Prior Authorization Criteria
2017 TEXAS_ERS
Last Updated: 12/01/2016

ACTEMRA IV (EH)

Products Affected

- Actemra INJ 200MG/10ML, 400MG/20ML, 80MG/4ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Failure, contraindication, or intolerance to one nonbiologic DMARD [eg, Rheumatrex/Trexall (MTX), Arava (leflunomide), Azulfidine (sulfasalazine)]. One of the following: Failure, contraindication, or intolerance to both Enbrel (etanercept) and Humira (adalimumab) OR for continuation of prior Actemra therapy. Systemic Juvenile Idiopathic arthritis (SJIA) (Initial): Diagnosis of active SJIA. Failure, contraindication, or intolerance to one NSAID or systemic glucocorticoid. Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of active PJIA. Failure, contraindication, or intolerance to one of the following nonbiologic DMARDs: Arava (leflunomide) or Rheumatrex/Trexall (MTX). One of the following: Failure, contraindication, or intolerance to Enbrel (etanercept) and Humira (adalimumab), OR for continuation of prior Actemra therapy. All indications (Initial, reauth): Patient is not receiving Actemra in combination with a biologic DMARD [eg, Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)]. Patient is not receiving Actemra in combination with a Janus kinase inhibitor [eg, Xeljanz (tofacitinib)].
Age Restrictions	N/A
Prescriber Restrictions	RA, SJIA, PJIA (Initial): Prescribed by or in consultation with a rheumatologist.

Coverage Duration	All indications (initial, reauth): plan year
Other Criteria	All indications (reauth): Documentation of positive clinical response to Actemra therapy.

ACTEMRA SC (EH)

Products Affected

- Actemra INJ 162MG/0.9ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Failure, contraindication, or intolerance to one nonbiologic DMARD [eg, Rheumatrex/Trexall (MTX), Arava (leflunomide), Azulfidine (sulfasalazine)]. One of the following: Failure, contraindication, or intolerance to both Enbrel (etanercept) and Humira (adalimumab) OR for continuation of prior Actemra therapy. RA (Initial, reauth): Patient is not receiving Actemra in combination with a biologic DMARD [eg, Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)]. Patient is not receiving Actemra in combination with a Janus kinase inhibitor [eg, Xeljanz (tofacitinib)].
Age Restrictions	N/A
Prescriber Restrictions	RA (Initial): Prescribed by or in consultation with a rheumatologist.
Coverage Duration	RA (initial, reauth): plan year
Other Criteria	RA (Reauth): Documentation of positive clinical response to Actemra therapy.

ACTHAR HP

Products Affected

- H.p. Acthar

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Infantile Spasm (West Syndrome): Diagnosis of infantile spasms (West Syndrome). Multiple Sclerosis (MS): Acute exacerbations of MS. Rheumatic disorders: As adjunctive therapy for short-term administration in: psoriatic arthritis, rheumatoid arthritis, including juvenile rheumatoid arthritis (selected cases may require low-dose maintenance therapy), ankylosing spondylitis. Collagen diseases: During an exacerbation or as maintenance therapy in selected cases of: systemic lupus erythematous, systemic dermatomyositis (polymyositis). Dermatologic diseases: Severe erythema multiforme, Stevens-Johnson syndrome. Allergic states: Serum sickness. Ophthalmic diseases: Severe acute and chronic allergic and inflammatory processes involving the eye and its adnexa, such as: keratitis, iritis and iridocyclitis, diffuse posterior uveitis and choroiditis, optic neuritis, chorioretinitis, anterior segment inflammation. Respiratory diseases: Symptomatic sarcoidosis. Edematous state: To induce a diuresis or a remission of proteinuria in the nephrotic syndrome without uremia of the idiopathic type or that due to lupus erythematosus. All indications except for infantile spasms: History of failure, contraindication, or intolerance to treatment with two corticosteroids.
Age Restrictions	Infantile spasms: less than 2 years old
Prescriber Restrictions	Infantile Spasm, MS: neurologist. Rheumatic disorder, collagen disease: rheumatologist. Dermatologic: dermatologist. Allergic state: allergist, immunologist. Ophthalmic disease: optometrist, ophthalmologist. Respiratory diseases: pulmonologist. Edematous state: nephrologist, rheumatologist.
Coverage Duration	Infantile Spasms: 4 weeks. MS: 3 weeks. All other FDA-approved uses: 3 months.
Other Criteria	N/A

ADCIRCA

Products Affected

- Adcirca

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
Age Restrictions	N/A
Prescriber Restrictions	PAH (Initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH: Initial: 6 months. Reauth: plan year
Other Criteria	PAH (Reauth): Documentation of positive clinical response to therapy.

ADEMPAS

Products Affected

- Adempas

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH AND PAH is symptomatic AND One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH. Chronic thromboembolic pulmonary hypertension (CTEPH) (Initial): One of the following: A) Both of the following: 1) Diagnosis of inoperable or persistent/recurrent CTEPH and 2) CTEPH is symptomatic OR B) Patient is currently on any therapy for the diagnosis of CTEPH.
Age Restrictions	N/A
Prescriber Restrictions	PAH, CTEPH (Initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH, CTEPH: Initial: 6 months. Reauth: plan year
Other Criteria	PAH, CTEPH (Reauth): Documentation of positive clinical response to therapy.

AFINITOR

Products Affected

- Afinitor
- Afinitor Disperz

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Islet Cell Tumor/Advanced Neuroendocrine Tumors (NET): Diagnosis (Dx) of islet cell/progressive neuroendocrine tumors of pancreatic origin OR progressive, well-differentiated, non-functional neuroendocrine tumors of gastrointestinal or lung origin. Disease is unresectable, locally advanced or metastatic. Advanced Renal Cell Carcinoma: Dx of renal cell cancer. One of the following: (1) relapse following surgical excision or (2) both of the following: medically or surgically unresectable tumor and diagnosis of stage IV disease. One of the following: Patient with non-clear cell histology or patient with predominantly clear cell histology. Renal cell carcinoma patient with predominantly clear cell histology: History of failure, contraindication, or intolerance (F/C/I) to at least one prior tyrosine kinase inhibitor therapy [eg, Nexavar (sorafenib), Sutent (sunitinib)]. Renal angiomyolipoma with tuberous sclerosis complex (TSC): Dx of renal angiomyolipoma and TSC, not requiring immediate surgery. Subependymal Giant Cell Astrocytoma (SEGA) with tuberous sclerosis (TS): Dx of SEGA associated with TS. Patient is not a candidate for curative surgical resection. Breast Cancer: Dx of hormone receptor positive, HER-2 negative breast cancer that is recurrent or metastatic. Patient is a postmenopausal woman. History of F/C/I to one of the following: a non-steroidal aromatase inhibitor [e.g., Arimidex (anastrozole), Femara (letrozole)] or tamoxifen. Used in combination with Aromasin (exemestane).
Age Restrictions	N/A
Prescriber Restrictions	Islet Cell Tumor/NET, SEGA with TS: Prescribed by or in consultation with an oncologist or neuro-oncologist. Renal Angiomyolipoma with TSC: Prescribed by or in consultation with a nephrologist. All other uses: Prescribed by or in consultation with an oncologist.
Coverage Duration	Plan year

Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

AFREZZA

Products Affected

- Afrezza

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of type 1 diabetes mellitus and used in combination with a long-acting insulin OR diagnosis of type 2 diabetes mellitus. Documented FEV1 within the last 60 days greater than or equal to 70% of expected normal as determined by the physician. Will not be approved in patients who smoke cigarettes, who recently quit smoking (within the past 6 months), or with chronic lung disease (eg, asthma, chronic obstructive pulmonary disease (COPD)). Reauthorization: Repeat pulmonary function test after the first 6 months of therapy confirms that the patient has NOT experienced a decline of 20% or more in FEV1. Documentation of positive clinical response to Afrezza therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months. Reauth: plan year
Other Criteria	N/A

AKYNZEO

Products Affected

- Akynzeo

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of prevention of nausea and vomiting associated with cancer chemotherapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Subject to B vs. D review. History of failure, contraindication, or intolerance to generic Zofran (ondansetron)

ALPHA-1 PROTEINASE INHIBITORS

Products Affected

- Aralast Np INJ 500MG
- Glassia
- Prolastin-c
- Zemaira

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Alpha-1 antitrypsin (AAT) deficiency (Initial): Diagnosis of congenital AAT deficiency. One of the following: Pi*ZZ, Pi*Z(null) or Pi*(null)(null) protein phenotypes (homozygous) or Other rare AAT disease-causing alleles associated with serum AAT level less than 11 µmol/L [eg, Pi(Malton, Malton)]. Circulating serum concentration of AAT level less than 11 µmol/L (which corresponds to less than 80 mg/dL if measured by radial immunodiffusion or less than 57 mg/dL if measured by nephelometry). Continued optimal conventional treatment for emphysema (eg, bronchodilators). Diagnosis of emphysema confirmed with pulmonary function testing. AAT deficiency (reauthorization): Documentation of positive clinical response to therapy. Continued optimal conventional treatment for emphysema (eg, bronchodilators).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	AAT deficiency (initial and reauth): plan year
Other Criteria	N/A

AMPYRA

Products Affected

- Ampyra

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Multiple Sclerosis (initial): Diagnosis of multiple sclerosis. Physician confirmation that patient has difficulty walking (eg, timed 25 foot walk test). One of the following: expanded disability status scale (EDSS) score less than or equal to 7, or not restricted to using a wheelchair (if EDSS is not measured). (Reauthorization): Physician confirmation that the patient's walking improved with Ampyra therapy. One of the following: EDSS score less than or equal to 7, or not restricted to using a wheelchair (if EDSS is not measured).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months. Reauth: 12 months
Other Criteria	N/A

ANADROL-50

Products Affected

- Anadrol-50

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Acquired Aplastic Anemia: Diagnosis of acquired aplastic anemia. Congenital aplastic anemia: Diagnosis of congenital aplastic anemia (Fanconi anemia). Myelofibrosis: Diagnosis of myelofibrosis. Hypoplastic Anemia due to myelotoxic drugs: Diagnosis of hypoplastic anemia due to myelotoxic drugs. Pure Red Cell Aplasia: Diagnosis of pure red cell aplasia. Chronic Renal failure: Diagnosis of chronic renal failure.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Acquired Aplastic Anemia: One of the following: History of failure, contraindication, or intolerance to antilymphocyte/antithymocyte globulin (eg, Atgam, Thymoglobulin) or antilymphocyte/antithymocyte globulin plus corticosteroid treatment, OR Used in combination with antilymphocyte/antithymocyte globulin (eg, Atgam, Thymoglobulin) or antilymphocyte/antithymocyte globulin plus corticosteroids (eg, methylprednisolone, prednisone). Hypoplastic Anemia Due to Myelotoxic Drugs: History of failure, contraindication, or intolerance to Aranesp (darbepoetin alfa) or Epogen/Procrit (epoetin alfa). Pure Red Cell Aplasia: History of failure, contraindication, or intolerance to immunosuppressive therapy (eg, cyclosporine A, prednisone). Chronic Renal Failure: History of failure, contraindication, or intolerance to Aranesp (darbepoetin alfa) or Epogen/Procrit (epoetin alfa).

APOKYN

Products Affected

- Apokyn

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Advanced Parkinson's disease diagnosis. Unable to control off symptoms with at least one adequate combination of conventional oral therapy [eg, Comtan (entacapone), Mirapex (pramipexole), Requip (ropinirole), Sinemet (carbidopa/levodopa), Stalevo (carbidopa/levodopa/entacapone), Symmetrel (amantadine), Tasmar (tolcapone)]. Used in combination with a non-5HT3 antagonist antiemetic [eg, Tigan (trimethobenzamide) 300 mg PO TID] for initial therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Apokyn will only be approved for intermittent subcutaneous injection.

ARANESP

Products Affected

- Aranesp Albumin Free INJ 100MCG/0.5ML, 100MCG/ML, 10MCG/0.4ML, 150MCG/0.3ML, 200MCG/0.4ML, 200MCG/ML, 25MCG/0.42ML, 25MCG/ML, 300MCG/0.6ML, 300MCG/ML, 40MCG/0.4ML, 40MCG/ML, 500MCG/ML, 60MCG/0.3ML, 60MCG/ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Anemia due to Chronic Kidney Disease (CKD) (Initial): Diagnosis of CKD. Anemia by lab values (Hct less than 30% or Hgb less than 10 g/dL) within 30 days of request. The rate of hemoglobin decline indicates the likelihood of requiring a red blood cell (RBC) transfusion, and reducing the risk of alloimmunization and/or other RBC transfusion-related risks is a goal. (Reauth): Diagnosis of CKD. Most recent or average (avg) Hct over 3 mo is 33% or less (Hgb 11 g/dL or less) for patients on dialysis OR Most recent or average (avg) Hct over 3 mo is 30% or less (Hgb 10 g/dL or less) for patients not on dialysis OR Most recent or average (avg) Hct over 3 mo is 36% or less (Hgb 12 g/dL or less) for pediatric patients. Decrease in the need for blood transfusion or Hgb increased by 1 g/dL or more from pre-treatment level. Anemia w/ chemo (Initial): Other causes of anemia ruled out. Anemia w/ labs (Hct less than 30%, Hgb less than 10 g/dL) within prior 2 weeks of request. Cancer is non-myeloid malignancy. Patient is concurrently on chemo, or will receive concomitant chemo for minimum of 2 months, or anemia caused by cancer chemo. (Reauth): Anemia by labs (Hgb less than 10 g/dl or Hct less than 30%) collected within the prior 2 weeks of request. Decrease in the need for blood transfusion or Hgb increased by 1 g/dL or more from pre-tx level. Patient is concurrently on chemo, or will receive concomitant chemo for minimum of 2 months, or anemia is caused by cancer chemo. Anemia in MDS (Init): Diagnosis of MDS. Serum erythropoietin 500 mU/mL or less, or transfusion dependent MDS. (Reauth): Most recent or avg Hct over 3 months was 36% or less, OR most recent or avg Hgb over 3 months is 12 g/dl or less. Decrease in the need for blood transfusion or Hgb increased by 1 g/dL or more from pre-treatment level.

Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	CKD(Init): 6 mo. CKD(reauth):plan yr. Chemo(init, reauth): 3 mo. MDS(init): 3 mo,(reauth): plan yr
Other Criteria	ESRD patients: Coverage is excluded under Medicare Part D for patients with ESRD on dialysis for any indication related or unrelated to treatment of ESRD since the payment for the drug is included in the ESRD PPS payment bundle. NON-ESRD PATIENTS for the following indications: Anemia in cancer patients on chemotherapy (init, reauth): Will not be approved if patient is not receiving cancer chemotherapy. Off-label uses (except Anemia in Myelodysplastic Syndrome (MDS): Will not be approved if patient has Hgb greater than 10 g/dL or Hct greater than 30%.CKD (init, reauth), Chemo (init), MDS (init): Verify Fe eval for adequate Fe stores.

ARCALYST

Products Affected

- Arcalyst

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Cryopyrin-Associated Period Syndromes (CAPS) (Initial): Dx of CAPS, including Familial Cold Autoinflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS). Dx confirmed by NLRP-3 (nucleotide-binding domain, leucine rich family (NLR), pyrin domain containing 3] gene (also known as Cold-Induced Auto-inflammatory Syndrome-1 [CIAS1]) mutation or evidence of active inflammation including both of the following: clinical symptoms (eg, rash, fever, arthralgia) and elevated acute phase reactants (eg, ESR, CRP). CAPS (Re-auth): Documentation of positive clinical response to Arcalyst therapy.
Age Restrictions	N/A
Prescriber Restrictions	CAPS: Prescribed by or in consultation with an allergist/immunologist, dermatologist, or rheumatologist.
Coverage Duration	CAPS (initial, reauth): plan year
Other Criteria	CAPS (initial and re-auth): Excluded if patient is receiving concomitant treatment with either of the following: Tumor necrosis factor (TNF) inhibitors [eg, Enbrel (etanercept), Humira (adalimumab), Remicade (infliximab)] or Interleukin-1 inhibitors [eg, Ilaris (canakinumab), Kineret (anakinra)]

ASTAGRAF

Products Affected

- Astagraf XL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Patient received a renal (kidney) transplant.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Subject to B v D review (not limited to new starts only). Approve for continuation of prior therapy if within the past 120 days. History of failure or intolerance to oral generic tacrolimus.

AUBAGIO

Products Affected

- Aubagio

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Multiple Sclerosis: Diagnosis of a relapsing form of multiple sclerosis (MS) (eg, relapsing-remitting MS, secondary-progressive MS with relapses, progressive-relapsing MS with relapses).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

AVONEX

Products Affected

- Avonex
- Avonex Pen

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Multiple Sclerosis: Diagnosis of a relapsing form of multiple sclerosis (MS) (eg, relapsing-remitting MS, secondary-progressive MS with relapses, progressive-relapsing MS with relapses).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

BACTROBAN NASAL

Products Affected

- Bactroban Nasal

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Methicillin resistant Staphylococcus aureus infection, nasal colonization: For eradication of nasal colonization with methicillin-resistant S. aureus. Used as part of a comprehensive infection control program during institutional outbreaks of infections with methicillin-resistant S. aureus.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

BELEODAQ

Products Affected

- Beleodaq

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Relapsed or refractory peripheral T-cell lymphoma (PTCL): Diagnosis of relapsed or refractory PTCL.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hematologist or oncologist.
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

BENLYSTA

Products Affected

- Benlysta

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Systemic Lupus Erythematosus (SLE): (Initial): Diagnosis of active SLE. Autoantibody positive (ie, anti-nuclear antibody [ANA] titer greater than or equal to 1:80 or anti-dsDNA level greater than or equal to 30 IU/mL). Currently receiving at least one standard of care treatment for active SLE (eg, antimalarials [eg, Plaquenil (hydroxychloroquine)], corticosteroids [eg, prednisone], or immunosuppressants [eg, methotrexate, Imuran (azathioprine), CellCept (mycophenolate mofetil)]) . (Reauthorization): Documentation of positive clinical response to Benlysta therapy.
Age Restrictions	N/A
Prescriber Restrictions	SLE (initial): Prescribed by or in consultation with a rheumatologist
Coverage Duration	SLE (initial and reauth): 6 months
Other Criteria	N/A

BERINERT

Products Affected

- Berinert

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of hereditary angioedema (HAE) and for the treatment of acute HAE attacks.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by an immunologist, allergist or rheumatologist
Coverage Duration	Plan year
Other Criteria	Not used in combination with other approved treatments for acute HAE attacks (eg, Firazyr, Kalbitor, or Ruconest).

BOSULIF

Products Affected

- Bosulif

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of Philadelphia chromosome-positive chronic myelogenous/myeloid leukemia (Ph+CML). History of failure, contraindication, or intolerance to one of the following: Gleevec (imatinib), Sprycel (dasatinib), or Tasigna (nilotinib), or post allogeneic hematopoietic stem cell transplantation (HSCT).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hematologist/oncologist
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

BOTOX

Products Affected

- Botox

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Neuromuscular Disorders (init): Strabismus, blepharospasm associated with dystonia (eg, benign essential blepharospasm), treatment of upper or lower limb spasticity, VII cranial nerve disorders (hemifacial spasms), cervical dystonia Hyperhidrosis(HH): (Init) Dx of primary axillary HH. Score of 3 or 4 on the Hyperhidrosis Disease Severity Scale (HDSS) or skin maceration with secondary infection. Failure, contraindication, or intolerance (F/C/I) to topical prescription strength drying agents [eg, Drysol, Hypercare, Xerac AC (aluminum chloride hexahydrate)]. Migraine:(Init) Dx of chronic migraines (greater than or equal to 15 migraine headache days per month with headache lasting 4 hours a day or longer). F/C/I to prophylactic therapy with at least two of the following agents, each given for a trial of at least two months: antidepressants [ie, Effexor (venlafaxine)], antiepileptics [ie, Depakote/Depakote ER (divalproex sodium), Topamax (topiramate)], beta-blockers [eg, atenolol, Inderal (propranolol), nadolol, timolol, Toprol XL (metoprolol)] Achalasia:(Init) High risk of complication from or failure to pneumatic dilation or myotomy, or prior dilation caused esophageal perforation, or patient has an epiphrenic diverticulum or hiatal hernia. Anal Fissure (AF)(Init): Dx of chronic AF. At least 2 months of either nocturnal pain and bleeding or postdefecation pain. Chronic Back Pain (CBP):(Init) Dx of low back pain lasting greater than or equal to six months. Urinary incont (UI):(init) Neurogenic detrusor overactivity associated with a neurologic condition (eg, spinal cord injury [SCI], multiple sclerosis) or detrusor sphincter dyssynergia with SCI. Overactive bladder (OAB): (init) Dx of OAB. One of the following symptoms: urge urinary incontinence, urgency, frequency.
Age Restrictions	N/A
Prescriber Restrictions	Migraine (Initial): Prescribed by a neurologist or pain specialist. CBP (Initial): Prescribed by a neurologist, neurosurgeon, orthopedist, or pain specialist. UI, OAB (initial): Prescribed by a neurologist, neurosurgeon, or urologist.

