2016 Prior Authorization Criteria
Effective: 03/01/2016
Last Updated: 03/2016

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	N/A

ADAGEN

Products Affected

- Adagen

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Contraindicated in bone marrow transplantation and in patients with severe thrombocytopenia due to increased risk of bleeding.
Required Medical Information	Adenosine deaminase deficiency in patients with severe combined immunodeficiency disease who are not suitable candidates for or who have failed bone marrow transplantation.
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	For the diagnosis of pulmonary hypertension, the member has had a documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of the following preferred alternatives, 1) a PDE-5 inhibitor (such as sildenafil) AND 2) Tracleer or Opsumit.

AFINITOR

Products Affected

- Afinitor
- Afinitor Disperz

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	For advanced renal cell carcinoma, prior therapy with Sutent (sunitinib) or Nexavar (sorafenib). For postmenopausal women with advanced hormone receptor-positive, HER2-negative breast cancer (advanced HR+ BC), Afinitor is being used in combination with exemestane after failure of treatment with letrozole or anastrozole. There are no additional requirements for advanced neuroendocrine tumors of the pancreatic origin, renal angiomyolipoma with tuberous sclerosis complex and subependymal giant cell astrocytoma with tuberculous sclerosis complex.

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 FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For metastatic (NSCLC): progressed on or intolerance to crizotinib (Xalkori).
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

ALIMTA

Products Affected

- Alimta

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	Requests for new starts are covered with malignant mesothelioma of pleura in combination with cisplatin in patients who are not candidates for surgical resection. Requests for new starts are covered with non-small cell lung cancer, locally advanced or metastatic, only after prior chemotherapy OR for non-small cell lung cancer as initial therapy in combination with cisplatin for locally advanced or metastatic disease OR as maintenance therapy for patients whose disease has not progressed after four cycles of platinum-based first-line chemotherapy.

ALPHA1-PROTEINASE INHIBITORS

Products Affected

- Prolastin-c

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	N/A

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 Androgel will not be required to provide labs and can be approved as continuation of therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

ANTIDEPRESSANTS-AGE EDIT

Products Affected

- Amitriptyline Hcl ORAL TABS
- Clomipramine Hcl ORAL CAPS
- Doxepin Hcl CONC
- Doxepin Hcl ORAL CAPS
- Imipramine Hcl ORAL TABS
- Surmontil
- 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	N/A

ANTIHISTAMINES-AGE EDIT

Products Affected

- Clemastine Fumarate SYRP
- Clemastine Fumarate TABS 2.68MG
- Diphenhydramine Hcl INJ
- 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	N/A

ANTISPASMOTICS-AGE EDIT

Products Affected

- Dicyclomine 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

APOKYN

Products Affected

- Apokyn

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	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 adjunct therapy for partial-onset seizure disorder are covered with documentation that the patient is currently on an anticonvulsant (including lamotrigine, phenytoin, divalproex, levetiracetam, gabapentin, carbamazepine, topiramate, zonisamide).

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 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 11g/dL.

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

ARISTADA

Products Affected

- Aristada

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

ARZERRA

Products Affected

- Arzerra

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	N/A

ATGAM

Products Affected

- Atgam

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	Drug is also subject to a Part B versus Part D coverage determination.

AVASTIN

Products Affected

- Avastin

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For metastatic colorectal cancer: Used in combination with fluorouracil (5FU) based chemotherapy. For non-squamous non-small cell lung cancer: Used in combination with carboplatin and paclitaxel for first line treatment of unresectable, locally advanced, recurrent or metastatic disease. For Glioblastoma: Patient has progressive disease. For metastatic renal cell carcinoma: Used in combination with interferon alfa. For persistent, recurrent or metastatic carcinoma of the cervix used in combination with paclitaxel and cisplatin or paclitaxel and topotecan. For patients with platinum-resistant recurrent epithelial ovarian, fallopian tube or primary peritoneal cancer who received no more than 2 prior chemotherapy regimens: Used in combination with paclitaxel, pegylated liposomal doxorubicin or topotecan.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

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	Requests for new starts are covered following a trial and failure of lamotrigine (unless lamotrigine is otherwise contraindicated). Only approved as adjunctive therapy.

BELEODAQ

Products Affected

- Beleodaq

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 the plan contract year
Other Criteria	For patients with a diagnosis of peripheral T-cell lymphoma (PTCL), patient has relapsed or is refractory to prior therapies.

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 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	N/A

BOSULIF

Products Affected

- Bosulif

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	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 Gleevic (imatinib) or Sprycel (dasatinib).

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: 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). In all patients with neonatal-onset deficiency (complete enzymatic deficiency, presenting within the first 28 days of life). 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

- Butalbital Compound/codeine
- Butalbital/acetaminophen/caffeine ORAL CAPS
- Butalbital/acetaminophen/caffeine TABS 325MG; 50MG; 40MG
- Butalbital/acetaminophen/caffeine/codeine
- Butalbital/aspirin/caffeine
- 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

CAPRELSA

Products Affected

- Caprelsa

PA Criteria	Criteria Details
Covered Uses	All FDA-approved 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	N/A

CARDIOVASCULAR-AGE EDIT

Products Affected

- Disopyramide Phosphate
- 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

CELLCEPT

Products Affected

- Cellcept SUSR
- Cellcept Intravenous
- Mycophenolate Mofetil

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	Drug is also subject to a Part B versus Part D coverage determination.

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

CIMZIA

Products Affected

- Cimzia
- Cimzia Starter 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	Gastroenterologist, Rheumatologist or Dermatologist
Coverage Duration	Through end of plan contract year
Other Criteria	Diagnosis of Crohn's disease and prior use of one of the following: Corticosteroids (ex. prednisone, budesonide, ethylprednisolone), mercaptopurine, azathioprine (Imuran) OR moderate to severe rheumatoid arthritis and failure of one non-biological DMARD (Auranofin, Azathioprine, Cyclosporine, Gold Sodium Thiomalate, Hydroxychloroquine, Leflunomide, Methotrexate, Minocycline, Penicillamine, Sulfasalazine) for 1 month. For psoriatic arthritis: Require documentation of an inadequate response to either MTX or other DMARD. For ankylosing spondylitis: Require documentation of inadequate response to maximum tolerated doses of at least (2) non-steroidal anti-inflammatory drugs (NSAIDs).

