected

- Repatha
- Repatha Pushtronex System
- Repatha Sureclick

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

REVLIMID

Products Affected

- Revlimid

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Not covered for patients who are pregnant.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only. Transfusion dependence is defined as having greater than 2 units of red blood cells within 8 weeks of treatment. Low- or intermediate-1 risk MDS is defined as having an International Prognostic Scoring System (IPSS) Score for MDS of 0 to 1.

RITUXAN

Products Affected

- Rituxan

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of ONE of the following: (A) For diagnosis of rheumatoid arthritis: combination use with methotrexate AND patient had an inadequate response to Remicade. (B) For diagnosis of previously untreated and previously treated CD20-positive Chronic Lymphocytic Leukemia (CLL): combination use with fludarabine and cyclophosphamide (FC). (C) For diagnoses of Granulomatosis with Polyangiitis (GPA) (Wegener's Granulomatosis) and Microscopic Polyangiitis (MPA): combination use with glucocorticoids. (D) For diagnosis of Non-Hodgkin lymphoma, one of the following: (1) As a single agent for the treatment of patients with relapsed or refractory low-grade or follicular, CD20-positive, B-cell non-Hodgkin lymphoma. (2) For previously untreated follicular, CD20-positive, B-cell non-Hodgkin lymphoma in combination with first-line chemotherapy and, in patients achieving a complete or partial response to rituximab in combination with chemotherapy, as single-agent maintenance chemotherapy. (3) For nonprogressing (including stable disease) low-grade, CD20-positive, B-cell non-Hodgkin lymphoma as a single agent following first-line treatment with cyclophosphamide, vincristine, and prednisone chemotherapy (4) for previously untreated diffuse large B-cell, CD20-positive non-Hodgkin lymphoma in combination with cyclophosphamide, doxorubicin, vincristine, and prednisone, or other anthracycline-based chemotherapy regimens.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

RUBRACA

Products Affected

- Rubraca

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	A deleterious or suspected deleterious BRCA mutated as detected by an FDA-approved test.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only. A documented diagnosis of advanced ovarian cancer which has been treated with at least two prior lines of platinum chemotherapy agents such as cisplatin, carboplatin, gemcitabine or paclitaxel.

SABRIL

Products Affected

- Sabril

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	The potential benefits for use of Sabril outweigh the potential risk of vision loss and documentation of ONE of the following: (1) Complex partial seizure disorder: (a) patient is currently stable on Sabril therapy OR is currently receiving another antiepileptic drug AND (b) patient has experienced treatment failure from two previous agents (lamotrigine, phenytoin, divalproex, levetiracetam, gabapentin, carbamazepine, topiramate, zonisamide) OR (2) Infantile spasms: used as monotherapy for pediatric patients with infantile spasms 1 month to 2 years of age
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

SAMSCA

Products Affected

- Samsca

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Documented concurrent use of strong CYP3A inhibitors (for example, ketoconazole, clarithromycin, itraconazole, ritonavir, indinavir, nelfinavir, saquinavir, nefazodone, telithromycin).
Required Medical Information	Treatment with Samsca is being initiated or re-initiated in a hospital where serum sodium can be monitored closely.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	30 days
Other Criteria	N/A

SIGNIFOR

Products Affected

- Signifor

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 Months
Other Criteria	Approvable in patients for whom pituitary surgery is not an option or has not been curative. For continuation of therapy, patient is responding to therapy.

SILDENAFIL

Products Affected

- Sildenafil TABS

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrent use of organic nitrates (for example, isosorbide mononitrate, isosorbide dinitrate, nitroglycerin). Sildenafil is not covered for the diagnosis of ED/impotence.
Required Medical Information	For Pulmonary Arterial Hypertension (PAH) (WHO Group 1) and WHO functional class II to IV symptoms AND patient has mean pulmonary artery pressure equal to or greater than 25 mm Hg at rest or greater than 30 mm Hg with exertion, documented by right-heart catheterization or echocardiography.
Age Restrictions	N/A
Prescriber Restrictions	Pulmonologist or cardiologist
Coverage Duration	Through end of plan contract year
Other Criteria	An acute vasoreactivity test is required for persons with primary pulmonary hypertension and other persons with Group 1 pulmonary hypertension. For persons with a positive acute vasoreactivity test result, documentation of a trial and failure of a calcium channel blocker (dihydropyridine or diltiazem) is required, unless contraindicated, such as in persons with right heart failure or hemodynamic instability. A trial of a calcium channel blocker is not required for persons with a negative acute vasoreactivity test result. A vasoreactivity test and a trial of a calcium channel blocker is not required for other pulmonary hypertension groups (i.e., persons with pulmonary hypertension secondary to sarcoidosis, congenital diaphragmatic hernia, or chronic thromboembolic pulmonary hypertension).