Coverage Duration	Achalasia: 6moCBP:1 tx(series of injxs)UI:3mo(1 dose,200units)Other:3mo
Other Criteria	UI, OAB, CBP, Neuromuscular Disorders:(Reauth) Confirmed improvement in symptoms with initial Botox treatment. At least 3 months have or will have elapsed since the last treatment with Botox HH:(Reauth) At least a 2-point improvement in HDSS. Migraine:(Reauth) Reduction in headache frequency or intensity. Submission of chart notes documenting decreased utilization of pain medications (eg, narcotic analgesics, NSAIDs) or triptans, or a reduction in the number of ER visits. Achalasia:(Reauth) Documentation of improvement or reduction in symptoms of achalasia (ie, dysphagia, regurgitation, chest pain). At least 6 months have or will have elapsed since last series of injections AF: (Reauth) Incomplete healing of fissure or recurrence of fissure. Improved symptoms with prior treatment with Botox.

BUPRENORPHINE SL

Products Affected

- Buprenorphine Hcl SUBLINGUAL SUBL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For the treatment of opioid dependence. One of the following: a) patient is being treated for induction therapy, b) patient is being treated for maintenance therapy because of intolerance to buprenorphine/naloxone, or c) patient is being treated for maintenance therapy because she is pregnant or breastfeeding.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

BUPRENORPHINE, NON-PREFERRED

Products Affected

- Bunavail
- Zubsolv

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For the treatment of opioid dependence.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	History of failure or intolerance to brand Suboxone sublingual film.

BUPRENORPHINE, PREFERRED

Products Affected

- Buprenorphine Hcl/naloxone Hcl
- Suboxone SUBLINGUAL FILM

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For the treatment of opioid dependence.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

CAYSTON

Products Affected

- Cayston

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Cystic Fibrosis (CF): Diagnosis of CF and lung infection with positive culture demonstrating Pseudomonas aeruginosa infection.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

CELLCEPT (IV)

Products Affected

- Cellcept Intravenous

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Transplant: Patient received a renal (kidney), cardiac (heart), or hepatic (liver) transplant. Patient is unable to take oral formulations of mycophenolate.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Subject to Part B vs. Part D review (not limited to new starts only). Approve for continuation of prior therapy if within the past 120 days if Part D.

CELLCEPT (ORAL)

Products Affected

- Mycophenolate Mofetil CAPS
- Mycophenolate Mofetil SUSR
- Mycophenolate Mofetil TABS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Transplant: Patient received a renal (kidney), cardiac (heart), or hepatic (liver) transplant.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Subject to Part B vs. Part D review (not limited to new starts only). Approve for continuation of prior therapy if within the past 120 days if Part D.

CERDELGA

Products Affected

- Cerdelga

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of type 1 Gaucher disease. Patients must be CYP2D6 extensive metabolizers (EMs), intermediate metabolizers (IMs), or poor metabolizers (PMs) as detected by an FDA-cleared test.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

CEREZYME

Products Affected

- Cerezyme

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Gaucher disease: Diagnosis of Type 1 Gaucher disease. Patient has evidence of symptomatic disease (eg, moderate to severe anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

CESAMET

Products Affected

- Cesamet

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Nausea and Vomiting Associated with Cancer Chemotherapy: Patient is receiving cancer chemotherapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	CINV: 6 months
Other Criteria	Subject to Part B vs. Part D review. CINV: Approve for continuation of prior therapy for treatment covered under Part B and when patient is receiving cancer chemotherapy. Failure, contraindication, or intolerance (F/C/I) to 5HT-3 receptor antagonist (eg, Anzemet [dolasetron], Kytril [granisetron], or Zofran [ondansetron]). F/C/I to one of the following: Ativan (lorazepam), Compazine (prochlorperazine), Decadron (dexamethasone), Haldol (haloperidol), Phenergan (promethazine), Reglan (metoclopramide), Zyprexa (olanzapine).

CHOLBAM

Products Affected

- Cholbam

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Bile acid synthesis disorders due to single enzyme defects (BAS) (initial): diagnosis of a bile acid synthesis disorder due to a single enzyme defect. Peroxisomal disorders (PD) (initial): All of the following: 1) diagnosis of peroxisomal disorder, 2) patient exhibits at least one of the following: a) liver disease (eg, jaundice, elevated serum transaminases), OR b) steatorrhea, OR c) complications from decreased fat-soluble vitamin absorption (eg, poor growth), AND 3) Cholbam will be used as an adjunctive treatment.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by a hepatologist, medical geneticist, pediatric gastroenterologist, OR other specialist that treats inborn errors of metabolism.
Coverage Duration	Initial: 3 months Reauth: Plan year
Other Criteria	All uses (reauth): documentation of positive clinical response to Cholbam therapy.

CHORIONIC GONADOTROPIN

Products Affected

- Chorionic Gonadotropin INJ
- Novarel
- Pregnyl W/diluent Benzyl Alcohol/nacl

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Excluded if used to promote fertility.
Required Medical Information	Prepubertal Cryptorchidism: Diagnosis of prepubertal cryptorchidism not due to anatomical obstruction. Male Hypogonadotropic Hypogonadism (initial): Diagnosis of male hypogonadism secondary to pituitary deficiency, and low testosterone (below normal reference value provided by the physician's laboratory) and low LH (below normal reference value provided by the physician's laboratory) or FSH (below normal reference value provided by the physician's laboratory). Hypogonadotropic Hypogonadism (Reauth): Documentation of positive clinical response to therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Prepubertal Cryptorchidism: 6 wks. Male Hypogonadotropic Hypogonadism (initial, reauth): plan yr
Other Criteria	N/A

CIALIS

Products Affected

- Cialis ORAL TABS 2.5MG, 5MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Excluded if used for the treatment of erectile dysfunction.
Required Medical Information	Benign prostatic hyperplasia (BPH): Diagnosis of BPH. Male Gender.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	BPH: plan year
Other Criteria	BPH: Failure/contraindication/intolerance to two formulary alpha blockers. Cialis 2.5mg strength: Patient has renal insufficiency.

CIMZIA (EH)

Products Affected

- Cimzia

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA): Diagnosis (dx) of moderately to severely active RA. Failure, contraindication, or intolerance (F/C/I) to one disease-modifying anti-rheumatic drug (DMARD) (eg, methotrexate, leflunomide, sulfasalazine). Crohn's Disease (CD): Dx of moderately to severely active CD. F/C/I to one of the following conventional therapies: 6-mercaptopurine (Purinethol), Azathioprine (Imuran), Corticosteroid (eg, prednisone, methylprednisolone), Methotrexate (Rheumatrex, Trexall). One of the following: F/C/I to Humira (adalimumab) OR for continuation of prior Cimzia therapy. Psoriatic Arthritis (PsA): Dx of active psoriatic arthritis. Ankylosing Spondylitis (AS): Dx of active AS. F/C/I to two or more non-steroidal anti-inflammatory drugs (NSAIDs). RA, PsA, AS (initial): F/C/I to Enbrel and Humira OR for continuation of prior Cimzia therapy.
Age Restrictions	N/A
Prescriber Restrictions	CD (initial): Prescribed by or in consultation with a gastroenterologist. RA, AS (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist.
Coverage Duration	All indications (initial/reauth): plan year
Other Criteria	Reauthorization (all indications): Documentation of positive clinical response to Cimzia therapy. All indications (initial and reauth): Patient is not receiving Cimzia in combination with either of the following: Biologic DMARD [e.g., Enbrel (etanercept), Humira (adalimumab), Simponi (golimumab), Orencia (abatacept)] or Janus kinase inhibitor [eg, Xeljanz (tofacitinib)]. For a diagnosis of PsA, Patient is not receiving Cimzia in combination with a phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)].

CINRYZE

Products Affected

- Cinryze

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Hereditary Angioedema (HAE) (prophylaxis): Diagnosis of HAE. For prophylaxis against HAE attacks.
Age Restrictions	N/A
Prescriber Restrictions	HAE (prophylaxis): Prescribed by an immunologist, allergist or rheumatologist
Coverage Duration	HAE (prophylaxis): plan year
Other Criteria	HAE (prophylaxis): Continuation of prior therapy or failure, intolerance, or contraindication to one of the following: 17-alpha alkylated androgen (eg, danazol, oxandrolone) or antifibrinolytics (eg, aminocaproic acid, tranexamic acid).

CNS STIMULANTS

Products Affected

- Methamphetamine Hcl

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Excluded if used to promote weight loss.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

COMETRIQ

Products Affected

- Cometriq

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Medullary Thyroid Cancer (MTC): Diagnosis of one of the following: metastatic medullary thyroid cancer (MTC).
Age Restrictions	N/A
Prescriber Restrictions	MTC: Prescribed by or in consultation with an oncologist/hematologist or endocrinologist.
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

COPAXONE

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Multiple Sclerosis: Diagnosis of a relapsing form of multiple sclerosis (MS) (eg, relapsing-remitting MS, secondary-progressive MS with relapses, progressive-relapsing MS with relapses).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

CORLANOR

Products Affected

- Corlanor

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Heart Failure (HF) Diagnosis of heart failure. HF is classified as one of the following: New York Heart Association (NYHA) Class II, NYHA Class III, or NYHA Class IV. Patient has a left ventricular ejection fraction of less than or equal to 35%, be in sinus rhythm, have a resting heart rate that is greater than or equal to 70 beats per minute and have one of the following: be on a beta-blocker at a maximally tolerated dose or have a contraindication to beta blocker therapy. (Reauth): Documentation of positive clinical response to Corlanor therapy.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist
Coverage Duration	Initial, reauth: plan year
Other Criteria	N/A

COSENTYX (EH)

Products Affected

- Cosentyx
- Cosentyx Sensoready Pen

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Plaque psoriasis (Initial): Diagnosis of moderate to severe plaque psoriasis. One of the following: Failure, contraindication, or intolerance to Enbrel (etanercept) OR Humira (adalimumab), OR for continuation of prior Cosentyx therapy. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: Failure, contraindication, or intolerance to both Enbrel (etanercept) and Humira (adalimumab), OR for continuation of prior Cosentyx therapy. Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. One of the following: Failure, contraindication, or intolerance to both Enbrel (etanercept) and Humira (adalimumab), OR for continuation of prior Cosentyx therapy. All indications (Initial, reauth): Patient is not receiving Cosentyx in combination with a biologic DMARD [eg, Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)]. Patient is not receiving Cosentyx in combination with a Janus kinase inhibitor [eg, Xeljanz (tofacitinib)]. For a diagnosis of PsA or plaque psoriasis, Patient is not receiving Cosentyx in combination with a phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)].
Age Restrictions	N/A
Prescriber Restrictions	Plaque psoriasis (Initial): Prescribed by or in consultation with a dermatologist. Psoriatic Arthritis (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. AS (initial): Prescribed by or in consultation with a rheumatologist.
Coverage Duration	Initial and reauth: plan year
Other Criteria	All indications (Reauth): Documentation of positive clinical response to Cosentyx therapy.

COTELLIC

Products Affected

- Cotellic

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Melanoma: Diagnosis of unresectable or metastatic melanoma. Disease is positive for BRAF V600E or V600K mutation.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

CRINONE

Products Affected

- Crinone

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	All indications: Excluded if for fertility uses.
Required Medical Information	Secondary amenorrhea: Diagnosis of secondary amenorrhea (the absence of menses in women who have already started menstruation who are not pregnant, breastfeeding, or in menopause).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

CUPRIMINE

Products Affected

- Cuprimine CAPS 250MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	(initial) Diagnosis of Wilson's disease (ie, hepatolenticular degeneration), cystinuria, or severe active rheumatoid arthritis. History of failure or intolerance to Depen (penicillamine).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	(reauthorization) Documentation of positive clinical response to therapy.

CYRAMZA

Products Affected

- Cyramza

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Gastric or gastro-esophageal junction adenocarcinoma: Diagnosis of gastric or gastro-esophageal junction adenocarcinoma. Disease is advanced or metastatic. Disease has progressed on or after one prior therapy. Non-small cell lung cancer (NSCLC): Diagnosis of metastatic NSCLC. Used in combination with docetaxel. Disease has progressed on or after platinum-based chemotherapy (eg, cisplatin, carboplatin, oxaliplatin). Metastatic colorectal cancer: Diagnosis of metastatic colorectal cancer (mCRC). Used in combination with irinotecan or FOLFIRI (fluorouracil, leucovorin, and irinotecan) regimen. Disease has progressed on or after prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

DAKLINZA

Products Affected

- Daklinza

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Criteria will be applied consistent with current AASLD/IDSA guideline. For genotype 1, ONE of the following: 1) Patient has a contraindication or intolerance to Harvoni and Zepatier OR 2) For continuation of prior Daklinza therapy. For genotype 3 patients with cirrhosis: patient is ineligible for treatment with peginterferon alfa confirmed by medical record documentation (eg, chart note, laboratory values) of ONE of the following: intolerance to interferon, autoimmune hepatitis or other autoimmune disorders, hypersensitivity to peginterferon or any of its components, major uncontrolled depressive illness, baseline neutrophil count below 1500/uL, baseline platelet count below 90,000/uL, baseline hemoglobin below 10 g/dL, history of preexisting cardiac disease, or decompensated hepatic disease. All: One of the following: 1) Patient has not failed a prior HCV NS5A-containing regimen (eg, Daklinza) OR 2) patient has failed prior therapy with an NS5A-containing regimen AND submission of medical records (eg, chart notes) documenting that the patient does not have NS5A inhibitor resistance-associated variants detected using commercially available assays. All: One of the following: 1) requested daily dosage is less than 90 mg OR 2) both of the following: requested daily dosage is equal to 90 mg and patient is concomitantly receiving a moderate CYP3A inducer (eg, bosentan, dexamethasone, efavirenz, etravirine, modafinil).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with one of the following: Hepatologist, Gastroenterologist, Infectious disease specialist, HIV specialist certified through the American Academy of HIV Medicine
Coverage Duration	12 to 24 weeks. Criteria will be applied consistent with current AASLD/IDSA guideline
Other Criteria	N/A

DALIRESP

Products Affected

- Daliresp

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Chronic Obstructive Pulmonary Disease (COPD): (Initial) Diagnosis of moderate to very severe COPD. (Reauthorization): Documentation of positive clinical response to Daliresp therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, reauth: plan year
Other Criteria	COPD: (Initial) History of failure, contraindication, or intolerance to two formulary inhaled COPD agents.

DARZALEX

Products Affected

- Darzalex INJ 100MG/5ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Multiple myeloma: Diagnosis of multiple myeloma. One of the following: a) Patient has received at least three prior treatment regimens which included both of the following: proteasome inhibitor (eg, bortezomib [Velcade], carfilzomib [Kyprolis]) and immunomodulatory agent (eg, lenalidomide [Revlimid], thalidomide [Thalomid]), or b) patient is double-refractory to a proteasome inhibitor and an immunomodulatory agent.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist/hematologist.
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

DEGARELIX

Products Affected

- Firmagon

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prostate Cancer: Diagnosis of advanced prostate cancer.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

DICLOFENAC GEL

Products Affected

- Diclofenac Sodium TRANSDERMAL GEL 1%

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	Plan year
Other Criteria	N/A

DULERA

Products Affected

- Dulera

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Asthma: Diagnosis of asthma.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

DUOPA

Products Affected

- Duopa

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Parkinson's disease (Initial): Diagnosis of Parkinson's disease. Patient is levodopa-responsive and experiences disabling "Off" periods for a minimum of 3 hours/day. Disabling "Off" periods occur despite therapy with both of the following: a) oral levodopa-carbidopa and b) one drug from a different class of anti-Parkinson's disease therapy (eg, COMT inhibitor [entacapone, tolcapone], MAO-B inhibitor [selegiline, rasagiline], dopamine agonist [pramipexole, ropinirole]). (Reauth): Documentation of positive clinical response to Duopa therapy.
Age Restrictions	N/A
Prescriber Restrictions	Parkinson's disease (Initial): Prescribed by a neurologist
Coverage Duration	Initial and reauth: plan year
Other Criteria	Subject to Part B vs. Part D review.

DYSPORT

Products Affected

- Dysport

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Cervical Dystonia (CD) (init): Diagnosis of CD (also known as spasmodic torticollis). Upper limb spasticity (ULS) (init): Diagnosis of ULS as a result of CNS disorder or CNS injury
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	CD (init, reauth): 3 months for a single dose (up to 500 units). ULS (init, reauth): 3 months
Other Criteria	CD, ULS (reauth): Confirmed improvement in symptoms with initial Dysport treatment. At least 3 months have elapsed since the last treatment with Dysport.

EGRIFTA

Products Affected

- Egrifta INJ 1MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	(Initial): Diagnosis of HIV-associated lipodystrophy. Waist-circumference greater than or equal to 95 cm (37.4 inches) in men, or greater than or equal to 94 cm (37 inches) for women. Waist-to-hip ratio greater than or equal to 0.94 for men, or greater than or equal to 0.88 for women. Body mass index (BMI) greater than 20 kg/m2. Fasting blood glucose (FBG) levels less than or equal to 150 mg/dL (8.33 mmol/L). Patient has been on a stable regimen of antiretrovirals (eg, NRTIs, NNRTI, Protease Inhibitors, Integrase Inhibitors) for at least 8 weeks. (Reauth): Documentation of clinical improvement (eg, improvement in VAT, decrease in waist circumference, belly appearance) while on Egrifta therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial and reauth: 6 months
Other Criteria	N/A

ELELYSO

Products Affected

- Elelyso

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Gaucher disease: Diagnosis of Type 1 Gaucher disease. Patient has evidence of symptomatic disease (eg, moderate to severe anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

ELIGARD

Products Affected

- Eligard

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prostate Cancer: Palliative treatment of advanced prostate cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Prostate Cancer: Approve for continuation of prior therapy. History of failure, contraindication, or intolerance to Lupron Depot (7.5 mg, 22.5 mg, 30 mg, and 45 mg).

EMEND

Products Affected

- Emend ORAL CAPS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Acute Chemotherapy-induced Nausea and Vomiting (CINV): Patient is currently receiving moderately or highly emetogenic chemotherapy. Patient is concurrently on both corticosteroid [eg, Decadron (dexamethasone)] and 5-HT3 receptor antagonist [eg, Aloxi (palonosetron), Anzemet (dolasetron), Kytril (granisetron), Zofran (ondansetron)]. Delayed Chemotherapy-induced Nausea and Vomiting Prevention: Patient is currently receiving highly emetogenic chemotherapy and corticosteroid [eg, Decadron (dexamethasone)], or patient is receiving an anthracycline [eg, Adriamycin (doxorubicin), Ellence (epirubicin)] and Cytoxan (cyclophosphamide), or patient is currently receiving moderately emetogenic chemotherapy and was given Emend (oral or IV) on day 1 of chemotherapy. Postoperative Nausea and Vomiting (PONV): For the prevention of postoperative nausea and vomiting when administered prior to the induction of anesthesia.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Acute CINV, Delayed CINV: plan year. PONV: 1 month
Other Criteria	Subject to Part B vs. Part D review.