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 Diagnosis of HAE is documented based on evidence of a normal C1 level and a low C4 level (C4 less than 14 mg/dL normal range 14 to 40 mg/dL), or C4 below the lower limit of normal as defined by the laboratory performing the test) plus: A low C1 inhibitor (C1INH) antigenic level (C1INH less than 19 mg/dL normal range 19 to 37 mg/dL, or C1INH antigenic level below the lower limit of normal as defined by the laboratory performing the test) OR A normal C1INH antigenic level (C1INH greater than or equal to 19 mg/dL) and a low C1INH functional level (functional C1INH less than 50% or C1INH functional level below the lower limit of normal as defined by the laboratory performing the test) OR A known HAE-causing C1INH mutation. Medications known to cause angioedema (i.e. ACE-Inhibitors, estrogens, angiotensin II receptor blockers) have been evaluated and discontinued when appropriate. Member has tried and failed or is intolerant to or has a contraindication to danazol.
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) use only. CMS endorsed compendia do not support inhalation/nebulization of colistimethate.

COMETRIQ

Products Affected

- Cometriq

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	N/A

COPAXONE

Products Affected

- Copaxone
- Glatopa

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 definite or probable relapsing-remitting MS, secondary progressive MS with relapses or progressive relapsing MS. Direct statement from a neurologist that diagnosis is a relapsing form of MS or a first MS attack with documented MRI scan abnormalities characteristic of MS OR evaluation documenting EITHER: history of at least two focal neurological deficits (e.g. loss of vision, double vision, localized numbness or weakness) in which the first resolved and the second followed after a period of at least 6 months OR History of one focal neurological deficit which has resolved and an MRI suggestive of MS: At least 3 total lesions, each at least 5mm: At least one lesion with contrast enhancement: At least 2 out of 3 lesions in either, Periventricular white matter OR Brain stem (e.g., cerebellar penducle, pons) OR (3) Spinal cord.
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	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	Failure of 1 month of ACE Inhibitor or ACE Inhibitor/HCTZ combination or Angiotensin-Receptor Blocker or Angiotensin-Receptor Blocker/HCTZ combination AND one of the following beta blockers: bisoprolol/bisoprolol-HCTZ, carvedilol, carvedilol CR, metoprolol succinate/metoprolol succinate-HCTZ, nevibolol.

COTELLIC

Products Affected

- Cotellic

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For unresectable or metastatic melanoma: confirmation of BRAF V600E or V600K mutation.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	For unresectable or metastatic melanoma with a BRAF V600E or V600K mutation: Must be used with vemurafenib (Zelboraf).

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	Plaque psoriasis (Severe) AND prior therapy of one of the following- cyclosporine or methotrexate or methoxsalen with UVA light (PUVA) OR rheumatoid arthritis (severe) AND prior therapy of methotrexate. Drug is also subject to a Part B versus Part D coverage determination.

CYRAMZA

Products Affected

- Cyramza

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	For patients with advanced or metastatic, gastric or gastro-esophageal junction adenocarcinoma: Patient has had disease progression on or after prior fluoropyrimidine- or platinum-containing chemotherapy. For Non-Small Cell Lung cancer: Used in combination with docetaxel.

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 FDA-approved 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	N/A

DEFERASIROX

Products Affected

- Exjade

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Deferasirox is indicated for the treatment of chronic iron overload due to blood transfusions (transfusional hemosiderosis) when the patient is receiving transfusions and has a serum ferritin consistently above 1000 mcg/L. Deferasirox is also covered when used for the indication of the treatment of chronic iron overload with non-transfusion-dependent thalassemia syndromes who have liver iron concentrations of at least 5 mg Fe/g dry weight and serum ferritin levels greater than 300 mcg/L. Coverage for this diagnosis is approved based upon laboratory values and when verified as not being used in combination with other iron chelators since safety has not been established.
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.

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 granisitron. 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	N/A

EMPLICITI

Products Affected

- Empliciti

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 previous treatment history.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or hematologist.
Coverage Duration	Through end of plan contract year.
Other Criteria	For multiple myeloma: must be used in combination with lenalidomide and dexamethasone.

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

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 FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	A documented diagnosis of colorectal cancer AND both of the below-documented evidence of positive EGFR expression from primary tumor or metastatic tumor site AND documented K-ras (KRAS) mutation analysis to predict non-response. There are no additional requirements for squamous cell carcinoma of the head and neck.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

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	N/A

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	For diagnosis of locally advanced basal cell carcinoma that has recurred following surgery or patient is not candidate for surgery or radiation. For Metastatic basal cell carcinoma, no additional information required.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

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	Patient has developed hypersensitivity to E. coli-derived asparaginase.

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 IPF.
Age Restrictions	N/A
Prescriber Restrictions	Pulmonologist
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

ESTROGEN-AGE EDIT

Products Affected

- Estradiol ORAL TABS
- Estradiol TRANSDERMAL PTTW
- Estradiol TRANSDERMAL PTWK
- Estradiol/norethindrone Acetate
- Jinteli
- Lopreeza
- Menest
- Mimvey
- Mimvey Lo
- Norethindrone Acetate/ethinyl Estradiol TABS 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	N/A

EVZIO

Products Affected

- Evzio

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

EXTAVIA

Products Affected

- Extavia

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 definite or probable relapsing-remitting MS, secondary progressive MS with relapses, or progressive relapsing MS. Direct statement from a neurologist that diagnosis is a relapsing form of MS, or a first MS attack with documented MRI scan abnormalities characteristic of MS. Or evaluation documenting EITHER: history of at least two focal neurological deficits (e.g. loss of vision, double vision , localized numbness or weakness), in which the first resolved and the second followed after a period of at least 6 months, OR History of one focal neurological deficit which has resolved, and an MRI suggestive of MS: At least 3 total lesions, each at least 5mm: At least one lesion with contrast enhancement: At least 2 out of 3 lesions in either, Periventricular white matter OR Brain stem (e.g., cerebellar penducle, pons) OR (3) Spinal cord.
Age Restrictions	N/A
Prescriber Restrictions	Neurologist
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

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	For multiple myeloma: Must be used with bortezomib and dexamethasone.

