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.