EMPLICITI

Products Affected

- Empliciti

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Multiple myeloma: Diagnosis of multiple myeloma. Used in combination with Revlimid (lenalidomide) and dexamethasone. Patient has received at least one prior therapy for multiple myeloma [eg, Revlimid (lenalidomide), Thalomid (thalidomide), Velcade (bortezomib)].
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hematologist/oncologist.
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

ENBREL

Products Affected

- Enbrel
- Enbrel Sureclick

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Failure, contraindication, or intolerance to one disease-modifying antirheumatic drug (DMARD) [eg, methotrexate (Rheumatrex/Trexall), Arava (leflunomide), Azulfidine (sulfasalazine)]. Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of moderately to severely active pJIA. Failure, contraindication, or intolerance to one of the following DMARDs: Arava (leflunomide) or methotrexate (Rheumatrex/Trexall). Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. Plaque psoriasis (Initial): Diagnosis of moderate to severe chronic plaque psoriasis. Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. Failure, contraindication, or intolerance to two NSAIDs.
Age Restrictions	N/A
Prescriber Restrictions	RA, JIA, AS (Initial): Prescribed by or in consultation with a rheumatologist. PsA (Initial): Prescribed by or in consultation with a rheumatologist or dermatologist. Plaque Psoriasis (Initial): Prescribed by or in consultation with a dermatologist.
Coverage Duration	All indications (initial, reauth): plan year
Other Criteria	All indications (Reauth): Documentation of positive clinical response to Enbrel therapy. All indications (Initial, reauth): Patient is not receiving Enbrel in combination with a biologic DMARD [eg, Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept)]. Patient is not receiving Enbrel in combination with a Janus kinase inhibitor [eg, Xeljanz (tofacitinib)]. For a diagnosis of PsA or plaque psoriasis, Patient is not receiving Enbrel in combination with a phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)].

ENTRESTO (UHCMR)

Products Affected

- Entresto

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Excluded if patient has a history of angioedema associated with use of the following: Angiotensin converting enzyme (ACE) Inhibitor therapy, Angiotensin receptor blocker (ARB) therapy. Excluded if patient is on any concomitant ACE Inhibitor or ARB before initiating treatment with Entresto (ACE inhibitors must be discontinued at least 36 hours prior to initiation of Entresto). Excluded if patient is on concomitant aliskiren therapy.
Required Medical Information	Heart Failure (with or without hypertension) (Initial): Diagnosis of heart failure (with or without hypertension). Ejection fraction is less than or equal to 40 percent. Heart failure is classified as one of the following: New York Heart Association Class II, New York Heart Association Class III, New York Heart Association Class IV. Patient is not pregnant. (Reauthorization): Documentation of positive clinical response to therapy.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist
Coverage Duration	Initial, reauth: plan year
Other Criteria	N/A

ENVARSUS XR

Products Affected

- Envarsus Xr

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Patient received a renal (kidney) transplant.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Subject to B v D review (not limited to new starts only). Approve for continuation of prior therapy if within the past 120 days if Part D. Patient is being converted from a stable dose of oral immediate-release tacrolimus. History of failure or intolerance to oral immediate-release tacrolimus.

EPOETIN ALFA

Products Affected

- Procrit

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Anemia due to Chronic Kidney Disease (CKD) (Initial): Diagnosis (dx) of CKD. Anemia by lab values (Hct less than 30% or Hgb less than 10 g/dL) within 30 days of request. The rate of hemoglobin decline indicates the likelihood of requiring a red blood cell (RBC) transfusion, and reducing the risk of alloimmunization and/or other RBC transfusion-related risks is a goal. (Reauth): Diagnosis of CKD. Most recent or average (avg) Hct over 3 months is 33% or less (Hgb 11 g/dL or less) for patients on dialysis OR Most recent or average (avg) Hct over 3 months is 30% or less (Hgb 10 g/dL or less) for patients not on dialysis OR Most recent or average (avg) Hct over 3 months is 36% or less (Hgb 12 g/dL or less) for pediatric patients. Decrease in the need for blood transfusion or Hgb increased by 1 g/dL or more from pre-treatment level. Anemia w/ HIV (Initial): Anemia by labs (Hgb less than 12 g/dL or Hct less than 36%) within 30 days of request. Serum erythropoietin level less than or equal to 500 mU/mL. Receiving zidovudine therapy or dx of HIV. (Reauth): Most recent or avg Hct over 3 months is below 36% or most recent or avg Hgb over 3 months is below 12 g/dl. Decrease in the need for blood transfusion or Hgb increased by 1 g/dL or more from pre-treatment level. Anemia with chemo (Initial):Other causes of anemia ruled out. Anemia with labs (Hct less than 30%, Hgb less than 10 g/dL) within prior 2 weeks of request. Cancer is non-myeloid malignancy. Patient is concurrently on chemo, or will receive concomitant chemo for minimum of 2 mos, or anemia caused by cancer chemo. (Reauth): Anemia by labs (Hgb less than 10 g/dl or Hct less than 30%) collected within the prior 2 wks of request. Decrease in the need for blood transfusion or Hgb increased by 1 g/dL or more from pre-treatment level. Patient is concurrently on chemo, or will receive concomitant chemo for minimum of 2 months, or anemia is caused by cancer chemo.
Age Restrictions	N/A
Prescriber Restrictions	N/A

Coverage Duration	CKD, HIV(Init): 6 mo. (reauth):plan yr. Chemo(init, reauth): 3 mo. MDS(init): 3 mo,(reauth): plan yr
Other Criteria	ESRD patients: Coverage is excluded under Medicare Part D for patients with ESRD on dialysis for any indication related or unrelated to treatment of ESRD since the payment for the drug is included in the ESRD PPS payment bundle. NON-ESRD PATIENTS for the following indications: Anemia in cancer patients on chemotherapy (init, reauth): Will not be approved if patient is not receiving cancer chemotherapy. Off-label uses (except Anemia in Myelodysplastic Syndrome (MDS): Will not be approved if patient has Hgb greater than 10 g/dL or Hct greater than 30%.CKD (init, reauth), Chemo (init), MDS (init): Verify Fe eval for adequate Fe stores.

ERIVEDGE

Products Affected

- Erivedge

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Metastatic basal cell carcinoma (BCC): Diagnosis of metastatic basal cell carcinoma. Advanced basal cell carcinoma: Diagnosis of locally advanced basal cell carcinoma. One of the following: Cancer has recurred following surgery, Patient is not a candidate for surgery, or Patient is not a candidate for radiation.
Age Restrictions	N/A
Prescriber Restrictions	Metastatic and Advanced BCC: Prescribed by or in consultation with a dermatologist or oncologist
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

ESBRIET

Products Affected

- Esbriet

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Idiopathic pulmonary fibrosis (IPF) (initial): Diagnosis of IPF, defined as exclusion of other known causes of interstitial lung disease and either the presence of usual interstitial pneumonia (UIP) pattern on high-resolution computed tomography (HRCT) revealing IPF or probable IPF in patients not subjected to lung biopsy, or HRCT and surgical lung biopsy pattern revealing IPF or probable IPF in patients subjected to a lung biopsy. IPF (reauth): Documentation of positive clinical response to therapy.
Age Restrictions	N/A
Prescriber Restrictions	(initial): Prescribed by a pulmonologist.
Coverage Duration	(initial, reauth): plan year
Other Criteria	(initial, reauth): Not used in combination with Ofev.

FARYDAK

Products Affected

- Farydak

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Multiple myeloma: Diagnosis of multiple myeloma. Used in combination with Velcade (bortezomib) and dexamethasone. Patient has received at least two prior treatment regimens which included both of the following: Velcade (bortezomib) and an immunomodulatory agent (eg, Revlimid (lenalidomide), Thalomid (thalidomide).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hematologist/oncologist
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

FENTANYL (NON-PREFERRED)

Products Affected

- Fentanyl Citrate Oral Transmucosal
- Subsys SUBLINGUAL LIQD 100MCG, 200MCG, 400MCG, 600MCG, 800MCG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Cancer pain: Chart documentation provided reflecting oral transmucosal fentanyl will be used to manage pain related to an active cancer diagnosis. At least a one week history of one of the following medications to demonstrate tolerance to opioids: morphine sulfate at doses of greater than or equal to 60 mg/day, fentanyl transdermal patch at doses greater than or equal to 25 µg/hr, oxycodone at a dose of greater than or equal to 30 mg/day , oral hydromorphone at a dose of greater than or equal to 8 mg/day, oral oxymorphone at a dose of greater than or equal to 25 mg/day, an alternative opioid at an equianalgesic dose (eg, oral methadone greater than or equal to 20 mg/day). The patient is currently taking a long-acting opioid around the clock for cancer pain
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist, pain specialist, hematologist, hospice care specialist, or palliative care specialist.
Coverage Duration	Plan year
Other Criteria	Cancer Pain: History of failure or intolerance to Abstral.

FENTANYL (PREFERRED, ABSTRAL)

Products Affected

- Abstral

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Cancer pain: Chart documentation provided reflecting oral transmucosal fentanyl will be used to manage pain related to an active cancer diagnosis. At least a one week history of one of the following medications to demonstrate tolerance to opioids: morphine sulfate at doses of greater than or equal to 60 mg/day, fentanyl transdermal patch at doses greater than or equal to 25 µg/hr, oxycodone at a dose of greater than or equal to 30 mg/day , oral hydromorphone at a dose of greater than or equal to 8 mg/day, oral oxymorphone at a dose of greater than or equal to 25 mg/day, an alternative opioid at an equianalgesic dose (eg, oral methadone greater than or equal to 20 mg/day). The patient is currently taking a long-acting opioid around the clock for cancer pain
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist, pain specialist, hematologist, hospice care specialist, or palliative care specialist.
Coverage Duration	Plan year
Other Criteria	N/A

FERRIPROX

Products Affected

- Ferriprox TABS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Transfusional iron overload due to thalassemia syndromes when current chelation therapy [eg, Desferal (deferoxamine), Exjade (deferasirox)] is inadequate.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by a hematologist/oncologist or hepatologist
Coverage Duration	Plan year
Other Criteria	Serum ferritin levels consistently greater than 1000 mcg/L prior to initiation of treatment with Ferriprox. Reauthorization: documentation of positive clinical response to Ferriprox therapy

FIRAZYR

Products Affected

- Firazyr

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of hereditary angioedema (HAE) and for the treatment of acute HAE attacks.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by an immunologist, allergist or rheumatologist
Coverage Duration	Plan year
Other Criteria	Not used in combination with other approved treatments for acute HAE attacks (eg, Berinert, Kalbitor, or Ruconest).

FLECTOR

Products Affected

- Flector

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Acute Pain: Topical treatment of acute pain due to one of the following: minor strain, sprain, contusion.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

FORTEO

Products Affected

- Forteo INJ 600MCG/2.4ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Postmenopausal Osteoporosis or men with primary or hypogonadal osteoporosis: Diagnosis of osteoporosis. Bone mineral density (BMD) T score of -3.5 or less based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site) OR Both of the following: BMD T-score between -2.5 and -3.5 (BMD T-score greater than -3.5 and less than or equal to -2.5) based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site) and either history of one of the following fractures (fx) resulting from minimal trauma (vertebral compression fx, fx of the hip, or fx of the distal radius) or failure, contraindication, or intolerance (F/C/I) to one bisphosphonate (BP) [eg Fosamax (alendronate)] OR Both of the following: History of one of the following fx resulting from minimal trauma (vertebral compression fx, fx of the hip, or fx of the distal radius) and F/C/I to one BP [eg Fosamax (alendronate)]. Glucocorticoid-Induced Osteoporosis: Dx of glucocorticoid-induced osteoporosis. History of prednisone or equivalent at a dose of 5mg/day or greater for 3 months or greater.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All indications: plan year, max 2 yrs of therapy.

Other Criteria	All indications: Treatment duration has not exceeded a total of 24 months during the patient's lifetime. Glucocorticoid-Induced Osteoporosis: BMD T score of -2.0 or less based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site) OR Both of the following: BMD T score between -1.0 and -2.0 (BMD T-score greater than -2.0 and less than or equal to -1.0) based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site) and either history of one of the following fx resulting from minimal trauma (vertebral compression fx, fx of the hip, or fx of the distal radius) or F/C/I to one BP [eg Fosamax (alendronate)] OR Both of the following: history of one of the following fx resulting from minimal trauma (vertebral compression fx, fx of the hip, or fx of the distal radius) and F/C/I to one BP [eg Fosamax (alendronate)].

GAMASTAN

Products Affected

- Gamastan S/d

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Hepatitis A: Excluded if patient has clinical manifestations of hepatitis A or exposure to hepatitis A for more than 2 weeks previously. Measles: Excluded if patient is receiving measles vaccine at the same time.
Required Medical Information	For prophylaxis before or soon after exposure to Hepatitis A. Measles: For use in susceptible individuals exposed to measles fewer than 6 days previously. Varicella: For passive immunization against varicella in immunosuppressed patients. Varicella zoster immune globulin (human) vaccine is not available. Rubella: For pregnant women who are exposed or susceptible to rubella who will not consider a therapeutic abortion.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 course of treatment
Other Criteria	N/A

GATTEX

Products Affected

- Gattex

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	(Initial) Diagnosis of short bowel syndrome. Patient is dependent on parenteral nutrition/intravenous (PN/IV) support for at least 12 consecutive months. (Reauthorization): Documentation of positive clinical response to Gattex therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months. Reauthorization: plan year
Other Criteria	N/A

GILENYA

Products Affected

- Gilenya

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Multiple Sclerosis: Diagnosis of a relapsing form of multiple sclerosis (MS) (eg, relapsing-remitting MS, secondary-progressive MS with relapses, progressive-relapsing MS with relapses).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

GILOTRIF

Products Affected

- Gilotrif

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLS): Diagnosis of metastatic NSCLC. One of the following: 1) tumors are positive for epidermal growth factor receptor (EGFR) exon 19 deletions OR 2) tumors are positive for exon 21 (L858R) substitution mutations OR 3) squamous disease progressing after previous platinum-based chemotherapy OR 4) tumors are positive for HER2 mutation OR 5) tumors are positive for a known sensitizing EGFR mutation.
Age Restrictions	N/A
Prescriber Restrictions	NSCLC: Prescribed by or in consultation with an oncologist
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

GLYCOPYRROLATE

Products Affected

- Glycopyrrolate ORAL TABS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For use as adjunctive therapy in the treatment of peptic ulcer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

GRALISE

Products Affected

- Gralise
- Gralise Starter

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Postherpetic Neuralgia (PHN): Diagnosis of PHN.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	PHN: History of failure or intolerance to generic gabapentin.

GRANIX

Products Affected

- Granix

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Primary prophylaxis of Chemotherapy-Induced Febrile Neutropenia (CFN): Patient is receiving chemotherapy regimen associated with more than 20% incidence of febrile neutropenia, or patient is receiving chemotherapy regimen associated with 10-20% incidence of febrile neutropenia and has 1 or more risk factors associated with chemotherapy-induced infection, febrile neutropenia, or neutropenia. Secondary prophylaxis of Febrile Neutropenia (FN): For patients receiving myelosuppressive anticancer drugs associated with neutropenia (ANC less than or equal to 500 cells/mm3). Patient has a history of febrile neutropenia during a previous course of chemotherapy. All indications: History of failure or intolerance to Zarxio (filgrastim-sndz).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hematologist/ oncologist
Coverage Duration	CFN, secondary prophylaxis of FN:3mo or duration of tx
Other Criteria	N/A

GRASTEK

Products Affected

- Grastek

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Initial: Excluded if received in combination with similar cross-reactive grass pollen immunotherapy (eg, Oralair). Excluded if patient has severe, unstable, or uncontrolled asthma.
Required Medical Information	Initial: Diagnosis of moderate to severe grass pollen-induced allergic rhinitis. Diagnosis confirmed by in vitro testing for pollen-specific IgE antibodies for, or positive skin test to, Timothy grass or cross-reactive grass pollens (eg, sweet vernal, orchard/cocksfoot, perennial rye, Kentucky blue/June grass, meadow fescue, or redtop). Treatment is started or will be started at least 12 weeks before the beginning of the grass pollen season. Reauth: Documentation of positive clinical response to Grastek therapy.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by a specialist in allergy and immunology
Coverage Duration	Initial, Reauth: plan year
Other Criteria	Initial: History of failure, contraindication, or intolerance to both of the following: 1) an oral or intranasal antihistamine, and 2) an intranasal corticosteroid.

GROWTH HORMONES (NON-PREFERRED)

Products Affected

- Norditropin Flexpro
- Omnitrope INJ 10MG/1.5ML, 5MG/1.5ML
- Saizen
- Saizen Click.easy

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D. Transition Phase Adolescent Patients (TPAP)
Exclusion Criteria	N/A
Required Medical Information	PGHD(initial):less than 4mo w/GD,or hx neonatal hypoglycemia assoc w/pituitary dz,or panhypopituitarism dx,or all of the following: PGHD dx [confrmd by ht (utilizing age and gender grwth charts related to ht) documented(doc) by ht more than 2.0SD below midparental ht or more than 2.25SD below population(pop) mean (below 1.2 percentile for age and gender),or grwth velocity more than 2SD below mean for age and gender, or delayed skeletal maturation more than 2SD below mean for age and gender (eg,delayed more than 2yrs compared w/chronological age)], and ped GH dosing used as defined by PI. PWS(reauth):evidence of positive response to tx(eg,incr in total LBM, decr in fat mass),or ht incr at least 2cm/yr over previous yr of tx (doc by previous ht and date and current ht and date) and expctd adult ht not attained and doc of expctd adult ht goal. GFSGA(initial):SGA dx based on catchup grwth failure in 1st 24mo of life using 0-36mo grwth chart confrmd by birth wt or length below 3rd percentile for gestational age(more than 2SD below pop mean) and ht remains at or below 3rd percentile (more than 2SD below pop mean). TS,NS(initial):ped grwth failure dx assoc w/TS w/doc female w/bone age less than 14yrs, or NS and ht below 5th percentile on grwth charts for age and gender. SHOX(initial):ped grwth failure dx w/SHOX gene deficiency confirmed by genetic testing. GFCRI(initial): ped grwth failure dx assoc w/CRI. ISS(initial):ISS dx, diagnostic eval excluded other causes assoc w/short stature(eg GHD, chronic renal insufficiency), doc ht at or below -2.25SD score below corresponding mean ht for age and gender, doc grwth velocity less than 25th percentile for bone age. PGHD,NS,SHOX,GFCRI,ISS (initial): doc male w/bone age less than 16yrs or female w/bone age less than 14yrs. PGHD,GFSGA,TS/NS,SHOX,GFCRI,ISS(reauth):ht incr of at least 2 cm/yr over previous yr of tx (doc by previous ht and date and current ht and date) and expctd adult ht not attained and doc of expctd adult ht goal.

Age Restrictions	N/A
Prescriber Restrictions	PGHD, PWS, GFSGA, TS/NS, SHOX, AGHD, TPAP, IGHDA, ISS: prescribed by endocrinologist. GFCRI: prescribed by endocrinologist or nephrologist
Coverage Duration	All indications (initial, reauth): Plan year

Other Criteria	All(initial): Hx of failure or intolerance to Genotropin and Nutropin AQ. AGHD(initial):dx of AGHD as a result of clin records supportng dx of childhood-onset GHD, or adult-onset GHD w/clin records doc hormone deficiency d/t hypothalamic-pituitary dz from organic or known causes (eg,damage from surgery, cranial irradiation, head trauma, subarachnoid hemorrhage) and pt has 1GH stim test (insulin tolerance test [ITT], arginine/GHRH,glucagon,arginine) to confirm adult GHD w/corresponding peak GH values ([ITT at or below 5mcg/L],[GHRH+ARG at or below 11mcg/L if BMI less than 25kg/m2, at or below 8mcg/L if BMI at or above 25 and below 30kg/m2, or at or below 4mcg/L if BMI at or above 30kg/m2],[glucagon at or below 3mcg/L],[Arg at or below 0.4mcg/L]) or doc deficiency of 3 anterior pituitary hormones (prolactin,ACTH,TSH,FSH/LH) and IFG-1/somatomedinC below age and gender adjstd nrml range as provided by physicians lab. AGHD(initial,reauth):panhypopituitarism OR other dx and not used in combo w/aromatase inhibitors(eg,anastrazole,letrazole) or androgens(eg,testosterone cypionate), and adult dosing utilized as def by PI. AGHD,IGHDA(reauth):evidence of ongoing monitoring as demonstrated by doc w/in past 12mo of IGF-1/somatomedinC level. TransitionPhaseAdolescent Pts(TPAP)(initial):adult GH dosing used as def by PI/AACE 2009 tx GL, attained expctd adult ht or closed epiphyses on bone radiograph, and doc high risk of GHD d/t GHD in childhood (from embryopathic/congenital defects, genetic mutations, irreversible structural hypothalamic-pituitary dz, panhypopituitarism, or deficiency of 3 anterior pituitary hormones:ACTH,TSH,prolactin,FSH/LH), w/IGF-1/somatomedinC below age and gender adj nrml range as provided by physicians lab, or pt does not have low IGF-1/somatomedinC and d/c GH tx for at least 1mo, and pt has 1 GH stim test (ITT,GHRH+ARG,ARG,glucagon) after d/c of tx for at least 1mo w/corresponding peak GH value [ITT at or below 5mcg/L], [GHRH+ARG at or below 11mcg/L if BMI less than 25kg/m2, at or below 8mcg/L if BMI at or above 25 and below 30kg/m2, or at or below 4mcg/L if BMI at or above 30kg/m2], [glucagon at or below 3mcg/L], [Arg at or below 0.4mcg/L], or at low risk of severe GHD(eg d/t isolated and/or idiopathic GHD) and d/c GH tx for at least 1mo, and pt has 1 GH stim test (ITT, GHRH+ARG, ARG, glucagon) after d/c of tx for at least 1mo w/corresponding peak GH value [ITT at or below 5mcg/L], [GHRH+ARG at or below 11mcg/L if BMI less than 25kg/m2, at or below 8mcg/L if BMI at or above 25 and below 30kg/m2, or at or below 4mcg/L if BMI at or above 30kg/m2], [glucagon at or below 3mcg/L], [Arg at or below 0.4mcg/L]. TPAP(reauth): evidence of positive response to therapy (eg,incr in total lean body mass, exercise capacity or IGF-1 and IGFBP-3), and cont adult GH dosing used as def by PI/AACE 2009 tx GL. IGHDA(initial):doc GHD by failure to produce peak serum GH greater than 5 mcg/L after 2 provocative pharmacol stim tests(insulin,L-ARG,glucagon).