FASLODEX

Products Affected

- Faslodex

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Breast cancer: Treatment of hormone receptor-positive metastatic breast cancer in postmenopausal women with disease progression following antiestrogen therapy.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

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 must have a diagnosis of HAE and where diagnosis is documented by documented based on evidence of a normal C1 level and a low C4 level (C4 less than 14 mg/dL normal range 14 to 40 mg/dL, or C4 below the lower limit of normal as defined by the laboratory performing the test) plus: a) A low C1 inhibitor (C1INH) antigenic level (C1INH less than 19 mg/dL normal range 19 to 37 mg/dL or C1INH antigenic level below the lower limit of normal as defined by the laboratory performing the test) OR b) A normal C1INH antigenic level (C1INH greater than or equal to 19 mg/dL) and a low C1INH functional level (functional C1INH less than 50%, or below the lower limit of normal as defined by the laboratory performing the test) and Member must be experiencing at least one symptom of the moderate or severe attack (e.g., airway swelling, severe abdominal pain, facial swelling, nausea and vomiting, painful facial distortion) and Medications known to cause angioedema (i.e. ACE-Inhibitors, estrogens, angiotensin II receptor blockers) have been evaluated and discontinued when appropriate.
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	Requests for new starts in patients with prostate cancer will be covered following a trial of Trelstar (unless Trelstar is otherwise contraindicated).

FORTEO

Products Affected

- Forteo

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.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	2 years from initiation of therapy
Other Criteria	For postmenopausal women with osteoporosis at high risk for fracture and men with primary or hypogonadal osteoporosis, require documentation of trial and failure on at least one first-line therapy (alendronate, Evista or ibandronate) or documentation of intolerance to at least two first-line therapies. For patients with glucocorticoid induced osteoporosis, require documentation of trial and failure to alendronate or documented intolerance to alendronate.

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	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	Requests for adjunct therapy for partial seizure disorder are covered with documentation that the patient is currently on an anticonvulsant such as carbamazepine, divalproex, gabapentin, lamotrigine, levetiracetam, oxcarbazepine, phenytoin, topiramate, valproic acid, or zonisamide.

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 FDA-approved 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	CLL is previously untreated. Gazyva will be used in combination with chlorambucil.

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	A documented epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 (L858R) substitution mutation as detected by an FDA-approved test.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

GLEEVEC

Products Affected

- Gleevec

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Chronic myeloid leukemia (CML) and acute lymphoblastic leukemia (ALL) must be positive for the Philadelphia chromosome or BCR-ABL gene. For CML, patient meets one of the following: 1) newly diagnosed, 2) resistance or intolerance to prior therapy, or 3) recurrence after stem cell transplant. For ALL, patient meets one of the following: 1) newly diagnosed and Gleevec is used in combination with chemotherapy, or 2) ALL is relapsed or refractory. For Kit (CD117) positive GIST, patient meets one of the following: 1) unresectable, recurrent, or metastatic disease, or 2) use of Gleevec for adjuvant therapy following resection, or 3) use of Gleevec for pre-operative therapy and patient is at risk for significant surgical morbidity. Myelodysplastic/myeloproliferative diseases (MDS/MPD) associated with PDGFR (platelet-derived growth factor receptor) gene re-arrangements. Aggressive systemic mastocytosis without the D816V c-Kit mutation or with c-Kit mutational status unknown. Hypereosinophilic syndrome (HES) and/or chronic eosinophilic leukemia (CEL) who have the FIP1L1-PDGFRα fusion kinase (mutational analysis or FISH demonstration of CHIC2 allele deletion) and for patients with HES and/or CEL who are FIP1L1-PDGFRα fusion kinase negative or unknown. Unresectable, recurrent and/or metastatic dermatofibrosarcoma protuberans,
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

HALAVEN

Products Affected

- Halaven

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	A documented diagnosis of metastatic breast cancer AND documented prior therapy with both an anthracycline (i.e. daunorubicin, bleomycin), and a taxane (i.e. paclitaxel, docetaxel).

HARVONI

Products Affected

- Harvoni

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 genotype 1a, 1b, 4, 5, or 6. Previous hepatitis C treatment history (if any). Other medications that will be used with Harvoni. Presence or absence of cirrhosis.
Age Restrictions	N/A
Prescriber Restrictions	Infectious disease, gastroenterologist, hepatologist
Coverage Duration	12-24 weeks depending on previous treatment history and cirrhosis status.

Other Criteria	Approval will be granted when ONE of the following is met: (A)Chronic Hepatitis C Virus infection (HCV) genotype 1a, 1b, 4, 5, or 6 AND member is treatment naive with or without cirrhosis: 12 weeks total OR (B) HCV genotype 1 or 4 AND member has infection in the allograft including compensated cirrhosis and is unable to take ribavirin: 24 weeks total OR (C) HCV genotype 1a or 1b AND member has cirrhosis AND has failed prior treatment with a sofosbuvir-containing regimen AND will be used in conjunction with ribavirin (RBV): 24 weeks total OR (D) HCV genotype 1a or 1b AND member has cirrhosis AND has failed prior treatment with HCV Protease Inhibitor (PI) simeprevir plus sofosbuvir: 24 weeks total OR (E) HCV genotype 1a or 1b AND member has infection in the allograft including compensated cirrhosis and has failed prior treatment with PEG/RBV: 24 weeks total OR (F) HCV genotype 1a or 1b AND member has decompensated cirrhosis AND has failed prior treatment with a sofosbuvir-containing regimen: 24 weeks total OR (G) HCV genotype 1a or 1b AND member has compensated cirrhosis AND has failed prior treatment with PEG/RBV: 24 weeks total OR (H) HCV genotype 1a or 1b AND member has no cirrhosis AND has failed prior treatment with a regimen containing sofosbuvir plus RBV with or without PEG: 12 weeks total OR (I) HCV genotype 1a or 1b AND member has cirrhosis AND has failed prior treatment with PEG/RBV AND will be used in conjunction with RBV: 12 weeks total (J) All other regimens for HCV genotype 1a or 1b not included in criteria (A) through (I) will be approved for 12 weeks total OR (K) HCV genotype 4 AND member has decompensated cirrhosis and has failed prior treatment with sofosbuvir AND will be used in conjunction with RBV : 24 weeks OR (L) HCV genotype 4, 5 or 6 AND member is either treatment naive or has failed prior treatment with PEG/RBV AND irrespective of presence/absence of cirrhosis or co-administration of other medications: 12 weeks total OR (M) All other regimens for HCV genotype 4 not included in criteria (A) through (L) will be approved for 12 weeks total.