SIRTURO

Products Affected

- Sirturo

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Not for the treatment of latent Mycobacterium TB infections, drug-sensitive TB, extrapulmonary TB, or nontuberculous mycobacterial infections . Not for treatment in HIV-1 infected patients.
Age Restrictions	N/A
Prescriber Restrictions	Infectious disease
Coverage Duration	24 weeks
Other Criteria	Patient has multidrug resistant TB and there is no other effective treatment regimen. Drug is being used in combination with at least 3 other drugs to which the patient's MDR-TB isolate has been shown to be susceptible in vitro. If in vitro testing results are unavailable, treatment may be initiated with SIRTURO in combination with at least 4 other drugs to which the patient's MDR-TB isolate is likely to be susceptible.

SOLTAMOX

Products Affected

- Soltamox

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of inability to swallow tablet formulation.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

SOMATULINE

Products Affected

- Somatuline Depot

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For acromegaly patients: who have had an inadequate response to surgery and/or radiotherapy, or for whom surgery and/or radiotherapy is not an option OR have failed an adequate trial of Octreotide.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

SOMAVERT

Products Affected

- Somavert

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Acromegaly: For the treatment of acromegaly in patients who have had an inadequate response to surgery and/or radiation therapy and/or other medical therapies, or for whom these therapies are not appropriate. Annual reauthorization is based upon patient's response to therapy as evidenced by normalization of IGF-I levels and liver function tests that are less than 5 times upper limit of normal, without signs/symptoms of hepatitis or other liver injury, or increase in serum TBIL.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

SORIATANE

Products Affected

- Acitretin

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Pregnancy, severely impaired liver or kidney function, chronic abnormally elevated blood lipid values, concomitant use with methotrexate or tetracyclines, hypersensitivity to the preparation (acitretin or excipients) or to other retinoids
Required Medical Information	Indicated for the treatment of severe psoriasis in adults as monotherapy or in combination with phototherapy.
Age Restrictions	N/A
Prescriber Restrictions	Rheumatologist or Dermatologist
Coverage Duration	6 months
Other Criteria	For the treatment of psoriasis, a trial of one of the following: methotrexate, DMARD or cyclosporine.

SOVALDI

Products Affected

- Sovaldi

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Confirmation of hepatitis C genotype. Previous hepatitis C treatment history (if any). Other medications that will be used with current AASLD/IDSA protocol (if any). Presence or absence of cirrhosis.
Age Restrictions	N/A
Prescriber Restrictions	Infectious disease, gastroenterologist, hepatologist
Coverage Duration	Duration will be applied consistent with current AASLD/IDSA guidance.
Other Criteria	(A) Patient must have documented failure/contraindication/intolerance to Harvoni if appropriate based on current AASLD/IDSA guidance AND (B) Criteria will be applied consistent with current AASLD/IDSA guidance.

SPRYCEL

Products Affected

- Sprycel

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

STIVARGA

Products Affected

- Stivarga

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only. Treatment of locally advanced, unresectable or metastatic gastrointestinal stromal tumors (GIST) in patients who have previously received imatinib or sunitinib OR for the treatment of adult patients with metastatic colorectal cancer who have been previously treated with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy, an anti-VEGF (vascular endothelial growth factor) therapy (e.g. Avastin). If KRAS wild type colorectal cancer, an anti-EGFR (endothelial growth factor receptor) therapy (e.g. Erbitux, Vectibix) must have been part of the treatment protocol.

STRATTERA

Products Affected

- Strattera

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	(1) Concomitant use with a monoamine oxidase inhibitor (MAOI), (2) Narrow-angle glaucoma, (3) Current or past history of pheochromocytoma
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	For diagnosis of ADHD: inadequate response or inability to tolerate ONE stimulant medication or documentation demonstrating that a trial may be inappropriate.