GROWTH HORMONES (PREFERRED)

Products Affected

- Nutropin Aq Nuspin 10
- Nutropin Aq Nuspin 20
- Nutropin Aq Nuspin 5
- Nutropin Aq Pen

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D. Transition Phase Adolescent Patients (TPAP)
Exclusion Criteria	N/A
Required Medical Information	PGHD(initial):less than 4mo w/GD,or hx neonatal hypoglycemia assoc w/pituitary dz,or panhypopituitarism dx,or all of the following: PGHD dx [confrmd by ht (utilizing age and gender grwth charts related to ht) documented(doc) by ht more than 2.0SD below midparental ht or more than 2.25SD below population(pop) mean (below 1.2 percentile for age and gender),or grwth velocity more than 2SD below mean for age and gender, or delayed skeletal maturation more than 2SD below mean for age and gender (eg,delayed more than 2yrs compared w/chronological age)], and ped GH dosing used as defined by PI. PWS(reauth):evidence of positive response to tx(eg,incr in total LBM, decr in fat mass),or ht incr at least 2cm/yr over previous yr of tx (doc by previous ht and date and current ht and date) and expctd adult ht not attained and doc of expctd adult ht goal. GFSGA(initial):SGA dx based on catchup grwth failure in 1st 24mo of life using 0-36mo grwth chart confrmd by birth wt or length below 3rd percentile for gestational age(more than 2SD below pop mean) and ht remains at or below 3rd percentile (more than 2SD below pop mean). TS,NS(initial):ped grwth failure dx assoc w/TS w/doc female w/bone age less than 14yrs, or NS and ht below 5th percentile on grwth charts for age and gender. SHOX(initial):ped grwth failure dx w/SHOX gene deficiency confirmed by genetic testing. GFCRI(initial): ped grwth failure dx assoc w/CRI. ISS(initial):ISS dx, diagnostic eval excluded other causes assoc w/short stature(eg GHD, chronic renal insufficiency), doc ht at or below -2.25SD score below corresponding mean ht for age and gender, doc grwth velocity less than 25th percentile for bone age. PGHD,NS,SHOX,GFCRI,ISS (initial): doc male w/bone age less than 16yrs or female w/bone age less than 14yrs. PGHD,GFSGA,TS/NS,SHOX,GFCRI,ISS(reauth):ht incr of at least 2 cm/yr over previous yr of tx (doc by previous ht and date and current ht and date) and expctd adult ht not attained and doc of expctd adult ht goal.
Age Restrictions	N/A

Prescriber Restrictions	PGHD, PWS, GFSGA, TS/NS, SHOX, AGHD, TPAP, IGHDA, ISS: prescribed by endocrinologist. GFCRI: prescribed by endocrinologist or nephrologist
Coverage Duration	All indications (initial, reauth): Plan year

Other Criteria	AGHD(initial):dx of AGHD as a result of clin records supportng dx of childhood-onset GHD, or adult-onset GHD w/clin records doc hormone deficiency d/t hypothalamic-pituitary dz from organic or known causes (eg,damage from surgery, cranial irradiation, head trauma, subarachnoid hemorrhage) and pt has 1GH stim test (insulin tolerance test [ITT], arginine/GHRH,glucagon,arginine) to confirm adult GHD w/corresponding peak GH values ([ITT at or below 5mcg/L],[GHRH+ARG at or below 11mcg/L if BMI less than 25kg/m2, at or below 8mcg/L if BMI at or above 25 and below 30kg/m2, or at or below 4mcg/L if BMI at or above 30kg/m2],[glucagon at or below 3mcg/L],[Arg at or below 0.4mcg/L]) or doc deficiency of 3 anterior pituitary hormones (prolactin,ACTH,TSH,FSH/LH) and IFG-1/somatomedinC below age and gender adjstd nrml range as provided by physicians lab. AGHD(initial,reauth):panhypopituitarism OR other dx and not used in combo w/aromatase inhibitors(eg,anastrazole,letrazole) or androgens(eg,testosterone cypionate), and adult dosing utilized as def by PI. AGHD,IGHDA(reauth):evidence of ongoing monitoring as demonstrated by doc w/in past 12mo of IGF-1/somatomedinC level. TransitionPhaseAdolescent Pts(TPAP)(initial):adult GH dosing used as def by PI/AACE 2009 tx GL, attained expctd adult ht or closed epiphyses on bone radiograph, and doc high risk of GHD d/t GHD in childhood (from embryopathic/congenital defects, genetic mutations, irreversible structural hypothalamic-pituitary dz, panhypopituitarism, or deficiency of 3 anterior pituitary hormones:ACTH,TSH,prolactin,FSH/LH), w/IGF-1/somatomedinC below age and gender adj nrml range as provided by physicians lab, or pt does not have low IGF-1/somatomedinC and d/c GH tx for at least 1mo, and pt has 1 GH stim test (ITT,GHRH+ARG,ARG,glucagon) after d/c of tx for at least 1mo w/corresponding peak GH value [ITT at or below 5mcg/L], [GHRH+ARG at or below 11mcg/L if BMI less than 25kg/m2, at or below 8mcg/L if BMI at or above 25 and below 30kg/m2, or at or below 4mcg/L if BMI at or above 30kg/m2], [glucagon at or below 3mcg/L], [Arg at or below 0.4mcg/L], or at low risk of severe GHD(eg d/t isolated and/or idiopathic GHD) and d/c GH tx for at least 1mo, and pt has 1 GH stim test (ITT, GHRH+ARG, ARG, glucagon) after d/c of tx for at least 1mo w/corresponding peak GH value [ITT at or below 5mcg/L], [GHRH+ARG at or below 11mcg/L if BMI less than 25kg/m2, at or below 8mcg/L if BMI at or above 25 and below 30kg/m2, or at or below 4mcg/L if BMI at or above 30kg/m2], [glucagon at or below 3mcg/L], [Arg at or below 0.4mcg/L]. TPAP(reauth): evidence of positive response to therapy (eg,incr in total lean body mass, exercise capacity or IGF-1 and IGFBP-3), and cont adult GH dosing used as def by PI/AACE 2009 tx GL. IGHDA(initial):doc GHD by failure to produce peak serum GH greater than 5 mcg/L after 2 provocative pharmacol stim tests(insulin,L-ARG,glucagon).

HALAVEN

Products Affected

- Halaven

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Breast Cancer: Diagnosis of recurrent or metastatic breast cancer. Liposarcoma: Diagnosis of unresectable or metastatic liposarcoma.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist and/or hematologist.
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

HARVONI

Products Affected

- Harvoni

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	All of the following: A) Criteria will be applied consistent with current AASLD/IDSA guideline AND B) Patient is not receiving Harvoni in combination with another HCV direct acting antiviral agent [eg, Sovaldi (sofosbuvir), Olysio (simeprevir)].
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with one of the following: Hepatologist, Gastroenterologist, Infectious disease specialist, HIV specialist certified through the American Academy of HIV Medicine
Coverage Duration	12 to 24 wks. Criteria will be applied consistent with current AASLD/IDSA guideline
Other Criteria	N/A

HERCEPTIN

Products Affected

- Herceptin

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Breast cancer: One of the following: A) diagnosis of HER2-overexpressing breast cancer. One of the following treatment regimens: a) As part of a treatment regimen consisting of doxorubicin, cyclophosphamide, and either paclitaxel or docetaxel, b) in combination with docetaxel and carboplatin, c) as monotherapy for the adjuvant treatment of breast cancer following multi-modality anthracycline based therapy (eg, doxorubicin), d) in combination with a taxane (pacitaxel, docetaxel) for the initial treatment of breast cancer, e) as monotherapy for the treatment of metastatic breast cancer that has relapsed following prior chemotherapy. OR B) Diagnosis of recurrent or stage IV estrogen receptor positive (ER+), human epidermal growth factor receptor 2-positive (HER2+) breast cancer. Patient is a postmenopausal female or patient is a male receiving testicular steroidogenesis suppression. Used in combination with an aromatase inhibitors [eg, Aromasin (exemestane), Femara (letrozole), Arimedex (anastrozole)]. Metastatic Gastric Cancer: Diagnosis of HER2-overexpressing gastric, esophageal, or gastroesophageal junction advanced or metastatic adenocarcinoma. In combination with systemic chemotherapy.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

HETLIOZ

Products Affected

- Hetlioz

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Non-24-hour sleep-wake disorder: Diagnosis of non-24-hour sleep-wake disorder (also known as free-running disorder, free-running or non-entrained type circadian rhythm sleep disorder, or hypernychthemeral syndrome).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	Patient is totally blind (has no light perception).

HORIZANT

Products Affected

- Horizant

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Postherpetic Neuralgia (PHN): Diagnosis of PHN. Restless Legs Syndrome (RLS): Diagnosis of moderate to severe primary RLS.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	PHN: History of failure or intolerance to Gralise and generic gabapentin. RLS: History of failure, contraindication, or intolerance to generic immediate-release pramipexole and ropinirole.

HRM: ANTI-PARKINSON AGENTS

Products Affected

- Benztropine Mesylate ORAL TABS
- Trihexyphenidyl Hcl

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Parkinsonism: Diagnosis (dx) of parkinsonism. History of failure, contraindication, or intolerance to pramipexole and ropinirole.
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population.

HRM: CYCLOBENZAPRINE

Products Affected

- Amrix
- Cyclobenzaprine Hcl ORAL TABS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Fibromyalgia: Diagnosis of fibromyalgia. History of F/C/I to two of the following: Lyrica (pregabalin), Savella (milnacipran), and fluvoxamine.
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population.

HRM: CYPROHEPTADINE

Products Affected

- Cyproheptadine Hcl SYRP
- Cyproheptadine Hcl TABS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Migraine: Used for the prophylaxis of migraines. History of failure, contraindication, or intolerance (F/C/I) to timolol and topiramate. Urticaria/angioedema: Diagnosis (dx) of urticaria or angioedema. History of F/C/I to levocetirizine and zafirlukast. Seasonal/perennial allergic rhinitis: Dx of seasonal or perennial allergic rhinitis. History of F/C/I to levocetirizine and fluticasone. Vasomotor rhinitis: Dx of vasomotor rhinitis. History of F/C/I to fluticasone.
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population.

HRM: DIGOXIN ORAL

Products Affected

- Digitek TABS 0.25MG
- Digoxin ORAL SOLN
- Digoxin TABS 250MCG
- Lanoxin TABS 187.5MCG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Heart failure: Diagnosis (dx) of heart failure. Used in combination with ACCF/AHA guideline-directed medical therapy (GDMT). Atrial fibrillation: History of failure, contraindication, or intolerance to combination therapy with both a beta blocker and a nondihydropyridine calcium channel blocker (ie, verapamil, diltiazem).
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population.

HRM: DIPHENHYDRAMINE, ORAL

Products Affected

- Diphenhydramine Hcl ELIX

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	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Subject to Part B vs D review. If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population.

HRM: DRUGS TO AVOID IN THE ELDERLY

Products Affected

- Arbinoxa TABS
- Ascomp/codeine
- Bupap TABS 300MG; 50MG
- Butalbital/acetaminophen
- Butalbital/acetaminophen/caffeine ORAL CAPS
- Butalbital/acetaminophen/caffeine TABS 325MG; 50MG; 40MG
- Butalbital/acetaminophen/caffeine/codeine
- Butalbital/aspirin/caffeine CAPS
- Butalbital/aspirin/caffeine/codeine
- Butisol Sodium TABS 30MG
- Carbinoxamine Maleate SOLN
- Carbinoxamine Maleate TABS
- Chlorpropamide ORAL TABS
- Clemastine Fumarate TABS 2.68MG
- Dipyridamole ORAL TABS
- Disopyramide Phosphate ORAL CAPS
- Ergoloid Mesylates TABS
- Guanfacine Er
- Guanfacine Hcl
- Karbinal Er
- Ketorolac Tromethamine INJ 15MG/ML, 30MG/ML, 30MG/ML
- Ketorolac Tromethamine TABS
- Meperidine Hcl ORAL SOLN
- Meperidine Hcl ORAL TABS
- Meprobamate
- Methyldopa ORAL TABS 250MG, 500MG
- Methyldopa/hydrochlorothiazide
- Nifedipine ORAL CAPS
- Norpace Cr
- Pentazocine/naloxone Hcl
- Phenadoz SUPP 12.5MG
- Phenergan RECTAL SUPP
- Promethazine Hcl INJ
- Promethazine Hcl RECTAL SUPP
- Promethazine Vc Plain
- Promethegan RECTAL SUPP 25MG, 50MG
- Reserpine ORAL TABS
- Talwin
- Tencon TABS 325MG; 50MG
- Tigan INJ
- Vanatol Lq
- Zebutal CAPS 325MG; 50MG; 40MG

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	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A

Coverage Duration	Plan year
Other Criteria	If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population.

HRM: ESTROGEN

Products Affected

- Alora
- Angeliq
- Climara Pro
- Duavee
- Estradiol ORAL TABS
- Estradiol TRANSDERMAL PTTW
- Estradiol TRANSDERMAL PTWK
- Estradiol/norethindrone Acetate
- Estropipate ORAL TABS
- Evamist
- Fyavolv
- Jinteli
- Lopreeza
- Menostar
- Mimvey
- Mimvey Lo
- Minivelle
- Norethindrone Acetate/ethinyl Estradiol ORAL TABS 2.5MCG; 0.5MG, 5MCG; 1MG
- Prefest
- Premarin ORAL TABS 0.3MG, 0.45MG, 0.625MG, 0.9MG, 1.25MG
- Premphase
- Prempro

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Vasomotor symptoms: Diagnosis (dx) of vasomotor symptoms associated with menopause. History of failure, contraindication, or intolerance (F/C/I) to two of the following: venlafaxine, fluoxetine, citalopram, gabapentin. Vulvar/vaginal atrophy (except Duavee): Dx of vulvar/vaginal atrophy associated with menopause. History of F/C/I to two of the following: Premarin vaginal cream, Estring (estradiol vaginal ring). Osteoporosis prophylaxis (except Evamist): For the prevention of osteoporosis. History of F/C/I to alendronate and raloxifene.
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population.

HRM: ESTROGEN - COMBIPATCH

Products Affected

- Combipatch

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Vasomotor symptoms: Diagnosis (dx) of vasomotor symptoms associated with menopause. History of failure, contraindication, or intolerance (F/C/I) to two of the following: venlafaxine, fluoxetine, citalopram, gabapentin. Vulvar/vaginal atrophy: Dx of vulvar/vaginal atrophy associated with menopause. History of F/C/I to all of the following: Premarin vaginal cream, Estring (estradiol vaginal ring).
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population.

HRM: ESTROGEN - DIVIGEL/ELESTRIN

Products Affected

- Divigel GEL 0.5MG/0.5GM
- Elestrin

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Vasomotor symptoms: Diagnosis (dx) of vasomotor symptoms associated with menopause. History of failure, contraindication, or intolerance (F/C/I) to two of the following: venlafaxine, fluoxetine, citalopram, gabapentin.
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population.

HRM: GLYBURIDE

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diabetes mellitus: Diagnosis of diabetes mellitus. History of failure, contraindication, or intolerance (F/C/I) to glimepiride and glipizide.
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population.

HRM: HYDROXYZINE

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Anxiety: Diagnosis (dx) of anxiety. History of failure, contraindication, or intolerance (F/C/I) to two of the following: sertraline, buspirone, mirtazapine. Seasonal allergic rhinitis (oral hydroxyzine): Dx of seasonal allergic rhinitis. History of F/C/I to levocetirizine and fluticasone. Pruritus: Dx of pruritus. History of F/C/I to levocetirizine and topical alclometasone.
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Injection, ESRD patients: Coverage is excluded under Medicare Part D for patients with ESRD on dialysis for any indication related or unrelated to treatment of ESRD since the payment for the drug is included in the ESRD PPS payment bundle. Oral (hydroxyzine pamoate): Subject to Part B vs D review. Injection for NON-ESRD patients and all oral: If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population.

HRM: INDOMETHACIN

Products Affected

- Indocin SUSP
- Indomethacin ORAL CAPS
- Indomethacin Er
- Tivorbex

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Gout (immediate release only), Osteoarthritis (OA), Rheumatoid arthritis (RA): Diagnosis (dx) of acute gouty arthritis, OA, or RA. History of failure, contraindication, or intolerance (F/C/I) flurbiprofen and sulindac. Ankylosing spondylitis (AS): Dx of AS. History of F/C/I to flurbiprofen and sulindac. Painful shoulder, bursitis/tendonitis: Dx of painful shoulder or bursitis/tendonitis. History of F/C/I to flurbiprofen and sulindac. Pain: Dx of pain. History of F/C/I to two of the following: duloxetine, etodolac, ketoprofen, sulindac.
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population.

HRM: MECLIZINE

Products Affected

- Meclizine Hcl ORAL TABS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Radiation-induced vomiting: For the use in the treatment or prophylaxis of radiation-induced vomiting. History of failure, contraindication, or intolerance to granisetron and ondansetron.
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population.

HRM: MEGESTROL

Products Affected

- Megestrol Acetate ORAL SUSP
- Megestrol Acetate ORAL TABS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Cancer-related cachexia: Diagnosis (dx) of cancer-related cachexia. History of failure, contraindication, or intolerance (F/C/I) to oral dexamethasone.
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days. If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population.

HRM: MENEST

Products Affected

- Menest

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Vasomotor symptoms: Diagnosis (dx) of vasomotor symptoms associated with menopause. History of failure, contraindication, or intolerance (F/C/I) to two of the following: venlafaxine, fluoxetine, citalopram, gabapentin. Vulvar/vaginal atrophy: Dx of vulvar/vaginal atrophy associated with menopause. History of F/C/I to all of the following: Premarin vaginal cream, Estring (estradiol vaginal ring). Other diagnoses: Dx of one of the following: Female hypogonadism, Female castration, Primary ovarian failure, Breast cancer, or Prostatic carcinoma.
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population.

HRM: NEW START HIGH RISK MEDICATION

Products Affected

- Chlordiazepoxide/amitriptyline
- Perphenazine/amitriptyline
- Phenobarbital ELIX 20MG/5ML
- Phenobarbital ORAL TABS 100MG, 15MG, 16.2MG, 30MG, 32.4MG, 60MG, 64.8MG, 97.2MG
- Thioridazine Hcl ORAL TABS 100MG, 10MG, 25MG, 50MG
- Trimipramine Maleate ORAL CAPS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days. If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population.

HRM: NEW START, AMITRIPTYLINE

Products Affected

- Amitriptyline Hcl ORAL TABS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Depression: Diagnosis (dx) of depression. History of failure, contraindication, or intolerance (F/C/I) to two of the following: sertraline, bupropion, mirtazapine. Fibromyalgia: Dx of fibromyalgia. History of F/C/I to two of the following: Lyrica (pregabalin), Savella (milnacipran), and fluvoxamine. Fibromyalgia-related Insomnia: Dx of Fibromyalgia-related insomnia. History of F/C/I to Rozerem (ramelteon), and Belsomra (suvorexant). Postherpetic neuralgia (PHN): Dx of PHN. History of F/C/I to gabapentin and Lyrica (pregabalin). Migraine: Used for the prophylaxis of migraines. History of F/C/I to timolol and topiramate. Diabetic neuropathy (DN): Dx of DN. History of F/C/I to Lyrica (pregabalin) and venlafaxine. Pain: Dx of pain. History of F/C/I to two of the following: duloxetine, etodolac, ketoprofen, and sulindac. Interstitial cystitis: Dx of interstitial cystitis. History of F/C/I to Elmiron (pentosan).
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days. If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population.