HERCEPTIN

Products Affected

- Herceptin

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). As part of a regimen for the adjuvant treatment of HER2-overexpressing, breast cancer. As first-line therapy for metastatic HER2 positive breast cancer in combination with paclitaxel. As a single agent, for the adjuvant treatment of HER2-overexpressing node-negative (ER/PR negative or with one high-risk feature) or node positive breast cancer, following multi-modality anthracycline based therapy. As a single agent for the treatment of HER2-overexpressing breast cancer in patients who have received one or more chemotherapy regimens for metastatic disease. As a single agent for the treatment of HER2-overexpressing breast cancer in patients who have received one or more chemotherapy regimens for metastatic disease. As part of a regimen for HER2-positive esophageal or gastric cancer. As first line treatment for HER2 overexpressing metastatic gastric or gastroesophageal junction adenocarcinoma in combination with cisplatin and either capecitabine (Xeloda) or 5-FU.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

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	N/A
Required Medical Information	For the treatment of adult patients with moderate to severe chronic plaque psoriasis: PASI score of 10 or more. For continuation of therapy, patient's condition must have improved or stabilized. For continuation therapy in plaque psoriasis, patient has shown a 50% reduction in baseline PASI score and dose requested does not exceed the FDA maximum dose.
Age Restrictions	N/A
Prescriber Restrictions	Rheumatologist, Dermatologist or Gastroenterologist
Coverage Duration	12 weeks for plaque psoriasis, 6 months for other indications. Then annual review.
Other Criteria	For the treatment of moderate to severe chronic plaque psoriasis: Documentation of trial of at least one non-biologic therapies, such as phototherapy, MTX, acitretin or cyclosporine.

HYDROXYZINE-AGE EDIT

Products Affected

- Hydroxyzine Hcl INJ

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

IBRANCE

Products Affected

- Ibrance

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documented diagnosis of advanced estrogen receptor-positive, HER2-negative breast cancer (advanced ER+ BC) in a postmenopausal female AND used in combination with letrozole.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

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	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 Autoinflammatory 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	N/A

IMMUNE GLOBULIN

Products Affected

- Gamastan S/d
- Gammaplex

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	Drug is also subject to a Part B versus Part D coverage determination.

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 has one of the following conditions: 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) AND Child has severe growth retardation with height standard deviation score (SDS) more than 3 SDS below the mean for chronological age and sex AND Child with IGF-1 level greater than or equal to 3 standard deviations below normal based on lab reference range for age and sex AND Child with normal or elevated growth hormone (GH) levels based on at least one growth hormone stimulation test AND Evidence of open epiphyses.
Age Restrictions	N/A
Prescriber Restrictions	Pediatrician 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	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.

INTRON-A

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Autoimmune hepatitis. Decompensated liver disease
Required Medical Information	For malignant melanoma: Adjuvant to surgical treatment with malignant melanoma who are free of disease but are at high risk for systemic recurrence within 56 days of surgery. For the initial treatment of clinically aggressive follicular non-Hodgkin lymphoma, used in conjunction with anthracycline-containing combination chemotherapy. Chronic hepatitis C: In patients with compensated liver disease who have a history of blood or blood product exposure and/or patients who are hepatitis C virus (HCV)-antibody-positive. Chronic hepatitis B: In patients with compensated liver disease and patients must be serum HBsAg-positive for at least 6 months and have HBV replication (serum HBeAg-positive) with elevated serum ALT.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

IRESSA

Products Affected

- Iressa

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For metastatic non-small cell lung cancer (NSCLC): patient's tumors have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations as detected by an FDA-approved test.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

ISTODAX

Products Affected

- Istodax

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	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	For the diagnosis of oropharyngeal or esophageal candidiasis, the solution will be used. For oropharyngeal or esophageal candidiasis, patient has failed fluconazole. 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. 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	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	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	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	N/A

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	For the diagnosis of unresectable or metastatic melanoma, the member has disease progression following ipilimumab (Yervoy) AND if the member is BRAF V600 mutation positive, member has disease progression following a BRAF inhibitor (i.e., trametinib dimethyl sulfoxide (Mekinist), dabrafenib mesylate (Tafinlar), vemurafenib (Zelboraf)).
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

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. Kuvan is to be used in conjunction with a Phe-restricted diet. 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 Documented compliance with a Phe-restricted diet 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 Documented compliance with a Phe-restricted diet AND Still under the appropriate care and re-evaluations of a specialist knowledgeable in the management of PKU.
Age Restrictions	N/A
Prescriber Restrictions	Endocrinologist
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.

LENVIMA

Products Affected

- Lenvima 10mg Daily Dose
- Lenvima 14mg Daily Dose
- Lenvima 20mg Daily Dose
- Lenvima 24mg 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	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
- Lupron Depot-ped

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	Requests for new starts in patients with prostate cancer will be covered following a trial of Trelstar (unless Trelstar is otherwise contraindicated).

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 FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For diagnosis of metastatic colorectal cancer, patient has been previously treated with fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy, an anti-VEGF biological therapy and for patients with RAS wild-type, patient has been previously treated with an anti-EGFR therapy.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

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	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	For neuropathic pain associated with diabetic peripheral neuropathy: a documented trial, failure, or contraindication of duloxetine (Cymbalta). For postherpetic neuralgia: a documented trial, failure, or contraindication of gabapentin. For partial seizures: a documented trial, failure, or contraindication of gabapentin. For fibromyalgia: a documented trial, failure, or contraindication of duloxetine (Cymbalta). For neuropathic pain associated with spinal cord injury, no prerequisite therapy is required.

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	N/A

MEKINIST

Products Affected

- Mekinist

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 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	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

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 patients with Pneumocystis pneumonia will be covered following a trial and failure of co-trimoxazole (SMZ/TMP). Request for prevention of Pneumocystis jiroveci pneumonia will be covered following a trial and failure of co-trimoxazole (SMZ/TMP).

MODAFINIL

Products Affected

- Modafinil

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Require diagnosis for excessive daytime sleepiness associated with narcolepsy. For treatment of excessive daytime sleepiness associated with obstructive sleep apnea (OSA) when the patient meets the following criteria: (1) A Standard Diagnostic Nocturnal Polysomnography (NPSG) has confirmed the diagnosis of OSA and meets ICSD or DSM diagnostic criteria AND (2) that the daytime fatigue is significantly impacting, impairing, or compromising the patient's ability to function normally AND (3) the prescribing physician has established a patient care plan to treat the cause of OSA in conjunction with treating the daily fatigue. For shift work sleep disorder (SWSD): Require confirmed 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	Board certified as a sleep specialist, ear, nose and throat, neurologist or pulmonologist or has obtained a consult from a board certified sleep specialist.
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

MUSCLE RELAXANTS-AGE EDIT

Products Affected

- Chlorzoxazone
- 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

NALOXONE

Products Affected

- Narcan

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

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	N/A

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 FDA-approved 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	N/A

NINLARO

Products Affected

- Ninlaro

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 previous treatment history.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	Through end of plan contract year.
Other Criteria	For multiple myeloma: must be used in combination with lenalidomide and dexamethasone.