SUBOXONE

Products Affected

- Buprenorphine Hcl/naloxone Hcl
- Suboxone SUBLINGUAL FILM

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial approval: 3 months. Extended approval: 6 months
Other Criteria	N/A

SUBUTEX

Products Affected

- Buprenorphine Hcl SUBLINGUAL SUBL

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of ONE of the following: (1) use for induction phase of treatment or (2) use in phase other than induction in patients who are unable to tolerate buprenorphine/naloxone or (3) patient is pregnant
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial approval: 3 months. Extended approval: 6 months
Other Criteria	N/A

SUTENT

Products Affected

- Sutent

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

SYLATRON

Products Affected

- Sylatron

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Autoimmune hepatitis. Hepatic decompensation (Child-Pugh score greater than 6 [class B and C].
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

SYLVANT

Products Affected

- Sylvant

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

SYNAGIS

Products Affected

- Synagis INJ 100MG/ML, 50MG/0.5ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

SYNRIBO

Products Affected

- Synribo

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only. For diagnosis of chronic or accelerated phase chronic myeloid leukemia (CML): documentation of resistance and/or intolerance to nilotinib (Tasigna) and one additional tyrosine kinase inhibitor.

TAFINLAR

Products Affected

- Tafinlar

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or dermatologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only. Tafinlar should not be used in patients with wild-type BRAF melanoma due to the potential risk of tumor promotion in these patients.

TAGRISSO

Products Affected

- Tagrisso

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

TARCEVA

Products Affected

- Tarceva

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

TARGRETIN CAPS

Products Affected

- Bexarotene
- Targretin CAPS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	This medication should not be administered to patients who are pregnant.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

TARGRETIN GEL

Products Affected

- Targretin GEL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	This medication should not be administered to patients who are pregnant.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

TASIGNA

Products Affected

- Tasigna

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

TECENTRIQ

Products Affected

- Tecentriq

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

TETRABENAZINE

Products Affected

- Tetrabenazine

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Not covered for members with the following: Patients who are actively suicidal, or patients with untreated or inadequately treated depression. Patients with impaired hepatic function. Patients currently taking monoamine oxidase inhibitors. Patients currently taking reserpine.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

THALOMID

Products Affected

- Thalomid

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Not covered for patients who are pregnant.
Required Medical Information	For erythema nodosum leprosum: cannot be used as monotherapy in the presence of moderate to severe neuritis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

THIORIDAZINE-AGE EDIT

Products Affected

- Thioridazine Hcl ORAL TABS 100MG, 10MG, 25MG, 50MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only. Inadequate response or inability to tolerate two formulary alternative drugs (aripiprazole, olanzapine, paliperidone, quetiapine, risperidone, ziprasidone).

TOPICAL TRETINOIN

Products Affected

- Avita
- Clindamycin Phosphate/tretinoin
- Tretinoin EXTERNAL CREA
- Tretinoin EXTERNAL GEL

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Cosmetic use
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

TRACLEER

Products Affected

- Tracleer

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	(1) Pregnancy (2) Concurrent use with glyburide or cyclosporine
Required Medical Information	Approved when all of the following inclusion criteria are met: (1) Documentation of a diagnosis of pulmonary arterial hypertension (PAH) WHO Group I with New York Heart Association (NYHA) Functional Class II- IV, (2) Diagnosis confirmed by catheterization (right-heart or Swan-Ganz) or echocardiography AND (3) Documentation of mean pulmonary artery pressure equal to or greater than 25 mm Hg at rest or greater than 30 mm Hg with exertion. RE-AUTHORIZATION CRITERIA: Documentation of stabilization or improvement as evaluated by a cardiologist or pulmonologist.
Age Restrictions	N/A
Prescriber Restrictions	Pulmonologist or cardiologist
Coverage Duration	6 month for initial authorization and 12 months for renewal authorizations
Other Criteria	N/A