HRM: NEW START, AMOXAPINE

Products Affected

- Amoxapine

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Depression: Diagnosis (dx) of depression. History of failure, contraindication, or intolerance (F/C/I) to two of the following: sertraline, bupropion, mirtazapine.
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days. If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population.

HRM: NEW START, CLOMIPRAMINE

Products Affected

- Clomipramine Hcl ORAL CAPS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Depression: Diagnosis (dx) of depression. History of failure, contraindication, or intolerance (F/C/I) to two of the following: sertraline, bupropion, mirtazapine. Migraine: Used for the prophylaxis of migraines. History of F/C/I to timolol and topiramate. Panic disorder: Dx of panic disorder. History of F/C/I to two of the following: fluoxetine, sertraline, venlafaxine. Obsessive-compulsive disorder (OCD): Dx of OCD. History of F/C/I to two of the following: fluoxetine, fluvoxamine, sertraline.
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days. If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population.

HRM: NEW START, DESIPRAMINE

Products Affected

- Desipramine Hcl ORAL TABS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Depression: Diagnosis (dx) of depression. History of failure, contraindication, or intolerance (F/C/I) to two of the following: sertraline, bupropion, mirtazapine. Postherpetic neuralgia (PHN): Dx of PHN. History of F/C/I to gabapentin and Lyrica (pregabalin). Diabetic neuropathy (DN): Dx of DN. History of F/C/I to Lyrica (pregabalin), and venlafaxine. Interstitial cystitis: Dx of interstitial cystitis. History of F/C/I to Elmiron (pentosan). Panic disorder: Dx of panic disorder. History of F/C/I to two of the following: fluoxetine, sertraline, venlafaxine. Bulimia nervosa/binge eating/ eating disorder: Dx of bulimia nervosa or binge eating or eating disorder. History of F/C/I to fluoxetine and fluvoxamine.
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days. If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population.

HRM: NEW START, DOXEPIN

Products Affected

- Doxepin Hcl CONC
- Doxepin Hcl ORAL CAPS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Depression: Diagnosis (dx) of depression. History of failure, contraindication, or intolerance (F/C/I) to two of the following: sertraline, bupropion, mirtazapine. Pain: Dx of pain. History of F/C/I to two of the following: duloxetine, etodolac, ketoprofen, and sulindac. Anxiety: Dx of anxiety. History of F/C/I to two of the following: sertraline, buspirone, mirtazapine. Nicotine dependence/ smoking cessation: For treatment of nicotine dependence (smoking cessation). History of F/C/I to two of the following: prescription nicotine inhaler (eg, Nicotrol), Chantix (varenicline), and bupropion. Chronic idiopathic urticaria (CIU): Dx of CIU. History of F/C/I to levocetirizine and zafirlukast.
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days. If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population.

HRM: NEW START, IMIPRAMINE

Products Affected

- Imipramine Hcl ORAL TABS
- Imipramine Pamoate

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Depression: Diagnosis (dx) of depression. History of failure, contraindication, or intolerance (F/C/I) to two of the following: sertraline, bupropion, mirtazapine. Diabetic neuropathy (DN): Dx of DN. History of F/C/I to Lyrica (pregabalin) and venlafaxine. Pain: Dx of pain. History of F/C/I to two of the following: duloxetine, etodolac, ketoprofen, and sulindac. Panic disorder: Dx of panic disorder. History of F/C/I to two of the following: fluoxetine, sertraline, and venlafaxine. Bulimia nervosa/binge eating/ eating disorder: Dx of bulimia nerovsa or binge eating or eating disorder. History of F/C/I to fluoxetine and fluvoxamine.
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days. If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population.

HRM: NEW START, NORTRIPTYLINE

Products Affected

- Nortriptyline Hcl ORAL CAPS
- Nortriptyline Hcl SOLN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Depression: Diagnosis (dx) of depression. History of failure, contraindication, or intolerance (F/C/I) to two of the following: sertraline, bupropion, mirtazapine. Postherpetic neuralgia (PHN): Dx of PHN. History of F/C/I to gabapentin and Lyrica (pregabalin). Diabetic neuropathy (DN): Dx of DN. History of F/C/I to Lyrica (pregabalin) and venlafaxine. Nicotine dependence/ smoking cessation: For treatment of nicotine dependence (smoking cessation). History of F/C/I to two of the following: prescription nicotine inhaler (eg, Nicotrol), Chantix (varenicline), and bupropion.
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days. If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population.

HRM: NEW START, PAROXETINE

Products Affected

- Paroxetine Hcl
- Paxil SUSP

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Social anxiety disorder (SAD)/social phobia: Diagnosis (dx) of SAD/social phobia. History of failure, contraindication, or intolerance (F/C/I) to sertraline, and venlafaxine. Depression: Dx of depression. History of F/C/I to two of the following: sertraline, bupropion, mirtazapine. Panic disorder: Dx of panic disorder. History of F/C/I to two of the following: fluoxetine, sertraline, and venlafaxine. Fibromyalgia: Dx of fibromyalgia. History of F/C/I to two of the following:Lyrica (pregabalin), Savella (milnacipran), fluvoxamine. Obsessive-compulsive disorder (OCD): Dx of OCD. History of F/C/I to two of the following: fluoxetine, fluvoxamine, sertraline. General anxiety disorder (GAD): Dx of GAD. History of F/C/I to two of the following: sertraline, buspirone, mirtazapine. Post-traumatic stress disorder (PTSD): Dx of PTSD. History of F/C/I to fluvoxamine and sertraline.
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days. If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population.

HRM: NEW START, PAROXETINE ER

Products Affected

- Paroxetine Hcl Er

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Social anxiety disorder (SAD)/social phobia: Diagnosis (dx) of SAD/social phobia. History of failure, contraindication, or intolerance (F/C/I) to sertraline and venlafaxine. Depression: Dx of depression. History of F/C/I to two of the following: sertraline, bupropion, mirtazapine. Panic disorder: Dx of panic disorder. History of F/C/I to two of the following: fluoxetine, sertraline, and venlafaxine. Fibromyalgia: Dx of fibromyalgia. History of F/C/I to two of the following: Lyrica (pregabalin), Savella (milnacipran), fluvoxamine. Hot flashes/night sweats: Dx of hot flashes/night sweats. History of F/C/I to fluoxetine.
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days. If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population.

HRM: NEW START, PEXEVA

Products Affected

- Pexeva

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Social anxiety disorder (SAD)/social phobia: Diagnosis (dx) of SAD/social phobia. History of failure, contraindication, or intolerance (F/C/I) to sertraline, and venlafaxine. Depression: Dx of depression. History of F/C/I to two of the following: sertraline, bupropion, mirtazapine. Panic disorder: Dx of panic disorder. History of F/C/I to two of the following: fluoxetine, sertraline, venlafaxine. Obsessive-compulsive disorder (OCD): Dx of OCD. History of F/C/I to two of the following: fluoxetine, fluvoxamine, sertraline.
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days. If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population.

HRM: NEW START, PROTRIPTYLINE

Products Affected

- Protriptyline Hcl

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Depression: Diagnosis (dx) of depression. History of failure, contraindication, or intolerance (F/C/I) to two of the following: sertraline, bupropion, mirtazapine. Migraine: Used for the prophylaxis of migraines. History of F/C/I to timolol and topiramate.
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days. If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population.

HRM: NON-BENZODIAZEPINE SEDATIVES

Products Affected

- Edluar
- Zaleplon
- Zolpidem Tartrate
- Zolpidem Tartrate Er

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Insomnia: Diagnosis (dx) of insomnia. History of failure, contraindication, or intolerance (F/C/I) to Rozerem (ramelteon) and Belsomra (suvorexant).
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population.

HRM: NON-BENZODIAZEPINE SEDATIVES, ESZOPICLONE

Products Affected

- Eszopiclone

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Insomnia: Diagnosis (dx) of insomnia. History of failure, contraindication, or intolerance (F/C/I) to Rozerem (ramelteon) and Belsomra (suvorexant).
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population.

HRM: PROMETHAZINE ORAL

Products Affected

- Promethazine Hcl ORAL TABS
- Promethazine Hcl SYRP

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Urticaria/angioedema: Diagnosis (dx) of urticaria or angioedema. History of failure, contraindication, or intolerance (F/C/I) to levocetirizine and zafirlukast. Seasonal/perennial allergic rhinitis: Dx of seasonal or perennial allergic rhinitis. History of F/C/I to levocetirizine and fluticasone. Vasomotor rhinitis: Dx of vasomotor rhinitis. History of F/C/I to fluticasone. Nausea/vomiting (N/V) a)Treatment of postoperative N/V or N/V due to labor. History of F/C/I to two from: chlorpromazine, perphenazine, and prochlorperazine, b) Treatment of N/V associated with motion sickness. History of F/C/I to chlorpromazine and prochlorperazine.
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Subject to Part B vs D review. If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population.

HRM: SILENOR

Products Affected

- Silenor

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Insomnia: Diagnosis (dx) of insomnia. History of failure, contraindication, or intolerance (F/C/I) to Rozerem (ramelteon) and Belsomra (suvorexant).
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population.

HRM: SKELETAL MUSCLE RELAXANTS

Products Affected

- Carisoprodol ORAL TABS
- Carisoprodol/aspirin
- Carisoprodol/aspirin/codeine
- Chlorzoxazone TABS 500MG
- Lorzone
- Metaxall
- Metaxalone
- Methocarbamol ORAL TABS
- Orphenadrine Citrate INJ
- Orphenadrine Citrate Er

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Acute, painful musculoskeletal conditions: Diagnosis (dx) of an acute, painful, musculoskeletal condition.
Age Restrictions	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population.

HRM: TRIMETHOBENZAMIDE ORAL

Products Affected

- Trimethobenzamide Hcl CAPS 300MG

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	No Prior Authorization if patient below age 65.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Subject to Part B vs D review. If member is age 65 or older, provider acknowledges that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population.

HUMIRA

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Failure, contraindication, or intolerance (F/C/I) to one disease modifying antirheumatic drug (DMARD) [eg, methotrexate (Rheumatrex/Trexall), Arava (leflunomide), Azulfidine (sulfasalazine)]. Juvenile Idiopathic Arthritis (JIA) (Initial): Diagnosis of moderately to severely active polyarticular JIA. F/C/I to one of the following DMARDs: Arava (leflunomide) or methotrexate (Rheumatrex/Trexall). Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. Plaque psoriasis (Initial): Diagnosis of moderate to severe chronic plaque psoriasis. Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. F/C/I to two NSAIDs. Crohn's Disease (CD) (Initial): Diagnosis of moderately to severely active CD. F/C/I to one of the following conventional therapies: 6-mercaptopurine, Imuran (azathioprine), corticosteroid (eg, prednisone, methylprednisolone), methotrexate (Rheumatrex/Trexall), or failure (ie, lost response) or intolerance to Remicade (infliximab). Ulcerative Colitis (UC) (Initial): Diagnosis of moderately to severely active UC. F/C/I to one of the following conventional therapies: 6-mercaptopurine, Imuran (azathioprine), corticosteroid (eg, prednisone, methylprednisolone), aminosalicylate [eg, mesalamine (Asacol, Pentasa, Rowasa), Dipentum (olsalazine), Azulfidine (sulfasalazine)]. Hidradenitis suppurativa (Initial): Diagnosis of moderate to severe hidradenitis suppurativa (ie, Hurley Stage II or III). All indications (initial, reauth): Patient is not receiving Humira in combination with a biologic DMARD [eg, Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept)]. Patient is not receiving Humira in combination with a Janus kinase inhibitor [eg, Xeljanz (tofacitinib)].For a diagnosis of PsA or plaque psoriasis, Patient is not receiving Humira in combination with a phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)].
Age Restrictions	N/A

Prescriber Restrictions	RA, AS, JIA: (Initial) Prescribed by or in consultation with a rheumatologist. PsA: (Initial) Prescribed by or in consultation with a dermatologist or rheumatologist. Plaque Psoriasis, HS: (Initial) Prescribed by or in consultation with a dermatologist. CD, UC: (Initial) Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	UC: (Initial) 12 wks, (reauth) plan year. Other indications (initial/reauth): plan year.
Other Criteria	RA, JIA, PsA, Plaque psoriasis, AS, CD, Hidradenitis suppurativa (HS) (Reauth): Documentation of positive clinical response to Humira therapy. UC (Reauth): For patients who initiated Humira therapy within the past 12 weeks: Documentation of clinical remission or significant clinical benefit by eight weeks (Day 57) of therapy OR For patients who have been maintained on Humira therapy for longer than 12 weeks: Documentation of positive clinical response to Humira therapy.

HYDROXYPROGESTERONE

Products Affected

- Hydroxyprogesterone Caproate INJ 1.25GM/5ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Amenorrhea: Diagnosis of of primary or secondary amenorrhea. Amenorrhea is due to hormonal imbalance in the absence of organic pathology (eg, submucous fibroids or uterine cancer). Endometrial disorder: Used for production of secretory endometrium and desquamation. Uterine cancer: Diagnosis of Stage III or IV adenocarcinoma of the uterine corpus. Estrogen testing: Used for the testing of endogenous estrogen production. All indications: Patient is not pregnant.
Age Restrictions	N/A
Prescriber Restrictions	Uterine cancer: Prescribed by or in consultation with an oncologist.
Coverage Duration	Amenorrhea: 4 months. Estrogen testing: 2 months. All other uses: plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

IBRANCE

Products Affected

- Ibrance

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Breast Cancer: Diagnosis of breast cancer. Disease is a) locally advanced, metastatic, recurrent, or Stage IV, b) hormone-receptor (HR)-positive, and c) human epidermal growth factor receptor 2 (HER2)-negative. One of the following: a) used in combination with Femara (letrozole) OR b) used in combination with Faslodex (fulvestrant) and disease has progressed following endocrine therapy.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

ICLUSIG

Products Affected

- Iclusig

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Chronic Myelogenous / Myeloid Leukemia (CML): Diagnosis of chronic myelogenous/myeloid leukemia (CML). One of the following: a) The patient is unable to take or has failed treatment with two or more alternative tyrosine kinase inhibitors (TKI) [eg, Bosulif (bosutinib), Gleevec (imatinib), Sprycel (dasatinib), Tasigna (nilotinib)], or b) confirmed documentation of T315I mutation. Acute Lymphoblastic Leukemia / Acute Lymphoblastic Lymphoma: Diagnosis of Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ALL)/acute lymphoblastic lymphoma. One of the following: a) the patient is unable to take or has failed treatment with two or more alternative tyrosine kinase inhibitors (TKI) [eg, Bosulif (bosutinib), Gleevec (imatinib), Sprycel (dasatinib), Tasigna (nilotinib)], or b) confirmed documentation of T315I mutation, or c) used in combination with an induction regimen not previously used.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hematologist or oncologist
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

ILARIS

Products Affected

- Ilaris

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Cryopyrin-Associated Period Syndromes (CAPS) (Initial): Diagnosis (dx) of CAPS, including Familial Cold Autoinflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS). Dx of CAPS confirmed by NRLP-3 (nucleotide-binding domain, leucine rich family (NLR), pyrin domain containing 3] gene (also known as Cold-Induced Auto-inflammatory Syndrome-1 [CIAS1]) mutation or evidence of active inflammation including both of the following: clinical symptoms (eg, rash, fever, arthralgia) and elevated acute phase reactants (eg, ESR, CRP). Systemic Juvenile Idiopathic Arthritis (SJIA) (Initial)): Dx of active SJIA (eg, fever, serositis, rash, arthritis). CAPS, SJIA (Reauth): Documentation of positive clinical response to Ilaris therapy.
Age Restrictions	N/A
Prescriber Restrictions	CAPS (initial): Prescribed by or in consultation with an allergist/immunologist, dermatologist, or rheumatologist. SJIA (initial): Prescribed by or in consultation with a rheumatologist.
Coverage Duration	CAPS, SJIA (initial, reauth): plan year
Other Criteria	SJIA (initial): History of failure, contraindication, or intolerance to NSAIDs or corticosteroids. CAPS, SJIA (initial and re-auth): Excluded if patient is receiving concomitant treatment with either of the following: Tumor necrosis factor (TNF) inhibitors [eg, Enbrel (etanercept), Humira (adalimumab), Remicade (infliximab)] or Interleukin-1 inhibitors [eg, Arcalyst (rilonacept), Kineret (anakinra)]

IMATINIB

Products Affected

- Imatinib Mesylate

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Chronic Myelogenous/Myeloid Leukemia (CML): Diagnosis of Philadelphia chromosome positive CML (Ph+CML). Acute Lymphoblastic Leukemia/Acute Lymphoblastic Lymphoma (ALL): Diagnosis of Philadelphia chromosome positive ALL (Ph+ALL)/ acute lymphoblastic lymphoma. Myelodysplastic/ myeloproliferative disease (MDS/MPD): Diagnosis of MDS/MPD associated with platelet-derived growth factor receptor (PDGFR) gene rearrangements. Aggressive systemic mastocytosis (ASM): Diagnosis of ASM. Patient is without the D816V c-Kit mutation or c-Kit mutational status unknown. Hypereosinophilic syndrome (HES) and/or chronic eosinophilic leukemia (CEL): Diagnosis of at least one of the following: HES or CEL. Dermatofibrosarcoma protuberans (DFSP): Diagnosis of DFSP. Gastrointestinal Stromal Tumors (GIST): Diagnosis of GIST.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hematologist/oncologist
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

IMBRUVICA

Products Affected

- Imbruvica

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Mantle cell lymphoma (MCL): Diagnosis of MCL and patient has received at least one prior therapy for MCL (eg, Rituxan [rituximab]). Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL): Diagnosis of CLL or SLL. Waldenstrom's Macroglobulinemia (WM)/Lymphoplasmacytic Lymphoma (LPL): Diagnosis of WM/LPL.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hematologist/oncologist
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

IMMUNE GLOBULIN

Products Affected

- Bivigam INJ 10GM/100ML
- Carimune Nanofiltered INJ 6GM
- Flebogamma Dif INJ 10%
- Gammagard Liquid INJ 2.5GM/25ML
- Gammaked INJ 1GM/10ML
- Gammaplex INJ 10GM/200ML
- Gamunex-c INJ 1GM/10ML
- Octagam INJ 1GM/20ML, 2GM/20ML
- Privigen INJ 20GM/200ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A

Required Medical Information	Primary immunodeficiency syndrome (PIS): patients with PIS. Idiopathic Thrombocytopenic Purpura (ITP): diagnosis (dx) of ITP. Documented (doc) platelet count of less than 50 x 10^9/L. Kawasaki disease (KD): dx of KD. B-cell Chronic Lymphocytic Leukemia (CLL): dx of B-Cell CLL. Doc hypogammaglobulinemia (IgG less than 500mg/dL) or history of bacterial infections associated with B-cell CLL. Bone Marrow Transplant (BMT): Confirmed allogeneic BMT within the last 100 days. Doc severe hypogammaglobulinemia (IgG less than 400 mg/dL). HIV:dx of HIV. 13 years of age or less. Doc hypogammaglobulinemia (IgG less than 400 mg/dL) or functional antibody deficiency demonstrated by poor specific antibody titers or recurrent bacterial infections. Guillain-Barre Syndrome (GBS) initial: dx of GBS. severe disease requiring aid to walk. Onset of neuropathic symptoms in the last 4 weeks. Myasthenia Gravis (MG): dx of generalized MG. Evidence of myasthenic exacerbation, defined by 1 of the following sxs in the last month: difficulty swallowing, acute respiratory failure, or major functional disability responsible for the discontinuation of physical activity. Concomitant immunomodulator therapy (tx)(eg, azathioprine, mycophenolate mofetil, cyclosporine), unless contraindicated, will be used for long-term management of MG. Dermatomyositis and Polymyositis (D/P) initial: dx of dermatomyositis or polymyositis. Failure, contraindication or intolerance (f/c/i) to immunosuppressive tx (eg corticosteroids, methotrexate, azathioprine, cyclophosphamide). Stiff person syndrome (SPS) initial:dx of SPS. f/c/i to GABAergic medication (eg, baclofen). f/c/i to immunosuppressive tx (eg, azathioprine, corticosteroids). Lambert-Eaton myasthenic syndrome (LEMS) initial: dx of LEMS. f/c/i to immunomodulator monotherapy (eg, azathioprine, corticosteroids). Concomitant immunomodulator tx (eg, azathioprine, corticosteroids), unless contraindicated, will be used for long-term management of LEMS.
Age Restrictions	N/A
Prescriber Restrictions	MG: Prescribed by a neurologist.
Coverage Duration	KD: 1 mo. GBS,CIDP (initial), MG: 3 mo. ITP: 6 mo. CIDP,GBS (reauth), other uses: plan year.