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 hypothalmus 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 then 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

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 oropharygeal 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	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	Documented diagnosis of of prophylaxis of organ rejection in kidney transplant in combination with basiliximab (Simulect) during induction therapy and used concurrently with mycophenolate mofetil and corticosteroids. Drug is also subject to a Part B versus Part D coverage determination.

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 FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For diagnosis of locally advanced basal cell carcinoma that has recurred following surgery or patient is not candidate for surgery or radiation.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

OPDIVO

Products Affected

- Opdivo

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For the diagnosis of unresectable or metastatic melanoma, the member has disease progression following ipilimumab (Yervoy) AND if the member is BRAF V600 mutation positive, member has disease progression following a BRAF inhibitor (i.e., Mekinist (trametinib), Tafinlar (dabrafenib), Zelboraf (vemurafenib)). For Metastatic squamous non-small cell lung cancer (NSCLC): patient has had progression on or after platinum based chemotherapy (for example cisplatin or carboplatin).
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

OPSUMIT

Products Affected

- Opsumit

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Pregnancy
Required Medical Information	Approval may be granted for the treatment of pulmonary hypertension in patients when the patient has been diagnosed with primary pulmonary hypertension OR the patient has been diagnosed with secondary pulmonary hypertension due to scleroderma, sclerosis or autoimmune disease. The patient is WHO Group I and patient has WHO functional class II to IV symptoms. 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	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).

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	Will be used as an adjunct to dietary restriction of tyrosine and phenylalanine in the treatment of hereditary tyrosinemia type 1.
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	N/A
Coverage Duration	Through end of plan contract year.
Other Criteria	N/A

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	Documentation to support diagnosis for use as follows: Bone pain: For the relief of the bone pain frequently accompanying osteoporosis. Protein catabolism: To offset the protein catabolism associated with prolonged administration of corticosteroids.
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 INJ 120MCG/0.5ML, 150MCG/0.5ML, 80MCG/0.5ML
- Peg-intron INJ 50MCG/0.5ML
- 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 with Pegasys. 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 FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	A documented diagnosis of HER2-positive metastatic breast cancer for patients who have not received prior anti-HER2 therapy or chemotherapy AND taken in combination with trastuzumab and docetaxel. Patient has not received prior anti-HER2 therapy or chemotherapy for metastatic disease.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

PHENOBARBITAL-AGE EDIT

Products Affected

- Phenobarbital ELIX
- Phenobarbital 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

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	N/A

PORTRAZZA

Products Affected

- Portrazza

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For metastatic squamous NSCLC: Confirmation of combination use with gemcitabine and cisplatin.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
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 (eg 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	Platelet count. Documented diagnosis of chronic, relapsed or refractory idiopathic thrombocytopenic purpura OR for the initiation and maintenance of interferon-based therapy in patients with chronic hepatitis C whose degree of thrombocytopenia prevents the initiation of interferon-based therapy or limits the ability to maintain interferon-based therapy. Documentation of concomitant hepatitis C treatment regimen.
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 AND the patient is not being treated with a direct acting antiviral such as boceprevir (Victrelis). 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	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). 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	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

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

RAPAMUNE

Products Affected

- Rapamune SOLN
- Sirolimus 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	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.

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

REGRANEX

Products Affected

- Regranex

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 lower-extremity diabetic neuropathic ulcers that extend into the subcutaneous tissue or beyond and have an adequate blood supply. To be used as an adjunct to, and not a substitute for, good ulcer care practices including initial sharp debridement, pressure relief and infection control. Confirmed underlying diagnosis/status of diabetes either by history of current diabetic medical treatment or labs provided by the prescriber. Documentation of a wound care plan. Ulcer description of the following: located on the lower extremity, extends into the subcutaneous tissue or beyond, and has adequate blood supply. Reapproval requires 30% 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 FDA-approved 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 50% 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	Initially- 6 months: Extended authorization -Annually based on documented therapeutic response.
Other Criteria	Moderate to severe active Crohn's disease AND inadequate response to one corticosteroid (ex. prednisone, budesonide, methylprednisolone) OR severe chronic plaque psoriasis AND prior use of one of the following- cyclosporine or methotrexate or methoxsalen with UVA light (PUVA) OR active psoriatic arthritis AND prior use of one corticosteroid (ex. dexamethasone, methylprednisolone) OR moderate to severe rheumatoid arthritis AND concomitant treatment with methotrexate OR moderate to severe active ulcerative colitis AND inadequate response to one 5-aminosalicylic acid product (5-ASA ex. sulfasalazine, mesalamine, balsalazide) or one corticosteroid (ex. prednisone, methylprednisolone). For ankylosing spondylitis: Require documentation of inadequate response to maximum tolerated doses of at least (2) non-steroidal anti-inflammatory drugs (NSAIDs).

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 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). Drug is also subject to a Part B versus Part D coverage determination.

REVLIMID

Products Affected

- Revlimid

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.
Required Medical Information	Covered for patients with transfusion-dependent anemia in low- or intermediate-1 risk MDS with a 5 q (q31-33) cytogenetic abnormality, OR for members with no 5q deletion that have failed or have a contraindication to erythropoietin therapy. 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. For the diagnosis of multiple myeloma patient is taking in combination with dexamethasone. For the diagnosis of mantle cell lymphoma (MCL) documentation that disease has relapsed or progressed after two prior therapies, one of which included bortezomib (Velcade).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	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.

RIBAVIRIN

Products Affected

- Moderiba TABS
- Ribavirin CAPS
- Ribavirin TABS

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Ribavirin combination therapy is contraindicated in: women who are or may become pregnant, men whose female partners are pregnant, patients with autoimmune hepatitis, patients with hemoglobinopathies (e.g., thalassemia major, sickle-cell anemia), patients with creatinine clearance less than 50 mL/min.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	Diagnosis of hepatitis C (non-A, non-B hepatitis) AND compensated liver disease AND is being used in combination with other anti-hepatitis agents.