TREATMENT OF ATTENTION DEFICIT DISORDER - AGE EDIT

Products Affected

- Amphetamine/dextroamphetamine ORAL TABS
- Dexmethylphenidate Hcl
- Dexmethylphenidate Hcl Er
- Dextroamphetamine Sulfate ORAL TABS
- Dextroamphetamine Sulfate SOLN
- Metadate Er TBCR 20MG
- Methylphenidate Hcl ORAL TABS
- Methylphenidate Hcl Er ORAL CP24
- Methylphenidate Hcl Er ORAL TBCR 10MG, 20MG
- Methylphenidate Hcl Er (la)
- Methylphenidate Hcl Sr

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

TRELSTAR

Products Affected

- Trelstar Mixject

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Pregnancy
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

TRICYCLIC ANTIDEPRESSANTS-AGE EDIT

Products Affected

- Amitriptyline Hcl ORAL TABS
- Clomipramine Hcl ORAL CAPS
- Doxepin Hcl CONC
- Doxepin Hcl ORAL CAPS
- Imipramine Hcl ORAL TABS
- Trimipramine Maleate ORAL CAPS

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in patients 65 years of age or older.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

TRISENOX

Products Affected

- Trisenox

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

TYKERB

Products Affected

- Tykerb

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

TYSABRI

Products Affected

- Tysabri

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	(1) For Crohn's Disease: Concurrent use of immunosuppressants or TNF inhibitors, (2) Current or history of PML (Progressive Multifocal Leukoencephalopathy)
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurologist or gastroenterologist
Coverage Duration	Through end of plan contract year
Other Criteria	Documentation of ONE of the following: (1) diagnosis of Crohn's disease with an inadequate response or inability to tolerate Humira OR (2) diagnosis of Multiple Sclerosis with an inadequate response or inability to tolerate two of the following: interferon beta-1a (Rebif), fingolimod hydrochloride (Gilenya), glatiramer (Copaxone).

VALCHLOR

Products Affected

- Valchlor

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Members that have experienced disease progression while on mechlorethamine (Valchlor)
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or Dermatologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only. Patient has a diagnosis of Stage IA OR IB mycosis fungoides-type cutaneous T-cell lymphoma AND Patient has received one or more skin directed therapies, such as topical corticosteroids, phototherapy, Targretin gel, or topical nitrogen mustard.

VANCOMYCIN CAPSULES

Products Affected

- Vancomycin Hcl ORAL CAPS

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of past therapies and outcomes. Require white blood count and serum creatinine levels (current and premorbid).
Age Restrictions	N/A
Prescriber Restrictions	Infectious disease (consult and/or referral)
Coverage Duration	14 days
Other Criteria	N/A

VECTIBIX

Products Affected

- Vectibix INJ 100MG/5ML, 400MG/20ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	A documented diagnosis of metastatic colorectal carcinoma (mCRC) AND evidence of positive EGFR expression from primary tumor or metastatic tumor site AND documented K-ras (KRAS) mutation analysis to predict non-response.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

VELCADE

Products Affected

- Velcade

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Intrathecal administration
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

VENCLEXTA

Products Affected

- Venclexta
- Venclexta Starting Pack

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For CLL: patient has 17p deletion detected by an FDA approved test (e.g., Vysis CLL FISH Probe Kit) and has received at least one prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

VENTAVIS

Products Affected

- Ventavis

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of ALL of the following: (1) Diagnosis of pulmonary arterial hypertension (PAH) WHO Group I with New York Heart Association (NYHA) Functional Class III or IV symptoms (2) Diagnosis confirmed by catheterization (right-heart or Swan-Ganz) or echocardiography (3) Documentation of mean pulmonary artery pressure equal to or greater than 25 mm Hg at rest or greater than 30 mm Hg with exertion.
Age Restrictions	N/A
Prescriber Restrictions	Cardiologist or Pulmonologist
Coverage Duration	Through end of plan contract year
Other Criteria	Drug is also subject to a Part B versus Part D coverage determination.

VIDAZA

Products Affected

- Azacitidine

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Patients with advanced malignant hepatic tumors.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

VOTRIENT

Products Affected

- Votrient

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

VPRIV

Products Affected

- Vpriv

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

XALKORI

Products Affected

- Xalkori

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Treatment of patients with locally advanced or metastatic non-small cell lung cancer (NSCLC) that is anaplastic lymphoma kinase (ALK)-positive as detected by an FDA-approved test. Positive result confirming ALK using Vysis ALK Break Apart FISH Probe Kit or equivalent.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

XELJANZ

Products Affected

- Xeljanz
- Xeljanz Xr

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Recommended by a rheumatologist
Coverage Duration	Through end of plan contract year.
Other Criteria	Inadequate response or inability to tolerate adalimumab (Humira) AND etanercept (Enbrel) or documentation demonstrating that a trial may be inappropriate. Should not be used in combination with biologic DMARDs or potent immunosuppressants such as azathioprine and cyclosporine.