Other Criteria	Subject to Part B vs. Part D review. PIS: Clinically significant functional deficiency of humoral immunity as evidenced by doc failure to produce antibodies to specific antigens or hx of significant recurrent infxns. Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) initial: dx of CIDP confirmed by: (1) progressive sxs present for at least 2 mo, (2) symptomatic polyradiculoneuropathy as indicated by progressive or relapsing motor impairment of more than 1 limb, OR Progressive or relapsing sensory impairment of more than 1 limb, (3) Electrophysiologic findings when 3 of the following 4 criteria are present: Partial conduction block of 1 or more motor nerve, Reduced conduction velocity of 2 or more motor nerves, Prolonged distal latency of 2 or more motor nerves, Prolonged F-wave latencies of 2 or more motor nerves or the absence of F waves, AND (4) both of the following findings following lumbar puncture: WBC less than 10/mm^3, and elevated CSF protein. Multifocal motor neuropathy (MMN) initial: dx of MMN as confirmed by all of the following: (1) weakness with slowly progressive or stepwise progressive course over at least 1 month, (2) asymmetric involvement of 2 or more nerves, AND (3) absence of motor neuron signs and bulbar signs. CIDP, MMN reauth: documentation of positive clinical response to tx as measured by an objective scale [eg, Rankin, Modified Rankin, Medical Research Council (MRC) scale]. Documentation of titration to the minimum dose and frequency needed to maintain a sustained clinical effect. Relapsing remitting Multiple Sclerosis (MS) initial: dx of relapsing remitting form of MS (RRMS). Documentation of an MS exacerbation or progression (worsening) of the patient's clinical status from the visit prior to the one prompting the decision to initiate immune globulin tx. F/c/I to 2 of the following: Aubagio (teriflunomide),Betaseron (interferon beta-1b), Avonex (interferon beta-1a), Copaxone (glatiramer acetate),Rebif (interferon beta-1a), Tysabri (natalizumab), Tecfidera (dimethyl fumarate), Extavia (interferon beta-1b), Gilenya (Fingolimod). RRMS reauth: The prescriber maintains and provides chart documentation of the patient's evaluation, including all of the following: findings of interval examination including neurological deficits incurred, and assessment of disability (eg, Expanded Disability Status Score [EDSS], Functional Systems Score [FSS], Multiple Sclerosis Functional Composite [MSFC], Disease Steps [DS]). Stable or improved disability score (eg, EDSS, FSS, MSFC, DS). Documentation of decreased number of relapses since starting immune globulin tx. Dx continues to be the relapsing-remitting form of MS. Documentation of titration to the minimum dose and frequency needed to maintain a sustained clinical effect. GBS, D/P, SPS, LEMS reauth: Documentation of titration to the minimum dose and frequency needed to maintain a sustained clinical effect.

INLYTA

Products Affected

- Inlyta

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Advanced Renal Cell Carcinoma: Diagnosis of renal cell cancer. One of the following: (1) relapse following surgical excision or (2) both of the following: medically or surgically unresectable tumor and diagnosis of stage IV disease. One of the following: (1) Patient with non-clear cell histology, or (2) both of the following: patient with predominantly clear cell histology and history of failure, contraindication or intolerance to one of the following: Cytokine-based therapy [eg, Interleukin (IL)-2], Kinase inhibitor therapy [eg, Nexavar (sorafenib), Sutent (sunitinib), Votrient (pazopanib)], Avastin (bevacizumab) in combination with Interferon (IFN)-alfa therapy, or Mammalian target of rapamycin (mTOR) inhibitor therapy [eg, Torisel (temsirolimus)].
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

INSULIN-LIKE GROWTH FACTOR

Products Affected

- Increlex

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Initial therapy: IGF-1 deficiency: Diagnosis of severe primary IGF-1 deficiency. Height standard deviation score of -3.0 or less. Basal IGF-1 standard deviation score of -3.0 or less. Normal or elevated growth hormone (GH). Documentation of open epiphyses on last bone radiograph. The patient will not be treated with concurrent GH therapy. GH gene deletion: Diagnosis of growth hormone gene deletion who have developed neutralizing antibodies to GH. Documentation of open epiphyses on last bone radiograph. The patient will not be treated with concurrent GH therapy. Reauthorization: Documentation of positive clinical response to therapy. Both of the following: (1) Expected adult height is not obtained and (2) Documentation of expected adult height goal
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, reauth: plan year
Other Criteria	N/A

INTRON-A

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Chronic hepatitis B: Diagnosis of chronic hepatitis B infection, and patient is without decompensated liver disease. Chronic Hepatitis C: Diagnosis of chronic hepatitis C, patient without decompensated liver disease, patients who have not previously been treated with interferon, and one of the following - 1) used in combination with ribavirin or 2) contraindication or intolerance to ribavirin. Metastatic renal cell carcinoma (RCC): diagnosis of metastatic RCC, used in combination with Avastin (bevacizumab). Other: diagnosis of condylomata acuminata (genital or perianal), diagnosis of hairy cell leukemia, diagnosis of AIDS-related Kaposi's sarcoma, diagnosis of malignant melanoma, diagnosis of Stage III or IV follicular Non-Hodgkin's Lymphoma, as maintenance therapy for the treatment of multiple myeloma.
Age Restrictions	N/A
Prescriber Restrictions	RCC: Prescribed by or in consultation with an oncologist.
Coverage Duration	HepB, HepC: 48 wks. Condylomata acuminata (genital or perianal): 6 wks. Other: 12 months
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

IRESSA

Products Affected

- Iressa

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of metastatic NSCLC, and One of the following: tumors are positive for epidermal growth factor receptor (EGFR) exon 19 deletions or tumors are positive for EGFR exon 21 (L858R) substitution mutations.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

ISOTRETINOIN

Products Affected

- Absorica
- Claravis
- Myorisan
- Zenatane

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	(initial): Diagnosis of severe recalcitrant nodular acne unresponsive to conventional therapy OR diagnosis of treatment resistant acne. History of failure, contraindication or intolerance to an adequate trial on two of the following conventional therapy regimens: a) topical retinoid or retinoid-like agent [eg, Retin-A/Retin-A Micro (tretinoin),] b) oral antibiotic [eg, Ery-Tab (erythromycin), Minocin (minocycline)], c) topical antibiotic with or without benzoyl peroxide [eg, Cleocin-T (clindamycin), erythromycin, BenzaClin (benzoyl peroxide/clindamycin), Benzamycin (benzoyl peroxide/erythromycin)]. (Reauthorization): One of the following: After greater than or equal to 2 months off therapy, persistent or recurring severe recalcitrant nodular acne is still present, OR the total cumulative dose for total duration of therapy is less than 150 mg/kg (will be approved up to a total of 150 mg/kg).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, reauth 6 months
Other Criteria	N/A

ISTODAX

Products Affected

- Istodax

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Cutaneous T-cell lymphoma (CTCL): Diagnosis of CTCL. History of failure to one systemic therapy for the treatment of CTCL [eg, Ontak (denileukin diftitox), Targretin (bexarotene), Cytoxan (cyclophosphamide)]. Peripheral T-cell lymphoma (PTCL): Diagnosis of PTCL. History of failure, contraindication, or intolerance to one therapy for the treatment of PTCL [eg, CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone), CHOEP (cyclophosphamide, doxorubicin, vincristine, etoposide, prednisone), Dose-adjusted EPOCH (etoposide, prednisone, vincristine, cyclophosphamide, doxorubicin), HyperCVAD (cyclophosphamide, vincristine, doxorubicin, dexamethasone) alternating with high-dose methotrexate and cytarabine].
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hematologist or oncologist.
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

JADENU

Products Affected

- Jadenu

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Chronic Iron Overload due to Blood Transfusions (initial): Diagnosis of chronic iron overload (eg, sickle cell anemia, thalassemia, etc.) due to blood transfusion. Patient has blood transfusion of at least 100 mL/kg of packed red blood cells (eg, at least 20 units of packed red blood cells for a 40-kg person or more in individuals weighing more than 40 kg) prior to initiation of treatment with deferasirox. Patient has serum ferritin levels consistently greater than 1000 mcg/L prior to initiation of treatment with deferasirox. Unable to comply or adhere to parenteral Desferal (deferoxamine mesylate) therapy. Chronic Overload in non-transfusion dependent thalassemia syndromes (initial): Diagnosis of chronic iron overload in non-transfusion dependent thalassemia syndrome. Patient has liver iron (Fe) concentration (LIC) levels consistently greater than or equal to 5 mg Fe per gram of dry weight prior to initiation of treatment with deferasirox. Patient has serum ferritin levels consistently more than 300 mcg/L prior to initiation of treatment with deferasirox. Chronic Iron Overload due to Blood Transfusions, Chronic Overload in non-transfusion dependent thalassemia syndromes (reauthorization): Documentation of positive clinical response to therapy.
Age Restrictions	N/A
Prescriber Restrictions	Initial authorization: Prescribed by a hematologist/oncologist or hepatologist.
Coverage Duration	Plan year
Other Criteria	N/A

JAKAFI

Products Affected

- Jakafi

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Myelofibrosis: One of the following: Primary myelofibrosis, post-polycythemia vera myelofibrosis, or post-essential thrombocythemia myelofibrosis. Polycythemia vera: Diagnosis of polycythemia vera and history of failure, contraindication, or intolerance to hydroxyurea.
Age Restrictions	N/A
Prescriber Restrictions	Myelofibrosis, polycythemia vera: Prescribed by or in consultation with a hematologist/oncologist
Coverage Duration	Myelofibrosis, polycythemia vera: 6 months
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

JEVTANA

Products Affected

- Jevtana

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prostate Cancer: Diagnosis of metastatic hormone-refractory or castration-resistant or recurrent prostate cancer. Used in combination with prednisone. Documented disease progression during or after previous treatment with docetaxel-based therapy.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

JUXTAPID

Products Affected

- Juxtapid

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Homozygous familial hypercholesterolemia (HoFH) (initial): Submission of medical records (eg, chart notes, laboratory values) documenting diagnosis of HoFH as confirmed by one of the following: a) genetic confirmation of 2 mutations in the LDL receptor, ApoB, PCSK9, or LDL receptor adaptor protein 1 (ie, LDLRAP1 or ARH), or b) both of the following: 1) either untreated LDL-C greater than 500 mg/dL or treated LDL-C greater than 300 mg/dL AND 2) either xanthoma before 10 years of age or evidence of heterozygous FH in both parents. Patient has been receiving at least 12 consecutive weeks of ONE LDL-C lowering prescription therapy and will continue to receive an LDL-C lowering prescription therapy. History of failure after 12 consecutive weeks or intolerance to Repatha therapy. One of the following LDL-C values while on maximally tolerated lipid-lowering regimen within the last 30 days: LDL-C greater than or equal to 100 mg/dL with ASCVD OR LDL-C greater than or equal to 130 mg/dL without ASCVD. Not used in combination with Kynamro (mipomersen). Not used in combination with a proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor. Patient is not pregnant. Patient does not have moderate or severe hepatic impairment (ie, Child-Pugh category B or C) or active liver disease including unexplained persistent abnormal liver function tests. Patient is not concomitantly on moderate or strong CYP 3A4 inhibitors (eg, clarithromycin).
Age Restrictions	N/A
Prescriber Restrictions	HoFH (initial, reauth): Prescribed by a cardiologist, endocrinologist, or lipid specialist.
Coverage Duration	HoFH (initial): 6 months. (reauth): plan year

Other Criteria	HoFH (reauthorization): Patient continues to receive statin at the maximally tolerated dose (or other LDL-C lowering prescription therapy if patient is unable to take a statin). Submission of medical records (eg, laboratory values) documenting a sustained LDL-C reduction from pre-treatment baseline (ie, prior Juxtapid therapy) while on Juxtapid therapy. Not used in combination with Kynamro (mipomersen). Not used in combination with a proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor. Patient is not pregnant. Patient does not have moderate or severe hepatic impairment (ie, Child-Pugh category B or C) or active liver disease including unexplained persistent abnormal liver function tests. Patient is not concomitantly on moderate or strong CYP 3A4 inhibitors (eg, clarithromycin).

KADCYLA

Products Affected

- Kadcyla INJ 100MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Metastatic breast cancer (MBC): Diagnosis of HER2-positive, recurrent, or metastatic breast cancer.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

KALYDECO

Products Affected

- Kalydeco

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Cystic Fibrosis (CF) (Initial): Diagnosis of CF. Submission of laboratory records confirming patient has one of the following mutations in the CFTR gene: G551D, G1244E, G1349D, G178R, G551S, S1251N, S1255P, S549N, S549R, or R117H. (Reauthorization): Documentation of one of the following while on Kalydeco therapy: Improved lung function or stable lung function.
Age Restrictions	N/A
Prescriber Restrictions	CF (initial): Prescribed by or in consultation with a prescriber who specializes in treating CF patients
Coverage Duration	CF (initial): 6 mos, (reauth): plan year
Other Criteria	N/A

KAPVAY

Products Affected

- Clonidine Hcl Er

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of attention deficit hyperactivity disorder (ADHD).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

KEVEYIS

Products Affected

- Keveyis

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Primary hyperkalemic periodic paralysis, primary hypokalemic periodic paralysis, related variants (initial): Diagnosis of one of the following: Primary hyperkalemic periodic paralysis, primary hypokalemic periodic paralysis, paramyotonia Congenita with periodic paralysis. Patient does not have hepatic insufficiency (ie, patient does not have Child Pugh Class B or C). Patient does not have severe pulmonary disease (eg, severe chronic obstructive pulmonary disease (COPD)). Patient is not concomitantly on high dose aspirin. (Reauthorization): Documentation of positive clinical response to Keveyis therapy. Patient does not have hepatic insufficiency (ie, patient does not have Child Pugh Class B or C). Patient does not have severe pulmonary disease (eg, severe chronic obstructive pulmonary disease (COPD)). Patient is not concomitantly on high dose aspirin.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by or in consultation with a neurologist.
Coverage Duration	Initial: 3 months. Reauth: plan year
Other Criteria	N/A

KEYTRUDA

Products Affected

- Keytruda

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Melanoma: Diagnosis of melanoma and disease is unresectable or metastatic. Non-Small Cell Lung Cancer (NSCLC): Diagnosis of metastatic NSCLC AND tumors express PD-L1 as determined by an FDA-approved test AND patient has history of failure, contraindication, or intolerance to platinum-containing therapy (eg, cisplatin, carboplatin). Recurrent or metastatic head and neck squamous cell carcinoma (HNSCC): Patient has a diagnosis of recurrent or metastatic HNSCC AND patient has disease progression on or after platinum-containing therapy.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

KINERET (EH)

Products Affected

- Kineret

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Failure, contraindication, or intolerance to one DMARD [eg, Rheumatrex/Trexall (methotrexate), Arava (leflunomide), Azulfidine (sulfasalazine)]. Failure, contraindication, or intolerance to both Enbrel (etanercept) and Humira (adalimumab), OR for continuation of prior Kineret therapy. Neonatal-Onset Multisystem Inflammatory Disease (NOMID) (initial): Diagnosis of NOMID. Dx of NOMID confirmed by NLRP-3 (nucleotide-binding domain, leucine rich family (NLR), pyrin domain containing 3] gene (also known as Cold-Induced Auto-inflammatory Syndrome-1 [CIAS1]) mutation or evidence of active inflammation including both of the following: clinical symptoms (eg, rash, fever, arthralgia) and elevated acute phase reactants (eg, ESR, CRP). All Uses (initial, reauth): Patient is not receiving Kineret in combination with a biologic disease modifying antirheumatic drug (DMARD) [eg, Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)]. Patient is not receiving Kineret in combination with a Janus kinase inhibitor [eg, Xeljanz (tofacitinib)].
Age Restrictions	N/A
Prescriber Restrictions	RA (initial): Prescribed by or in consultation with a rheumatologist. NOMID (initial): Prescribed by or in consultation with an allergist/immunologist, pediatrician, or rheumatologist.
Coverage Duration	All uses (initial and reauth): plan year
Other Criteria	All Uses (Reauth): Documentation of positive clinical response to Kineret therapy.

KLARON

Products Affected

- Sulfacetamide Sodium SUSP

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of acne vulgaris.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

KORLYM

Products Affected

- Korlym

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	(Initial): Diagnosis of endogenous Cushing's syndrome (i.e., hypercortisolism is not a result of chronic administration of high dose glucocorticoids). Diagnosis of either type 2 diabetes mellitus or diagnosis of glucose intolerance. Patient has either failed surgery or patient is not a candidate for surgery. Patient is not pregnant. (Reauthorization): Documentation of one of the following: patient has improved glucose tolerance while on Korlym therapy or patient has stable glucose tolerance while on Korlym therapy.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by an endocrinologist.
Coverage Duration	6 months
Other Criteria	N/A

KYNAMRO

Products Affected

- Kynamro

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Homozygous familial hypercholesterolemia (HoFH) (initial):Submission of medical records (eg, chart notes, laboratory values) documenting diagnosis of HoFH as confirmed by one of the following: a) genetic confirmation of 2 mutations in the LDL receptor, ApoB, PCSK9, or LDL receptor adaptor protein 1 (ie, LDLRAP1 or ARH) , or b) both of the following: 1) either untreated LDL-C greater than 500 mg/dL or treated LDL-C greater than 300 mg/dL AND 2) either xanthoma before 10 years of age or evidence of heterozygous FH in both parents. Patient has been receiving at least 12 consecutive weeks of ONE LDL-C lowering prescription therapy and will continue to receive an LDL-C lowering prescription therapy. History of failure after 12 consecutive weeks or intolerance to Repatha therapy. One of the following LDL-C values while on maximally tolerated lipid-lowering regimen within the last 30 days: LDL-C greater than or equal to 100 mg/dL with ASCVD OR LDL-C greater than or equal to 130 mg/dL without ASCVD. Not used in combination with Juxtapid (lomitapide). Not used in combination with a proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor. Patient does not have moderate or severe hepatic impairment (ie, Child-Pugh category B or C) or active liver disease including unexplained persistent abnormal liver function tests.
Age Restrictions	N/A
Prescriber Restrictions	HoFH (initial, reauth): Prescribed by a cardiologist, endocrinologist, or lipid specialist.
Coverage Duration	HoFH (initial): 6 months. (reauth): plan year

Other Criteria	HoFH (reauthorization): Patient continues to receive statin at the maximally tolerated dose (or other LDL-C lowering prescription therapy if patient is unable to take a statin). Submission of medical records (eg, laboratory values) documenting a sustained LDL-C reduction from pre-treatment baseline (ie, prior Juxtapid therapy) while on Kynamro therapy. Not used in combination with Juxtapid (lomitapide). Not used in combination with a proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor. Patient does not have moderate or severe hepatic impairment (ie, Child-Pugh category B or C) or active liver disease including unexplained persistent abnormal liver function tests.

LENVIMA

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Differentiated thyroid cancer (DTC): Diagnosis of DTC. Disease is locally recurrent or metastatic. Patient has symptomatic or progressive disease. Disease is refractory to radioactive iodine treatment.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

LETAIRIS

Products Affected

- Letairis

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
Age Restrictions	N/A
Prescriber Restrictions	PAH (Initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH: Initial: 6 months. Reauth: plan year
Other Criteria	PAH (Reauth): Documentation of positive clinical response to therapy.