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	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	For the diagnosis of rheumatoid arthitis, Rituxan is being used in combination with methotrexate AND patient has had an inadequate response to Remicade. For diagnosis of previously untreated and previously treated CD20-positive Chronic Lymphocytic Leukemia (CLL) used in combination with fludarabine and cyclophosphamide (FC). For diagnosis of Granulomatosis with Polyangiitis (GPA) (Wegener's Granulomatosis) and Microscopic Polyangiitis (MPA) used in combination with glucocorticoids.

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	For complex partial seizure disorder: Require documentation that the patient is currently stable on Sabril therapy OR that the patient is currently receiving another antiepileptic drug AND the patient has experienced treatment failure from two previous agents (antiepileptics include lamotrigine, phenytoin, divalproex, levetiracetam, gabapentin, carbamazepine, topiramate, zonisamide).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

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 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). Sildenafil citrate-PAH is only approved for 20 mg three times a day.

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	N/A
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	N/A

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	N/A

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 reauthororization 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	Not covered in pregnant females.
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: methotexate, DMARD or cyclosporine.

SOVALDI

Products Affected

- Sovaldi

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 genotype, previous hepatitis C treatment history, other medications that will be used with Sovaldi. Whether or not the member is Peg-ineligible*: A member is considered PEG-ineligible* when the member has one or more of the following: Intolerance to interferon, Autoimmune hepatitis and other autoimmune disorders, Hypersensitivity to PEG or any of its components, Decompensated hepatic disease, Major uncontrolled depressive illness, A baseline neutrophil count below 1500/µL, a baseline platelet count below 90,000/µL or baseline hemoglobin below 10 g/dL, a history of preexisting cardiac disease.
Age Restrictions	N/A
Prescriber Restrictions	Infectious disease, gastroenterologist, hepatologist
Coverage Duration	12-48 wks depending on tx regimen, genotype, liver transplantation status and decompensation

Other Criteria	Approval granted when ONE of the following is met: (A) HCV Genotype (GT) 1a or 1b AND either treatment naive (naive) or failed PEG/RBV AND either no cirrhosis or GT 1a or 1b in the allograft AND failure/contraindication/intolerance (F/C/I) to Harvoni AND used with Olysio (simeprevir) or Daklinza (daclatasvir): 12 wk OR (B) GT 1a AND either naive OR failed PEG/RBV AND cirrhosis AND negative for the Q80K polymorphism AND F/C/I to Harvoni AND used with simeprevir: 24 wk OR (C) GT 1b AND either naive OR failed PEG/RBV AND cirrhosis AND F/C/I to Harvoni AND used with simeprevir: 24 wk OR (D) GT 1a, 1b AND either naive or RBV intolerant or failed PEG/RBV or PEG/RBV with a HCV Protease Inhibitor AND presence of cirrhosis AND F/C/I to Harvoni AND used with daclatasvir: 24 wk OR (E) GT 1 AND F/C/I to Harvoni: 12 wk with PEG/RBV or daclatasvir/ RBV OR (F) GT 2 AND naive: 12 wk with RBV if no cirrhosis or 16 wk with RBV or daclatasvir if cirrhosis is present. If failed PEG/RBV: 16 or 24 wk with RBV. If failed sobosfuvir/RBV: 12 wk with PEG/RBV or 24 wk with daclatasvir OR (G) GT 2 regardless of cirrhosis status AND failed PEG/RBV AND used with RBV:16 wk OR (H) GT 2 AND not eligible to receive IFN AND failed sofosbuvir and RBV AND used with daclatasvir: 24 wk OR (I) GT 2 or 3 AND decompensated cirrhosis and may or may not be candidate for liver transplant, including pts with hepatocellular carcinoma AND used with daclatasvir and RBV: 12 wk OR (J) GT 3 in the allograft AND with daclatasvir and RBV: 12 wk OR (K) GT 2 OR 3 regardless of previous history AND presence of decompensated cirrhosis AND may or may not be a candidate for liver transplant, including patients with hepatocellular carcinoma AND used with RBV: 48 wk OR (L) GT 3 regardless of previous history or cirrhosis status AND used with PEG/RBV: 12 wk OR (M) GT 3 AND either naive or failed PEG/RBV AND used with daclatasvir: 12 wk without cirrhosis, 24 wk for cirrhosis OR (N) GT 2 or 3 in the allograft with compensated cirrhosis: 12 wk with daclatasvir/RBV or 24 wk with RBV or daclatasvir (RBV intolerant). GT 2 or 3 AND naive or PEG ineligible: 12 wk with daclatasvir. GT 3 AND naive or IFN ineligible: 24 wk with RBV OR (O) GT 3 in the allograft AND regardless of treatment history AND decompensated cirrhosis AND used with RBV: 24 wk OR (P) GT 3 AND cirrhosis AND failed PEG/RBV AND IFN ineligible AND used with daclatasvir/ RBV: 24 wk OR (Q) GT 1, 2, 3,4 ONLY in the allograft AND regardless of previous treatment: 12 wk with daclatasvir/RBV in patients with compensated cirrhosis, 24 wk with daclatasvir in compensated cirrhosis for GT 1 and 4 only (RBV intolerant), 24 wk with RBV in compensated cirrhosis for GT2, 24 wk with RBV in decompensated cirrhosis (Child Turcotte Pugh (CTP) class B or C) for GT 3 OR (R) GT 4 AND F/C/I to Harvoni: 12 wk with PEG/RBV, 24 wk with RBV OR (S) GT 5 or 6 AND F/C/I to Harvoni: 12 wk

SPRYCEL

Products Affected

- Sprycel

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	A documented diagnosis of one of the following: 1. Newly diagnosed Philadelphia chromosome-positive chronic phase chronic myeloid leukemia (Ph+ CP-CML) AND resistance or intolerance to prior therapy with nilotinib (Tasigna). 2. Chronic, accelerated, or myeloid or lymphoid blast phase Philadelphia chromosome-positive chronic myeloid leukemia (CML) AND resistance or intolerance to prior therapy with nilotinib (Tasigna). 3. Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ ALL) AND resistance or intolerance to prior therapy with imatinib mesylate (Gleevec).

STIVARGA

Products Affected

- Stivarga

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	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.