XGEVA

Products Affected

- Xgeva

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Hypocalcemia
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

XOLAIR

Products Affected

- Xolair

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For moderate to severe persistent asthma (NHLBI definition) meeting all the following criteria: (A) Evidence of reversible disease (12% or greater improvement in FEV1 with at least a 200ml increase or 20% or greater improvement in PEF as a result of a short-acting bronchodilator challenge) AND Evidence of specific allergic sensitivity to a perennial aeroallergen (positive skin test or in vitro test) AND Failure/contraindication/intolerance of an adequate trial of standard therapy as defined by a trial of at least a 3 month course of high-dose inhaled corticosteroids and long-acting beta2-agonists. Extended approval for 6 months if demonstrated benefit, meeting at least TWO of the following criteria: (1) PEF improvement OR (2) FEV1 improvement OR (3) reduction in symptoms (wheezing, shortness of breath, cough, chest tightness) OR (4) reduction in systemic corticosteroids and rescue drug use OR (5) reduction of asthma-related hospitalizations and other medical contacts. For chronic idiopathic urticarial: (B) in patients who remain symptomatic despite trial/intolerance/contraindication of two oral antihistamines, extended approval for patients who are no longer symptomatic after 6 months of treatment.
Age Restrictions	N/A
Prescriber Restrictions	Allergist, dermatologist, immunologist or pulmonologist
Coverage Duration	Initial: 6 months trial. Extended approval: 6 months if demonstrated benefit
Other Criteria	N/A

XTANDI

Products Affected

- Xtandi

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Pregnancy
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or urologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only. Covered following unsatisfactory effects or contraindication to Zytiga (abiraterone).

XYREM

Products Affected

- Xyrem

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concomitant use of sedative hypnotic agents AND members with succinic semialdehyde dehydrogenase deficiency
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

YERVOY

Products Affected

- Yervoy

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

YONDELIS

Products Affected

- Yondelis

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

ZALTRAP

Products Affected

- Zaltrap

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

ZAVESCA

Products Affected

- Zavesca

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

ZELBORAF

Products Affected

- Zelboraf

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Treatment of unresectable or metastatic malignant melanoma in patients with V600E mutation of the BRAF gene as detected by an FDA-approved test. Positive result confirming mutation using Cobas 4800 BRAF V600 Mutation Test or equivalent.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

ZEPATIER

Products Affected

- Zepatier

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Moderate or severe hepatic impairment (Child-Pugh B or C). Concomitant use with organic anion transporting polypeptides 1B1/3 (OATP1B1/3) inhibitors, strong inducers of cytochrome P450 3A (CYP3A), and efavirenz.
Required Medical Information	Confirmation of hepatitis C genotype. Previous hepatitis C treatment history (if any). Other medications that will be used with current AASLD/IDSA protocol (if any). Presence or absence of cirrhosis. If genotype 1a: testing for the presence of virus with NS5A resistance-associated polymorphisms will be performed.
Age Restrictions	N/A
Prescriber Restrictions	Infectious disease, gastroenterologist, hepatologist
Coverage Duration	Duration will be applied consistent with current AASLD/IDSA guidance.
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance.

ZOLINZA

Products Affected

- Zolinza

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

ZORTRESS

Products Affected

- Zortress

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only. Drug is also subject to a Part B versus Part D coverage determination.

ZYDELIG

Products Affected

- Zydelig

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	History of serious allergic reactions including anaphylaxis and toxic epidermal necrolysis
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

ZYKADIA

Products Affected

- Zykadia

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

ZYTIGA

Products Affected

- Zytiga

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Women who are or may become pregnant
Required Medical Information	Documentation that prednisone will be used in combination.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or urologist
Coverage Duration	Through end of plan contract year
Other Criteria	Applies to new starts only.