LEUKINE

Products Affected

- Leukine INJ 250MCG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Bone Marrow/Stem Cell Transplant (BMSCT): Patients with non-myeloid malignancies undergoing myeloablative chemotherapy followed by autologous or allogeneic bone marrow transplant (BMT), or for mobilization of hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis, or for peripheral stem cell transplant (PSCT) patients who have received myeloablative chemotherapy. Acute myeloid leukemia (AML): For patients with AML following induction or consolidation chemotherapy. Neutropenia Associated Dose Dense Chemotherapy (NDDC): Patient is receiving NCI's Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer, or a dose-dense regimen for which the incidence of febrile neutropenia is unknown. Chemotherapy-Induced Febrile Neutropenia (CFN): Patient is receiving a chemotherapy regimen associated with more than 20% incidence of febrile neutropenia, or patient is receiving chemotherapy regimen associated with 10-20% incidence of febrile neutropenia and has 1 or more risk factors associated with chemotherapy-induced infection, febrile neutropenia or neutropenia. Febrile Neutropenia (FN): For patients receiving myelosuppressive anticancer drugs associated with neutropenia (ANC less than or equal to 500 cells/mm3). Patient either has febrile neutropenia at high risk for infection-associated complications or has a history of febrile neutropenia during a previous course of chemotherapy. HIV-Related Neutropenia (HIVN): HIV-infected patients with an ANC less than or equal to 1,000 cells/mm3.
Age Restrictions	AML: greater than or equal to 55 years old.
Prescriber Restrictions	Prescribed by or in consultation with a hematologist/oncologist except HIVN: Prescribed by or in consultation with a hematologist/oncologist or infectious disease specialist.
Coverage Duration	BMSCT,NDDC,CFN,FN (prophylaxis), AML: 3 mo or duration of tx. HIVN: 6 mo. FN (treatment): 1 mo.
Other Criteria	N/A

LEUPROLIDE ACETATE

Products Affected

- Leuprolide Acetate INJ

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prostate Cancer: Palliative treatment of advanced prostate cancer. Central Precocious Puberty (initial): diagnosis of central precocious puberty (idiopathic or neurogenic). Onset of secondary sexual characteristics in one of the following: females less than age 8 or males less than age 9. Confirmation of diagnosis defined by one of the following: a pubertal response to a GnRH stimulation test or bone age advanced one year beyond the chronological age. (Reauthorization): Documentation of Bone age monitoring (eg, radiographic imaging).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Prostate Cancer, Central Precocious Puberty (all): plan year
Other Criteria	Prostate Cancer: Approve for continuation of prior therapy.

LIDODERM

Products Affected

- Lidocaine PTCH

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Post-herpetic neuralgia: Diagnosis of post-herpetic neuralgia
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

LONSURF

Products Affected

- Lonsurf

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Metastatic colorectal cancer (mCRC): Diagnosis of mCRC. History of failure, contraindication, or intolerance with all of the following: fluoropyrimidine-based chemotherapy, oxaliplatin-based chemotherapy, irinotecan-based chemotherapy, and anti-VEGF biological therapy. One of the following: a) tumor is RAS mutant-type or b) tumor is RAS wild-type and history of failure, contraindication or intolerance to one anti-EGFR therapy (eg, Vectibix [panitumumab], Erbitux [cetuximab]).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

LOTRONEX

Products Affected

- Alosetron Hydrochloride

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Irritable bowel syndrome (IBS) (Initial): Exclude if patient is of the male gender.
Required Medical Information	IBS (Initial): Diagnosis of chronic severe diarrhea-predominant IBS. IBS (Reauthorization): Symptoms of IBS continue to persist. Documentation of positive clinical response to Lotronex.
Age Restrictions	IBS (Initial): 18 years and older.
Prescriber Restrictions	N/A
Coverage Duration	IBS (Initial): 12 weeks. IBS (Reauthorization): 6 months.
Other Criteria	IBS (initial): History of failure, contraindication, or intolerance to an anti-diarrheal agent [eg, loperamide].

LUPANETA

Products Affected

- Lupaneta Pack

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Endometriosis (initial): Diagnosis of endometriosis. One of the following: Patient has had surgical ablation to prevent recurrence, or history of failure, contraindication, or intolerance to NSAIDs and oral contraceptives. (reauthorization): symptoms recur after one course.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Endometriosis (Initial, reauthorization): 6 months.
Other Criteria	Endometriosis (initial): History of failure, contraindication, or intolerance to Lupron Depot (3.75 mg, 11.25 mg)

LUPRON DEPOT

Products Affected

- Lupron Depot
- Lupron Depot-ped INJ 11.25MG, 15MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	LUPRON DEPOT: Prostate Cancer (7.5 mg, 22.5 mg, 30 mg, 45 mg): Palliative treatment of advanced prostate cancer. LUPRON DEPOT Endometriosis (3.75 mg, 11.25 mg) (initial): Diagnosis of endometriosis. One of the following: Patient has had surgical ablation to prevent recurrence, or history of failure, contraindication, or intolerance to NSAIDs and oral contraceptives. (reauthorization): symptoms recur after one course. Used in combination with one of the following: norethindrone 5 mg daily, other "add -back" sex hormones, other bone-sparing agents. LUPRON DEPOT: Uterine Leiomyomata (3.75 mg, 11.25 mg) (fibroids) : Either for use prior to surgery to reduce size of fibroids to facilitate a surgical procedure (eg, myomectomy, hysterectomy) Or all of the following: treatment of anemia, anemia caused by uterine leiomyomata (fibroids), and use prior to surgery. LUPRON PED: Central Precocious Puberty (CPP) (initial): diagnosis of central precocious puberty (idiopathic or neurogenic). Onset of secondary sexual characteristics in one of the following: females less than age 8 or males less than age 9. Confirmation of diagnosis defined by one of the following: a pubertal response to a GnRH stimulation test or bone age advanced one year beyond the chronological age. (Reauthorization): Documentation of bone age monitoring (eg, radiographic imaging).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Prostate CA, CPP: plan yr. Endometrosis(all), Uterine leiomyomata (anemia): 6 mo. (fibroids): 4 mo.
Other Criteria	LUPRON DEPOT: Prostate Cancer (7.5 mg, 22.5 mg, 30 mg, 45 mg): Approve for continuation of prior therapy.

LYNPARZA

Products Affected

- Lynparza

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Ovarian cancer: Diagnosis of advanced, persistent, or recurrent ovarian cancer, presence of deleterious or suspected deleterious germline BRCA-mutations as detected by an FDA approved test, and history of failure, contraindication or intolerance to three or more prior lines of chemotherapy (eg, paclitaxel with cisplatin).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

MAKENA

Products Affected

- Makena

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Preterm birth prophylaxis: Preterm birth prophylaxis: Patient is having a current singleton pregnancy. Patient has a history of prior spontaneous preterm birth of a single pregnancy. Initiation of treatment between 16 weeks, 0 days and 26 weeks, 6 days of gestation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Up to week 37 of gestation or delivery, whichever occurs first.
Other Criteria	N/A

MARINOL

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	Nausea and Vomiting Associated with Cancer Chemotherapy (CINV): Patient is receiving cancer chemotherapy. AIDS anorexia: Diagnosis of anorexia with weight loss in patients with AIDS.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	CINV: 6 months. AIDS anorexia: 3 months.
Other Criteria	Subject to Part B vs. Part D review. CINV: Approve for continuation of therapy for treatment covered under Part B when patient is receiving chemotherapy. Failure, contraindication, or intolerance (F/C/I) to 5HT-3 receptor antagonist (eg, Anzemet [dolasetron], Kytril [granisetron], or Zofran [ondansetron]). F/C/I to one of the following: Ativan (lorazepam), Compazine (prochlorperazine), Decadron (dexamethasone), Haldol (haloperidol), Phenergan (promethazine), Reglan (metoclopramide), Zyprexa (olanzapine).

MEKINIST

Products Affected

- Mekinist

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Melanoma: Diagnosis of unresectable melanoma or metastatic melanoma. Cancer is BRAFV600 mutant type (MT).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

MEMANTINE

Products Affected

- Memantine Hcl
- Memantine Hcl Titration Pak
- Memantine Hydrochloride SOLN
- Namenda Xr
- Namenda Xr Titration Pack
- Namzaric ORAL CP24 10MG; 14MG, 10MG; 28MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Age 41 or older, or diagnosis of moderate to severe dementia of the Alzheimer's type.
Age Restrictions	No Prior Authorization if patient is age 41 or older.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

MIACALCIN

Products Affected

- Miacalcin INJ

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Postmenopausal Osteoporosis: History (Hx) of one of the following fractures resulting from minimal trauma: vertebral compression fractures, fractures of the hip, or fracture of the distal radius, or BMD scan indicative of osteoporosis: T score of less than or equal to -2.5 (2.5 standard deviations or greater below the mean for young adults). Paget's Disease (Reauth): One of the following: Patient continues to have symptoms (eg, bone pain and/or deformity, neurologic disorders, elevated cardiac output, and other vascular disorders, high output heart failure) or serum alkaline phosphatase and/or urinary hydroxyproline levels are elevated based on the normal reference ranges provided by the physician's laboratory. Hypercalcemia: Verification of severe hypercalcemia confirmed by one of the following: Corrected total serum calcium of 12 mg/dL or greater or corrected total serum calcium of 6 mEq/L or greater.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Postmenopausal osteoporosis: plan year. Hypercalcemia: 1 week. Paget's (all): 6 months
Other Criteria	ESRD patients: Coverage is excluded under Medicare Part D for patients with ESRD on dialysis for any indication related or unrelated to treatment of ESRD since the payment for the drug is included in the ESRD PPS payment bundle. NON-ESRD PATIENTS for the following numbered indications: 1) Postmenopausal Osteoporosis: Both hx of failure, contraindication, or intolerance (F/C/I) to one standard therapy [eg, Fosamax (alendronate), Evista (raloxifene)] and hx of failure or intolerance to Miacalcin Nasal Spray. 2) Paget's Disease (initial): F/C/I to one oral bisphosphonate [eg, Fosamax (alendronate)].

MIRCERA

Products Affected

- Mircera

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Anemia due to Chronic Kidney Disease (CKD) (Initial): Diagnosis (dx) of CKD. Anemia by lab values (Hct less than 30% or Hgb less than 10 g/dL) within 30 days of request. The rate of hemoglobin decline indicates the likelihood of requiring a red blood cell (RBC) transfusion, and reducing the risk of alloimmunization and/or other RBC transfusion-related risks is a goal. (Reauth): Most recent or average (avg) Hct over 3 mo is 33% or less (Hgb 11 g/dL or less) for patients on dialysis OR Most recent or average (avg) Hct over 3 mo is 30% or less (Hgb 10 g/dL or less) for patients not on dialysis. Decrease in the need for blood transfusion or Hgb increased by 1 g/dL or more from pre-treatment level.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	CKD: (Init) 6mo, (reauth) plan year
Other Criteria	ESRD patients: Coverage is excluded under Medicare Part D for patients with ESRD on dialysis for any indication related or unrelated to treatment of ESRD since the payment for the drug is included in the ESRD PPS payment bundle. NON-ESRD PATIENTS for the following numbered indications: 1) Off-label uses: Will not be approved if patient has Hgb greater than 10 g/dL or Hct greater than 30%. 2) CKD (init, reauth): Verify Fe evaluation for adequate Fe stores.

MIRVASO

Products Affected

- Mirvaso

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of rosacea, patient has moderate to severe persistent (nontransient) facial erythema. Reauthorization: Documentation of positive clinical response to Mirvaso therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: plan year
Other Criteria	N/A

MOZOBIL

Products Affected

- Mozobil

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Patient with non-Hodgkin's lymphoma or multiple myeloma who will be undergoing autologous hematopoietic stem cell (HSC) transplantation. Used in combination with granulocyte-colony stimulating factor (G-CSF).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hematologist/oncologist
Coverage Duration	One course of therapy up to 4 days
Other Criteria	N/A

MYALEPT

Products Affected

- Myalept

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Initial: Diagnosis of congenital or acquired generalized lipodystrophy associated with leptin deficiency. Reauth: Documentation of positive clinical response to Myalept therapy.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by an endocrinologist.
Coverage Duration	Initial, Reauth: plan year
Other Criteria	Initial: One of the following: a) Diabetes mellitus or insulin resistance with persistent hyperglycemia (HgbA1C greater than 7.0%) despite optimized insulin therapy at maximum tolerated doses OR b) Persistent hypertriglyceridemia (TG greater than 250mg/dL) despite optimized therapy with at least two triglyceride-lowering agents from different classes (e.g., fibrates, statins) at maximum tolerated doses.

NATPARA

Products Affected

- Natpara

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Hypoparathyroidism (initial): Diagnosis of hypoparathyroidism. Unable to control hypocalcemia with both of the following standard treatments alone: calcium supplements and active vitamin D supplements (eg, calcitriol). Used as adjunctive therapy to both of the following at treatment initiation: calcium supplements and active vitamin D supplements (eg, calcitriol). Hypoparathyroidism (reauthorization): Documentation of positive clinical response to Natpara therapy.
Age Restrictions	N/A
Prescriber Restrictions	Initial authorization: Prescribed by an endocrinologist
Coverage Duration	Initial: 6 months Reauthorization: plan year
Other Criteria	N/A

NEULASTA

Products Affected

- Neulasta

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Neutropenia Associated with Dose Dense Chemotherapy (NDDC): Patient is receiving NCI's Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer, or a dose-dense regimen for which the incidence of febrile neutropenia is unknown. Chemotherapy-Induced Febrile Neutropenia (CFN): Patient is receiving a chemotherapy regimen associated with more than 20% incidence of febrile neutropenia, or patient is receiving chemotherapy regimen associated with 10-20% incidence of febrile neutropenia and has 1 or more risk factors associated with chemotherapy-induced infection, febrile neutropenia or neutropenia. Febrile Neutropenia (FN): For patients receiving myelosuppressive anticancer drugs associated with neutropenia (ANC less than or equal to 500 cells/mm3). Patient either has febrile neutropenia at high risk for infection-associated complications or has a history of febrile neutropenia during a previous course of chemotherapy. Acute radiation syndrome (ARS): Patient was/will be acutely exposed to myelosuppressive doses of radiation (hematopoietic subsyndrome of ARS).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hematologist/oncologist.
Coverage Duration	FN (treatment), ARS: 1 mo. CFN, NDDC, FN (prophylaxis): 3 mo or duration of tx.
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	Bone marrow/stem cell transplant (BMSCT): One of the following: 1) pts with non-myeloid malignancies undergoing myeloablative chemotherapy followed by autologous or allogeneic BMT, OR 2) for mobilization of hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis, OR 3) for peripheral stem cell transplant (PSCT) pts who have received myeloablative chemotherapy. Acute myeloid leukemia (AML): patients with AML following induction or consolidation chemotherapy. Primary prophylaxis of chemotherapy-induced febrile neutropenia (CFN): One of the following: 1) Pt is receiving chemotherapy regimens associated with a greater than 20% incidence of FN, OR 2) both of the following: a) Pt receiving chemotherapy regimen associated with 10-20% incidence of FN, AND b) one or more risk factors associated with chemotherapy-induced infection, FN, or neutropenia. Secondary prophylaxis of FN: Both of the following: 1) Pts receiving myelosuppressive anticancer drugs associated with neutropenia (ANC less than or equal to 500 cells/mm^3), AND 2) Pts with a history of FN during a previous course of chemotherapy. Neutropenia associated with dose-dense chemotherapy (NDDC): One of the following: 1) Pt is receiving National Cancer Institute's Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer, OR 2) Pt is receiving a dose-dense chemotherapy regimen for which the incidence of FN is unknown. Severe chronic neutropenia (SCN): Pts with SCN (ie, congenital, cyclic, and idiopathic neutropenias with chronic ANC less than or equal to 500 cells/mm^3). Treatment of FN (off-label): Both of the following: 1) Pts receiving myelosuppressive anticancer drugs associated with neutropenia (ANC less than or equal to 500 cells/mm^3), AND 2) Pts with FN at high risk for infection-associated complications. Acute radiation syndrome (ARS): Pt is/was acutely exposed to myelosuppressive doses of radiation (hematopoietic subsyndrome of ARS).
Age Restrictions	N/A

Prescriber Restrictions	Prescribed by or in consultation with a hematologist/oncologist except HIVN: Prescribed by or in consultation with a hematologist/oncologist or infectious disease specialist
Coverage Duration	BMSCT,NDDC,CFN,FN(ppx),AML:3mo or duration of tx. HIVN,ARS:6mo. FN(tx):1 mo. SCN,HCN:plan yr
Other Criteria	HIV-related neutropenia (HIVN)(off-label): Patients infected with HIV, and ANC less than or equal to 1000 (cells/mm^3). Hepatitis C treatment-related neutropenia (HCN)(off-label): One of the following: 1) patients infected with Hepatitis C virus undergoing treatment with Peg-Intron (peginterferon alfa-2b) or Pegasys (peginterferon alfa-2a) who experience neutropenia (ANC less than or equal to 500 cells/mm3) after dose reduction of Peg-Intron or Pegasys, OR 2) patients who experience interferon-induced neutropenia (ANC less than or equal to 500 cells/mm3) due to treatment with Peg-Intron (peginterferon alfa-2b) or Pegasys (peginterferon alfa-2a), AND one of the following: a) patient with HIV co-infection, OR b) status post liver transplant, OR c) patient with established cirrhosis. All indications: History of failure or intolerance to Zarxio (filgrastim-sndz).

NEXAVAR

Products Affected

- Nexavar

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Renal cell carcinoma (RCC): Diagnosis of RCC and one of the following: (1) relapse following surgical excision, or (2) both of the following: medically or surgically unresectable tumor and Stage IV disease. Hepatocellular carcinoma (HCC): Diagnosis of HCC. One of the following: patient has metastatic disease, or patient has extensive liver tumor burden, or patient is inoperable by performance status or comorbidity (local disease or local disease with minimal extrahepatic disease only), or both of the following: patient is not a transplant candidate and disease is unresectable. Differentiated thyroid carcinoma (DTC): Diagnosis of one of the following: follicular carcinoma, Hurthle cell carcinoma, or papillary carcinoma. One of the following: metastatic disease, unresectable recurrent disease, or persistent locoregional disease. One of the following: patient has symptomatic disease or patient has progressive disease. Disease is refractory to radioactive iodine (RAI) treatment. Medullary thyroid carcinoma (MTC): Diagnosis of disseminated MTC and one of the following: a) disease is progressive or disease is symptomatic with distant metastases. History of failure, contraindication, or intolerance to one of the following: Caprelsa (vandetanib) or Cometriq (cabozantinib).
Age Restrictions	N/A
Prescriber Restrictions	RCC, DTC, MTC: Prescribed by or in consultation with an oncologist, HCC: Prescribed by or in consultation with one of the following: oncologist, hepatologist, gastroenterologist.
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

NINLARO

Products Affected

- Ninlaro

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Multiple myeloma: Diagnosis of multiple myeloma. Patient has received at least one prior therapy for multiple myeloma [eg, Revlimid (lenalidomide), Thalomid (thalidomide), Velcade (bortezomib)].
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hematologist/oncologist.
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

NORTHERA

Products Affected

- Northera

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Neurogenic orthostatic hypotension (NOH): (Initial): Diagnosis of symptomatic NOH. NOH is caused by one of the following conditions: primary autonomic failure (eg, Parkinson's disease, multiple system atrophy, pure autonomic failure), dopamine beta-hydroxylase deficiency, non-diabetic autonomic neuropathy. (Reauth): Documentation of positive clinical response to therapy.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with one of the following specialists: cardiologist, neurologist, nephrologist.
Coverage Duration	Initial: 1 month. Reauth: plan year
Other Criteria	History of failure, contraindication, or intolerance to one of the following agents: Fludrocortisone acetate, midodrine.