SUBOXONE

Products Affected

- Buprenorphine Hcl/naloxone Hcl
- Suboxone

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	The patient must have a diagnosis of opioid dependence AND a formal substance abuse counseling/treatment program must be in place for the beneficiary AND a treatment plan must be documented AND include a dose maintenance plan. Extended Approval: 6 months, based on Suboxone compliance and the absence of concurrent opioid use. All renewal requests will be reviewed by a Pharmacist. The Pharmacist will verify the patient is still in a psychosocial support program and perform a profile review. The profile review will look for compliance with Suboxone therapy and ensure that the patient has not been concurrently receiving narcotics or doctor shopping. If the renewal criteria are met, authorizations will be allowed for 6 month time periods.
Age Restrictions	N/A
Prescriber Restrictions	For treatment of opioid dependence-physician must have DATA 2000 waiver with a unique identification number and a DEA number.
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	The patient must have a diagnosis of opioid dependence AND a formal substance abuse counseling/treatment program must be in place for the beneficiary AND a treatment plan must be documented AND include a dose maintenance plan. Extended Approval: 6 months, based on Suboxone compliance and the absence of concurrent opioid use. All renewal requests will be reviewed by a Pharmacist. The Pharmacist will verify the patient is still in a psychosocial support program and perform a profile review. The profile review will look for compliance with Suboxone therapy and ensure that the patient has not been concurrently receiving narcotics or doctor shopping. If the renewal criteria are met, authorizations will be allowed for 6 month time periods.
Age Restrictions	N/A
Prescriber Restrictions	For treatment of opioid dependence-physician must have DATA 2000 waiver with a unique identification number and a DEA number.
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 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	Gastrointestinal stromal tumor AND after disease progression on or intolerance to imatinib.

SYLATRON

Products Affected

- Sylatron

PA Criteria	Criteria Details
Covered Uses	All FDA-approved 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	N/A

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	For patients with multicentric Castleman's disease (MCD), patient is HIV negative and human herpesvirus-8 (HHV-8) negative.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

SYNAGIS

Products Affected

- Synagis

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	A documented diagnosis of chronic or accelerated phase chronic myeloid leukemia (CML) with resistance and/or intolerance to nilotinib (Tasigna).

TACROLIMUS

Products Affected

- Envarsus Xr
- Hecoria
- Prograf INJ
- Tacrolimus 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	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.

TAFINLAR

Products Affected

- Tafinlar

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 positive BRAF V600E or V600K mutation 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	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 FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Previous treatment with EGFR tyrosine kinase inhibitor (TKI) therapy such as: Tarceva, Iressa, or Gilotrif. Confirmation of T790M mutation prior to initiation of therapy.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

TARCEVA

Products Affected

- Tarceva

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	Covered for the treatment of locally advanced or metastatic NSCLC after failure of at least one prior chemotherapy regimen. Covered for first line treatment for locally advanced or metastatic NSCLC, with or without platinium-based therapy, in patients with a known active EGFR mutation. Covered for maintenance treatment in patients with locally advanced or metastatic non-small cell lung cancer (NSCLC) whose disease has not progressed after four cycles of platinum-based first-line chemotherapy. Covered in combination with gemcitabine (Gemzar) for the first-line treatment of patients with locally advanced, unresectable or metastatic pancreatic cancer.

TARGRETIN CAPS

Products Affected

- Bexarotene
- Targretin CAPS

PA Criteria	Criteria Details
Covered Uses	All FDA-approved 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	Definite diagnosis of cutaneous T-cell lymphoma (CTCL) AND refractory to any prior systemic therapy (such as methotrexate).

TARGRETIN GEL

Products Affected

- Targretin GEL

PA Criteria	Criteria Details
Covered Uses	All FDA-approved 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	Diagnosis of cutaneous lesions in patients with cutaneous T-cell lymphoma (CTCL) (Stage IA and IB) AND have refractory or persistent disease after one or more other therapies or who have not tolerated one or more other therapies. Other therapies may include: topical corticosteroids, methoxsalen, phototherapy, topical chemotherapy (mechlorethamine, carmustine)

TASIGNA

Products Affected

- Tasigna

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Hypokalemia. Hypomagnesemia. Long QT 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	Coverage is provided for the treatment of newly diagnosed adult patients with Philadelphia chromosome positive chronic myeloid leukemia (Ph+ CML) in chronic phase OR the treatment of chronic phase (CP) and accelerated phase (AP) Ph+ CML in adult patients resistant to or intolerant to prior therapy that included imatinib.

TESTOSTERONE INJ

Products Affected

- Testosterone Cypionate INJ
- Testosterone Enanthate INJ

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 will not be required to provide labs and can be approved as continuation of therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

THALOMID

Products Affected

- Thalomid

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.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through end of plan contract year
Other Criteria	For multiple myeloma, covered for previously treated and untreated patients in combination with dexamethasone.

THIORIDAZINE-AGE EDIT

Products Affected

- Thioridazine 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

TOPICAL TRETINOIN

Products Affected

- Avita
- 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	Not covered for the following: concomitant administration with cyclosporine or glyburide, AND pregnancy (monthly pregnancy tests should be obtained while on therapy).
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 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).

TREATMENT OF ATTENTION DEFICIT DISORDER - AGE EDIT

Products Affected

- Amphetamine/dextroamphetamine ORAL TABS
- Dextroamphetamine Sulfate ORAL TABS
- Dextroamphetamine Sulfate SOLN
- Metadate Er
- Methylphenidate Hcl ORAL TABS
- Methylphenidate Hcl Er ORAL TBCR 10MG, 20MG
- 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 FDA-approved 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	N/A

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	Indicated for induction and consolidation of acute promyelocytic leukemia (APL) characterized by t(15,17) translocation or PML/RAR-alpha gene expression, in patients who are refractory to or have relapsed from retinoid and anthracycline chemotherapy.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	Through end of plan contract year
Other Criteria	N/A

TYKERB

Products Affected

- Tykerb

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	Coverage is provided in combination with capecitabine, for the treatment of patients with advanced or metastatic breast cancer whose tumors overexpress HER2 and who have received prior therapy including an anthracycline, a taxane, and trastuzumab OR in combination with letrozole for the treatment of postmenopausal women with hormone receptor positive metastatic breast cancer that overexpresses the HER2 receptor for whom hormonal therapy is indicated.