ZYVOX

Products Affected

- Linezolid
- Zyvox INJ 600MG/300ML
- Zyvox SUSR
- Zyvox TABS

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Not covered with concomitant use of MAOI therapy.
Required Medical Information	Documentation of ONE of the following: (1) initial treatment with vancomycin OR intravenous (IV) Zyvox (linezolid) while in the hospital/medical facility OR (2) Inadequate response or inability to tolerate TWO antibiotics to which the organism is susceptible or linezolid is the only antibiotic to which the organism is susceptible.
Age Restrictions	N/A
Prescriber Restrictions	Infectious Disease (consult and/or referral)
Coverage Duration	28 days
Other Criteria	Requests for Zyvox: Inadequate response or inability to tolerate generic linezolid

PART B VERSUS PART D

Products Affected

- Abelcet
- Acetylcysteine INHALATION SOLN
- Acyclovir Sodium INJ 50MG/ML
- Adriamycin INJ 2MG/ML
- Adrucil INJ 2.5GM/50ML, 500MG/10ML, 5GM/100ML
- Albuterol Sulfate INHALATION NEBU
- Alkeran TABS
- Ambisome
- Aminosyn INJ 148MEQ/L; 1280MG/100ML; 980MG/100ML; 1280MG/100ML; 300MG/100ML; 720MG/100ML; 940MG/100ML; 720MG/100ML; 400MG/100ML; 440MG/100ML; 5.4MEQ/L; 860MG/100ML; 420MG/100ML; 520MG/100ML; 160MG/100ML; 44MG/100ML; 800MG/100ML, 90MEQ/L; 1100MG/100ML; 850MG/100ML; 35MEQ/L; 1100MG/100ML; 260MG/100ML; 620MG/100ML; 810MG/100ML; 624MG/100ML; 340MG/100ML; 380MG/100ML; 5.4MEQ/L; 750MG/100ML; 370MG/100ML; 460MG/100ML; 150MG/100ML; 44MG/100ML; 680MG/100ML
- Aminosyn 7%/electrolytes
- Aminosyn 8.5%/electrolytes
- Aminosyn II INJ 50.3MEQ/L; 695MG/100ML; 713MG/100ML; 490MG/100ML; 517MG/100ML; 350MG/100ML; 210MG/100ML; 462MG/100ML; 700MG/100ML; 735MG/100ML; 120MG/100ML; 209MG/100ML; 505MG/100ML; 371MG/100ML; 31.3MEQ/L; 280MG/100ML; 140MG/100ML; 189MG/100ML; 350MG/100ML, 61.1MEQ/L; 844MG/100ML; 865MG/100ML; 595MG/100ML; 627MG/100ML; 425MG/100ML; 255MG/100ML; 561MG/100ML; 850MG/100ML; 893MG/100ML; 146MG/100ML; 253MG/100ML; 614MG/100ML; 450MG/100ML; 33.3MEQ/L; 340MG/100ML; 170MG/100ML; 230MG/100ML; 425MG/100ML, 71.8MEQ/L; 993MG/100ML; 1018MG/100ML; 700MG/100ML; 738MG/100ML; 500MG/100ML; 300MG/100ML; 660MG/100ML; 1000MG/100ML; 1050MG/100ML; 172MG/100ML; 298MG/100ML; 722MG/100ML; 530MG/100ML; 44.4MEQ/L; 400MG/100ML; 200MG/100ML; 270MG/100ML; 500MG/100ML
- Aminosyn II 8.5%/electrolytes
- Aminosyn M INJ 65MEQ/L; 448MG/100ML; 343MG/100ML; 40MEQ/L; 448MG/100ML; 105MG/100ML; 252MG/100ML; 329MG/100ML; 252MG/100ML; 3MEQ/L; 140MG/100ML; 154MG/100ML; 3.5MMOLE/L; 13MEQ/L; 300MG/100ML; 147MG/100ML; 40MEQ/L; 182MG/100ML; 56MG/100ML; 31MG/100ML; 280MG/100ML
- Aminosyn-hbc

- Aminosyn-pf INJ 46MEQ/L; 698MG/100ML; 1227MG/100ML; 527MG/100ML; 820MG/100ML; 385MG/100ML; 312MG/100ML; 760MG/100ML; 1200MG/100ML; 677MG/100ML; 180MG/100ML; 427MG/100ML; 812MG/100ML; 495MG/100ML; 3.4MEQ/L; 70MG/100ML; 512MG/100ML; 180MG/100ML; 44MG/100ML; 673MG/100ML
- Aminosyn-pf 7%
- Aminosyn-rf
- Amphotericin B INJ
- Aprepitant
- Atgam
- Azathioprine INJ
- Azathioprine TABS
- Bleo 15k
- Bleomycin Sulfate INJ
- Budesonide INHALATION SUSP 0.25MG/2ML, 0.5MG/2ML, 1MG/2ML
- Cellcept Intravenous
- Cladribine
- Clinisol Sf 15%
- Cromolyn Sodium NEBU
- Cyclophosphamide ORAL CAPS
- Cytarabine Aqueous
- Dextrose 20%
- Dextrose 25% INJ 250MG/ML
- Dextrose 30%
- Dextrose 40%
- Dextrose 50%
- Dextrose 70%
- Doxorubicin Hcl INJ 10MG, 2MG/ML, 50MG
- Duramorph
- Emend ORAL CAPS
- Emend SUSR
- Engerix-b
- Envarsus Xr
- Fluorouracil INJ 1GM/20ML, 2.5GM/50ML
- Freamine III INJ 89MEQ/L; 710MG/100ML; 950MG/100ML; 3MEQ/L; 24MG/100ML; 1400MG/100ML; 280MG/100ML; 690MG/100ML; 910MG/100ML; 730MG/100ML; 530MG/100ML; 560MG/100ML; 10MMOLE/L; 120MG/100ML; 1120MG/100ML; 590MG/100ML; 10MEQ/L; 400MG/100ML; 150MG/100ML; 660MG/100ML
- Ganciclovir INJ
- Granisetron Hcl TABS
- Hecoria
- Hepatamine
- Hydromorphone Hcl INJ 10MG/ML, 1MG/ML, 2MG/ML, 4MG/ML, 50MG/5ML
- Imovax Rabies (h.d.c.v.)
- Intralipid INJ 20GM/100ML, 30GM/100ML
- Ipratropium Bromide INHALATION SOLN 0.02%
- Ipratropium Bromide/albuterol Sulfate
- Kabiven
- Levalbuterol
- Levalbuterol Hcl INHALATION NEBU
- Morphine Sulfate INJ 0.5MG/ML, 10MG/ML, 10MG/ML, 150MG/30ML, 15MG/ML, 15MG/ML, 1MG/ML, 1MG/ML, 25MG/ML, 2MG/ML, 4MG/ML, 50MG/ML, 5MG/ML, 8MG/ML, 8MG/ML
- Mycophenolate Mofetil
- Nebupent
- Nephramine
- Nutrilipid
- Ondansetron Hcl ORAL SOLN
- Ondansetron Hcl ORAL TABS
- Ondansetron Odt
- Perikabiven
- Plenamine

- Premasol
- Prograf INJ
- Pulmozyme
- Rabavert
- Rapamune SOLN
- Recombivax Hb
- Simulect
- Sirolimus ORAL TABS
- Tacrolimus ORAL CAPS
- Temodar INJ
- Thymoglobulin
- Tobramycin NEBU
- Tpn Electrolytes
- Travasol INJ 52MEQ/L; 1760MG/100ML; 880MG/100ML; 34MEQ/L; 1760MG/100ML; 372MG/100ML; 406MG/100ML; 526MG/100ML; 492MG/100ML; 492MG/100ML; 526MG/100ML; 356MG/100ML; 356MG/100ML; 390MG/100ML; 34MG/100ML; 152MG/100ML
- Trophamine INJ 97MEQ/L; 0.54GM/100ML; 1.2GM/100ML; 0.32GM/100ML; 0; 0; 0.5GM/100ML; 0.36GM/100ML; 0.48GM/100ML; 0.82GM/100ML; 1.4GM/100ML; 1.2GM/100ML; 0.34GM/100ML; 0.48GM/100ML; 0.68GM/100ML; 0.38GM/100ML; 5MEQ/L; 0.025GM/100ML; 0.42GM/100ML; 0.2GM/100ML; 0.24GM/100ML; 0.78GM/100ML
- Vinblastine Sulfate INJ 1MG/ML
- Vincasar Pfs
- Vincristine Sulfate INJ

Details

This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.