VALCHLOR

Products Affected

- Valchlor

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 Dermatologist
Coverage Duration	Through end of plan contract year
Other Criteria	Patient has a diagnosis of Stage IA OR IB mycosis fungoides -type cutaneous T cell lymphoma AND Patient has tried and had an inadequate response to or cannot use other 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	N/A
Coverage Duration	14 days
Other Criteria	Vancomycin oral is not covered for initial episodes of C. difficile infections (CDI) unless the episode is severe. CDI is severe when there is leukocytosis with a white blood cell count of 15,000 cells/microliter or higher or a serum creatinine level greater than or equal to 1.5 times the premorbid level. Vancomycin oral is not covered for the first recurrent episode if the initial therapy was metronidazole and the recurrent episode is not severe. Requests for Vancomycin oral will be covered in recurrent episodes of CDI following a trial of metronidazole and documentation that the recurrent episode is severe. Requests for Vancomycin oral in patients with a second recurrence will be covered following 2 recent trials of metronidazole.

VECTIBIX

Products Affected

- Vectibix

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	N/A

VELCADE

Products Affected

- Velcade

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	N/A

VIDAZA

Products Affected

- Azacitidine

PA Criteria	Criteria Details
Covered Uses	All FDA-approved 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	N/A

VOTRIENT

Products Affected

- Votrient

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	N/A

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 FDA-approved 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	N/A

XENAZINE

Products Affected

- Tetrabenazine
- Xenazine

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Xenazine is 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

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	N/A

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	Documentation of the following: Moderate to severe persistent asthma (NHLBI definition) meeting all the following criteria: 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). Evidence of specific allergic sensitivity to a perennial aeroallergen (positive skin test or in vitro test). Failure 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 2 of the following criteria: PEF improvement (12% or greater from baseline (prior to start of Xolair)) OR FEV1 improvement (12% or greater from baseline (prior to start of Xolair)) OR reduction in symptoms (wheezing, shortness of breath, cough, chest tightness) OR reduction in systemic corticosteroids and rescue drug use OR reduction of asthma-related hospitalizations and other medical contacts. OR Diagnosis of chronic idiopathic urticaria in patients who remain symptomatic despite trial 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, 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
Coverage Duration	Through end of plan contract year
Other Criteria	Requests for new starts are 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	N/A
Required Medical Information	Treatment of excessive daytime sleepiness associated with narcolepsy OR cataplexy associated with narcolepsy
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	N/A

YONDELIS

Products Affected

- Yondelis

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	N/A

ZALEPLON-AGE EDIT

Products Affected

- Zaleplon

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

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	A documented diagnosis of metastatic colorectal cancer AND documentation of the following: resistance to or progression of the disease following an oxaliplatin-containing regimen and will be used in combination with 5-fluorouracil, leucovorin, and irinotecan.

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	Mild to moderate type 1 Gaucher disease for whom enzyme replacement therapy is not a therapeutic option due to allergy, hypersensitivity, or poor venous access.
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 FDA-approved 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	N/A

ZOLINZA

Products Affected

- Zolinza

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 Cutaneous T-cell lymphoma, patient has progressive, persistent or recurrent disease.

ZOLPIDEM-AGE EDIT

Products Affected

- Zolpidem Tartrate

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

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	For prophylaxis of organ rejection in kidney transplant in combination with basiliximab (Simulect) during induction therapy and used concurrently with reduced doses of cyclosporine and corticosteroids OR for prophylaxis of organ rejection in liver transplant in adults no earlier than 30 days post-transplant and used in combination with tacrolimus (reduced doses) and corticosteroids. Drug is also subject to a Part B versus Part D coverage determination.

ZYDELIG

Products Affected

- Zydelig

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	For Relapsed Chronic Lymphocytic Leukemia, Zydelig will be used in combination with rituximab (Rituxan). For Relapsed Follicular B-cell non-Hodgkin Lymphoma and Relapsed Small Lymphocytic Lymphoma, patient has received at least two prior systemic therapies such as Rituxan, Treanda, or other chemotherapy.

ZYKADIA

Products Affected

- Zykadia

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	Patient has a diagnosis of anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer (NSCLC) AND has progressed on or is intolerant to crizotinib (Xalkori).

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

ZYVOX

Products Affected

- Linezolid
- Zyvox INJ
- Zyvox SUSR

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	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	28 days
Other Criteria	Trial of three days each of two preferred antibiotics indicated for the members condition such as amoxicillin or moxifloxacin or azithromycin or cephalosporin or clindamycin or dicloxicillin OR Discharge from hospital or medical facility due to a documented diagnosis/covered use AND Documented initial treatment with vancomycin OR intravenous (IV) Zyvox (linezolid) while in the hospital/medical facility.

PART B VERSUS PART D

Products Affected

- Abelcet
- Acetylcysteine INHALATION SOLN
- Acyclovir Sodium
- Adrucil
- 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
- Aminosyn II 8.5%/electrolytes
- Aminosyn M
- Aminosyn-hbc
- Aminosyn-pf
- Aminosyn-pf 7%
- Aminosyn-rf
- Amphotericin B INJ
- Azathioprine TABS
- Bleomycin Sulfate
- Budesonide INHALATION SUSP 0.25MG/2ML, 0.5MG/2ML, 1MG/2ML
- Cladribine
- Clinisol Sf 15%
- Cromolyn Sodium NEBU
- Cyclophosphamide ORAL CAPS
- Cytarabine Aqueous
- Dextrose 10% Flex Container
- Dextrose 20%
- Dextrose 25%
- Dextrose 30%
- Dextrose 40%
- Dextrose 50%
- Dextrose 70%
- Doxorubicin Hcl
- Duramorph
- Emend ORAL CAPS
- Engerix-b
- Floxuridine INJ
- Fluorouracil INJ 1GM/20ML, 2.5GM/50ML, 5GM/100ML
- Ganciclovir INJ
- Granisetron Hcl TABS
- Hepatamine
- Hydromorphone Hcl INJ 1MG/ML, 2MG/ML, 4MG/ML, 500MG/50ML
- Imovax Rabies (h.d.c.v.)
- Intralipid
- Ipratropium Bromide INHALATION SOLN 0.02%
- Ipratropium Bromide/albuterol Sulfate
- Kabiven
- Levalbuterol NEBU
- Levalbuterol Hcl INHALATION NEBU
- Liposyn III INJ 1.2GM/100ML; 2.5GM/100ML; 10GM/100ML, 1.2GM/100ML; 2.5GM/100ML; 20GM/100ML
- Morphine Sulfate INJ
- Nebupent
- Nephramine
- Perikabiven

- Plenamine
- Premasol
- Pulmozyme
- Rabavert
- Recombivax Hb
- Simulect
- Temodar INJ
- Thymoglobulin
- Tobramycin NEBU
- 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.

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