NUCALA

Products Affected

- Nucala

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Severe eosinophilic asthma (initial): Diagnosis of severe asthma. Asthma is an eosinophilic phenotype as defined by (1) baseline peripheral blood eosinophil levels are greater than or equal to 150 cells/microliter or (2) peripheral blood eosinophil levels were greater than or equal to 300 cells/microliter within the past 12 months. Patient has had at least two or more asthma exacerbations requiring systemic corticosteroids within the past 12 months. Patient is currently being treated with, or has a contraindication, or intolerance to (1) both a high dose inhaled corticosteroid (ICS) (eg, greater than or equal to 880 mcg fluticasone propionate equivalent/day) and additional asthma controller medication (eg, leukotriene receptor antagonist, long-acting beta-2 agonist [LABA], theophylline) or (2) one maximally-dosed combination ICS/ LABA product (eg, Advair [fluticasone propionate/ salmeterol], Dulera [mometasone/ formoterol], Symbicort [budesonide/ formoterol]). Reauth: Documentation of positive clinical response (eg, reduction in exacerbations). Patient is currently being treated with, or has a contraindication or intolerance to (1) both a high dose inhaled corticosteroid (ICS) (eg, greater than or equal to 880 mcg fluticasone propionate equivalent/day) and additional asthma controller medication (eg, leukotriene receptor antagonist, long-acting beta-2 agonist [LABA], theophylline) or (2) one maximally-dosed combination ICS/LABA product (eg, Advair [fluticasone propionate/salmeterol], Dulera [mometasone/formoterol], Symbicort [budesonide/formoterol]).
Age Restrictions	Initial: Age greater than or equal to 12 years
Prescriber Restrictions	Initial, reauth: Prescribed by or in consultation with pulmonologist or allergy/immunology specialist
Coverage Duration	Initial, reauth: plan year
Other Criteria	N/A

NUEDEXTA

Products Affected

- Nuedexta

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Pseudobulbar affect (PBA) (initial): Diagnosis of PBA. (Reauthorization): Documentation of clinical benefit from ongoing therapy with Nuedexta.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	PBA (initial): 3 months, PBA (reauth): plan year
Other Criteria	N/A

NUPLAZID

Products Affected

- Nuplazid

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Parkinson's disease psychosis: Diagnosis of Parkinson's disease. Patient has at least one of the following: hallucinations or delusions.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

NUVIGIL

Products Affected

- Armodafinil

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Obstructive sleep apnea/hypopnea syndrome (OSAHS) (Initial): Diagnosis (dx) of OSAHS defined by one of the following: a) 15 or more obstructive respiratory events per hour of sleep confirmed by a sleep study (unless prescriber provides justification confirming that a sleep study is not feasible), or b) both of the following: 5 or more obstructive respiratory events per hour of sleep confirmed by a sleep study (unless prescriber provides justification confirming that a sleep study is not feasible), AND 1 of the following symptoms: unintentional sleep episodes during wakefulness, daytime sleepiness, unrefreshing sleep, fatigue, insomnia, waking up breath holding/gasping/choking, loud snoring, or breathing interruptions during sleep. Shift-work sleep disorder (SWSD) (Initial):Dx of SWSD confirmed by symptoms of excessive sleepiness or insomnia for at least 3 months, which is associated with a work period (usually night work) that occurs during the normal sleep period, or sleep study demonstrating loss of a normal sleep-wake pattern (ie, disturbed chronobiologic rhythmicity). No other medical condition or medication accounts for the symptoms. Narcolepsy (initial): Dx of narcolepsy as confirmed by sleep study (unless prescriber provides justification confirming that a sleep study is not feasible).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	OSAHS (Initial): 3 months (Reauth): plan yr. SWSD (Initial, Reauth): 3 months. Other:plan yr
Other Criteria	OSAHS (Reauth): Documentation of positive clinical response to prior therapy. SWSD (Reauth): Documentation of positive clinical response to prior therapy. Patient still requires treatment for SWSD. Narcolepsy (reauth): Documentation of positive clinical response to prior therapy.

ODOMZO

Products Affected

- Odomzo

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Advanced basal cell carcinoma: Diagnosis of locally advanced basal cell carcinoma. One of the following: cancer that has recurred following surgery or radiation therapy, or patient is not a candidate for surgery or radiation therapy.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a dermatologist or oncologist.
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

OFEV

Products Affected

- Ofev

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Idiopathic pulmonary fibrosis (IPF) (initial): Diagnosis of IPF, defined as exclusion of other known causes of interstitial lung disease and either the presence of usual interstitial pneumonia (UIP) pattern on high-resolution computed tomography (HRCT) revealing IPF or probable IPF in patients not subjected to lung biopsy, or HRCT and surgical lung biopsy pattern revealing IPF or probable IPF in patients subjected to a lung biopsy. IPF (reauth): Documentation of positive clinical response to therapy.
Age Restrictions	N/A
Prescriber Restrictions	(initial): Prescribed by a pulmonologist.
Coverage Duration	(initial, reauth): plan year
Other Criteria	(initial, reauth): Not used in combination with Esbriet.

ONMEL

Products Affected

- Onmel

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Onychomycosis (initial): Diagnosis of toenail onychomycosis confirmed by one of the following: KOH test, fungal culture, or nail biopsy. (Retreatment): Nine months has elapsed since completion of initial therapy for toenail onychomycosis. Documentation of positive clinical response to therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Onychomycosis toenail (initial, retreatment): 3 months
Other Criteria	Initial: Failure to generic itraconazole.

OPDIVO

Products Affected

- Opdivo INJ 40MG/4ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Melanoma: Diagnosis of melanoma and disease is unresectable or metastatic. Non-small cell lung cancer (NSCLC): Diagnosis of NSCLC, disease is metastatic, and history of failure, contraindication, or intolerance to platinum-based chemotherapy (eg, cisplatin, carboplatin). Renal cell carcinoma (RCC): Diagnosis of renal cell carcinoma. Disease is advanced, relapsed, or surgically unresectable Stage IV. History of failure, contraindication, or intolerance to at least one anti-angiogenic or tyrosine kinase inhibitor therapy (eg, axitinib, pazopanib, sorafenib, sunitinib).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

OPSUMIT

Products Affected

- Opsumit

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
Age Restrictions	N/A
Prescriber Restrictions	PAH (Initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH: Initial: 6 months. Reauth: plan year
Other Criteria	PAH (Reauth): Documentation of positive clinical response to therapy.

ORALAIR

Products Affected

- Oralair

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Initial: Excluded if received in combination with similar cross-reactive grass pollen immunotherapy (eg, Grastek). Excluded if patient has severe, unstable, or uncontrolled asthma.
Required Medical Information	Initial: Diagnosis of moderate to severe grass pollen-induced allergic rhinitis. Diagnosis confirmed by in vitro testing for pollen-specific IgE antibodies for, or positive skin test to, any of the five grass species contained in Oralair (ie, Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue grass) or cross-reactive grass pollens (eg, cocksfoot, meadow fescue, or redtop). Treatment is started or will be started at least 4 months before the beginning of the grass pollen season. Reauth: Documentation of positive clinical response to Oralair therapy.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by a specialist in allergy and immunology
Coverage Duration	Initial, Reauth: plan year
Other Criteria	Initial: History of failure, contraindication, or intolerance to both of the following: 1) an oral or intranasal antihistamine, and 2) an intranasal corticosteroid.

ORENCIA IV (EH)

Products Affected

- Orencia INJ 250MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Failure, contraindication, or intolerance to one DMARD [eg, Rheumatrex/Trexall (methotrexate), Arava (leflunomide), Azulfidine (sulfasalazine)]. Juvenile Idiopathic Arthritis (JIA) (Initial): Diagnosis of moderately to severely active polyarticular JIA. Failure, contraindication, or intolerance to one of the following DMARDs: Arava (leflunomide) or Rheumatrex/Trexall (methotrexate). All indications (Initial, reauth): One of the following: Failure, contraindication, or intolerance to both Enbrel (etanercept) and Humira (adalimumab), OR for continuation of prior Orencia IV therapy. Patient is not receiving Orencia in combination with a biologic DMARD [eg, Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)]. Patient is not receiving Orencia in combination with a Janus kinase inhibitor [eg, Xeljanz (tofacitinib)].
Age Restrictions	N/A
Prescriber Restrictions	RA (initial), JIA (initial): Prescribed by or in consultation with a rheumatologist.
Coverage Duration	All indications (initial and reauth): plan year
Other Criteria	All indications (reauth): Documentation of positive clinical response to Orencia therapy.

ORENCIA SC (EH)

Products Affected

- Orencia INJ 125MG/ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Failure, contraindication, or intolerance to one DMARD [eg, Rheumatrex/Trexall (methotrexate), Arava (leflunomide), Azulfidine (sulfasalazine)]. One of the following: Failure, contraindication, or intolerance to both Enbrel (etanercept) and Humira (adalimumab), OR for continuation of prior Orencia SC therapy, OR prior maintenance therapy of at least 4 weeks with Orencia IV. RA (initial, reauth): Patient is not receiving Orencia in combination with a biologic disease modifying antirheumatic drug (DMARD) [eg, Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)]. Patient is not receiving Orencia in combination with a Janus kinase inhibitor [eg, Xeljanz (tofacitinib)].
Age Restrictions	N/A
Prescriber Restrictions	RA (initial): Prescribed by or in consultation with a rheumatologist.
Coverage Duration	RA (Initial, reauth): plan year
Other Criteria	RA (Reauth): Documentation of positive clinical response to Orencia therapy.

ORENITRAM

Products Affected

- Orenitram

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
Age Restrictions	N/A
Prescriber Restrictions	PAH (Initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH: Initial: 6 months. Reauth: plan year
Other Criteria	PAH (Reauth): Documentation of positive clinical response to therapy.

ORKAMBI

Products Affected

- Orkambi TABS 125MG; 200MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Cystic fibrosis (initial): Diagnosis of cystic fibrosis (CF). Submission of laboratory records confirming the patient is homozygous for the F508del mutation in the CFTR gene. (Reauthorization): Prescriber attests that the patient has achieved a clinically meaningful response while on Orkambi therapy to one of the following: lung function as demonstrated by percent predicted forced expiratory volume in 1 second (ppFEV1), body mass index (BMI), pulmonary exacerbations, quality of life as demonstrated by Cystic Fibrosis Questionnaire-Revised (CFQ-R) respiratory domain score.
Age Restrictions	Patient is greater than or equal to 12 years of age
Prescriber Restrictions	CF (initial, reauthorization): Prescribed by or in consultation with a prescriber who specializes in treating CF patients
Coverage Duration	Initial: 6 months. Reauth: plan year
Other Criteria	N/A

OTEZLA (EH)

Products Affected

- Otezla

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Psoriatic arthritis (PsA, initial): Diagnosis of active PsA. Plaque psoriasis (Initial): Diagnosis of moderate to severe plaque psoriasis. PsA, plaque psoriasis (initial): Failure, contraindication, or intolerance to both Humira and Enbrel, OR for continuation of prior Otezla therapy.
Age Restrictions	N/A
Prescriber Restrictions	PsA (init): Prescribed by or in consultation with one of the following specialists: dermatologist or rheumatologist. Plaque psoriasis (init): Prescribed by or in consultation with a dermatologist.
Coverage Duration	Initial, Reauth: plan year
Other Criteria	Reauthorization (all indications): Documentation of positive clinical response to Otezla therapy.

OTREXUP

Products Affected

- Otrexup INJ 10MG/0.4ML, 15MG/0.4ML, 17.5MG/0.4ML, 20MG/0.4ML, 22.5MG/0.4ML, 25MG/0.4ML, 7.5MG/0.4ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid arthritis (RA): Diagnosis of severe, active RA. Polyarticular juvenile idiopathic arthritis (PJIA): Diagnosis of active PJIA. Psoriasis: Diagnosis of severe psoriasis. (Reauth): Documentation of positive clinical response to therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: plan year
Other Criteria	History of failure or intolerance to oral or injectable methotrexate.

OXANDRIN

Products Affected

- Oxandrolone ORAL TABS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Bone Pain: Diagnosis of bone pain due to osteoporosis. AIDS Wasting (Initial): Diagnosis of AIDS wasting or cachexia associated with AIDS. AIDS wasting (Reauth): Evidence of positive response to therapy while taking Oxandrin.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	AIDS Wasting (Initial therapy): 3 mo. (Reauth): plan year. Bone Pain: plan year
Other Criteria	N/A

OXTELLAR XR

Products Affected

- Oxtellar Xr

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of partial seizures.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

PEGASYS

Products Affected

- Pegasys
- Pegasys Proclick

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Criteria will be applied consistent with current AASLD-IDSA guidance.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	HepB: 48 wks. HepC: 20-28wks. Criteria will be applied consistent with current AASLD/IDSA guideline
Other Criteria	N/A

PEG-INTRON

Products Affected

- Pegintron
- Peg-intron Redipen

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Criteria will be applied consistent with current AASLD-IDSA guidance.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	HepC: 20-28wks. Criteria will be applied consistent with current AASLD/IDSA guideline
Other Criteria	N/A

PENNSAID

Products Affected

- Diclofenac Sodium TRANSDERMAL SOLN 1.5%
- Pennsaid SOLN 2%

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Treatment of pain of osteoarthritis of the knee(s).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

PERJETA

Products Affected

- Perjeta

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Metastatic breast cancer: Diagnosis of HER2-positive metastatic breast cancer. One of the following: (1) patient has not received prior anti-HER2 therapy or chemotherapy for metastatic disease and Perjeta is used in combination with both of the following: Herceptin (trastuzumab) and a taxane (eg, docetaxel, paclitaxel), OR (2) patient was previously treated with chemotherapy and Herceptin (trastuzumab) without Perjeta and Perjeta is used in combination with Herceptin (trastuzumab). Non-metastatic breast cancer: One of the following diagnoses: HER2-positive early stage breast cancer, HER2-positive locally advanced breast cancer, or HER2-positive inflammatory breast cancer. Perjeta is used in combination with both of the following: Herceptin (trastuzumab) and a taxane (eg, docetaxel, paclitaxel).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

POMALYST

Products Affected

- Pomalyst

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Multiple myeloma: Diagnosis of multiple myeloma. History of failure, contraindication or intolerance to both an immunomodulatory agent [eg, Revlimid (lenalidomide)] and a proteasome inhibitor [eg, Velcade (bortezomib)].
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hematologist/oncologist.
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

PRALUENT (UHCMR)

Products Affected

- Praluent

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Initial: Submission of medical records (eg, chart notes, laboratory values) documenting one of the following diagnoses: Heterozygous familial hypercholesterolemia (HeFH) as confirmed by one of the following: (1) Documented assessment of patient using Dutch Lipid Clinic Network diagnostic criteria with a cumulative score greater than or equal to 9 points (ie, definite FH), (2) Presence of tendinous xanthomas in patient, first degree relative, or second degree relative, AND Untreated/pre-treatment LDL-C greater than 190 mg/dL in an adult, (3) Genetic confirmation of a mutation in the LDL receptor, ApoB, or PCSK9. OR Atherosclerotic cardiovascular disease (ASCVD) as confirmed by acute coronary syndromes, history of myocardial infarction, stable or unstable angina, coronary or other arterial revascularization, stroke, transient ischemic attack, or peripheral arterial disease presumed to be of atherosclerotic origin. One of the following LDL-C values while on maximally tolerated statin therapy within the last 30 days: (1) LDL-C greater than or equal to 100 mg/dL with ASCVD, or (2) LDL-C greater than or equal to 130 mg/dL without ASCVD.
Age Restrictions	N/A
Prescriber Restrictions	Initial, reauth: Prescribed by a cardiologist, endocrinologist, or lipid specialist
Coverage Duration	Initial: 6 months. Reauth: plan year

Other Criteria	HeFH/ASCVD: Initial: One of the following: (1) Patient has been receiving at least 12 consecutive weeks of one high-intensity statin therapy and will continue to receive a HIGH-INTENSITY statin [ie, atorvastatin 40-80 mg, Crestor (rosuvastatin) 20-40 mg] at maximally tolerated dose, OR (2) Both of the following: A) Patient is unable to tolerate high-intensity statin as evidenced by intolerable and persistent (ie, more than 2 weeks) myalgia (muscle symptoms without CK elevations) or myositis (muscle symptoms with CK elevations less than 10 times upper limit of normal [ULN]), AND B) One of the following: a) Patient has been receiving at least 12 consecutive weeks of one moderate-intensity or low-intensity statin therapy and will continue to receive a MODERATE-INTENSITY or LOW-INTENSITY statin [ie, atorvastatin 10-20 mg, Crestor (rosuvastatin) 5-10 mg, simvastatin 10-40 mg, pravastatin 10-80 mg, lovastatin 20-40 mg, Lescol XL (fluvastatin XL) 80 mg, fluvastatin 20-40 mg, or Livalo (pitavastatin) 1-4 mg] at maximally tolerated dose, OR b) Patient is unable to tolerate moderate-intensity or low-intensity statin as evidenced by intolerable and persistent (ie, more than 2 weeks) myalgia (muscle symptoms without CK elevations) or myositis (muscle symptoms with CK elevations less than 10 times upper limit of normal [ULN]), OR (3) Submission of medical records documenting patient has a labeled contraindication to all statins, OR (4) Patient has experienced rhabdomyolysis on one statin therapy. Reauth: Patient continues to receive statin at the maximally tolerated dose (unless patient has documented inability to take statins). Submission of medical records (eg, laboratory values) documenting a sustained LDL-C reduction from pre-treatment baseline (ie, prior to Praluent therapy) while on Praluent therapy. Initial, reauth: Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor.

PROGRAF (IV)

Products Affected

- Prograf INJ

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Transplant: Patient received a renal (kidney), cardiac (heart), or hepatic (liver) transplant.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days. Unable to take oral tacrolimus.

PROGRAF (ORAL)

Products Affected

- Tacrolimus ORAL CAPS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Transplant: Patient received a renal (kidney), cardiac (heart), or hepatic (liver) transplant.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Subject to Part B vs. Part D review (not limited to new starts only). Approve for continuation of prior therapy if within the past 120 days if Part D.

PROLIA

Products Affected

- Prolia

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Postmenopausal osteoporosis (PMO) (initial): Diagnosis (dx) of PMO. History (hx) of vertebral compression fractures (fx), or fx of the hip, or distal radius resulting from minimal trauma, or bone mineral density score (BMD) indicative of osteoporosis (OP): T-score less than or equal to -2.5 (2.5 standard deviations [SD] or greater below the mean for young adults). PMO, prophylaxis (initial): For prevention of PMO. BMD scan indicative of osteopenia: T-score -1.0 to -2.5. Nonmetastatic prostate cancer (NMPC) bone loss (initial): Dx of NMPC. Pt is 70 yrs or older, or less than 70 yrs old with BMD T-score below -1.0 (1.0 SD or greater below the mean for young adults) or hx of vertebral compression fx or fx of the hip or distal radius resulting from minimal trauma. NMPC (reauth): No evidence of metastases. Breast cancer (BC) bone loss (initial): Dx of BC. BMD T-score below -1.0 (1.0 SD or greater below the mean for young adults) or hx of vertebral compression fx or fx of the hip or distal radius resulting from minimal trauma. OP in men (initial): Pt is a male with OP. Hx of vertebral compression fx or fx of the hip or distal radius resulting from minimal trauma, or BMD indicative of OP: T-score less than or equal to -2.0 (2.0 SD or greater below the mean for young adults). PMO, PMO (prophylaxis), OP in men (reauth): Documentation of positive clinical response to Prolia therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All indications (initial and reauth): plan year

Other Criteria	Postmenopausal osteoporosis, Postmenopausal osteoporosis (prophylaxis), Osteoporosis in men (initial): Hx of failure, contraindication, or intolerance (F/C/I) to one bisphosphonate (eg, alendronate). Nonmetastatic prostate cancer (NMPC) bone loss (initial): Receiving androgen deprivation therapy (ADT) from luteinizing hormone/gonadotropin releasing hormone (LHRH/GnRH) agonist [eg, Eligard/Lupron (leuprolide), Trelstar (triptorelin), Vantas (histrelin), Zoladex (goserelin)] or bilateral orchiectomy (ie, surgical castration). NMPC (Reauth): ADT from LHRH/GnRH agonist [eg, Eligard/Lupron (leuprolide), Trelstar (triptorelin), Vantas (histrelin), Zoladex (goserelin)] or bilateral orchiectomy (ie, surgical castration). Breast cancer (BC) bone loss (initial): Pt is receiving aromatase inhibitor (AI) therapy [eg, Arimidex (anastrozole), Aromasin (exemestane), Femara (letrozole)]. BC (reauth): Receiving AI therapy [eg, Arimidex (anastrozole), Aromasin (exemestane), Femara (letrozole)].

PROMACTA

Products Affected

- Promacta

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Chronic idiopathic thrombocytopenic purpura (ITP): Diagnosis of chronic ITP. Chronic Hepatitis C-associated thrombocytopenia (initial): Diagnosis of chronic hepatitis C-associated thrombocytopenia. One of the following: planning to initiate and maintain interferon-based treatment or currently receiving interferon-based treatment. (Reauthorization): One of the following criteria: For patients that started treatment with Promacta prior to initiation of treatment with interferon, Promacta will be approved when both of the following are met: currently on antiviral interferon treatment for treatment of chronic hepatitis C and documentation that patient reached threshold platelet count that allows initiation of antiviral interferon therapy with Promacta treatment by week 9. OR for patients that started treatment with Promacta while on concomitant treatment with interferon, Promacta will be approved based on the following criterion: currently on antiviral interferon therapy for treatment of chronic hepatitis C. Severe Aplastic Anemia (SAA) (initial): Diagnosis of SAA. SAA (reauthorization): Documentation of positive clinical response to Promacta therapy.
Age Restrictions	N/A
Prescriber Restrictions	Chronic ITP and SAA: Prescribed by or in consultation with a hematologist/oncologist. Chronic hepatitis C associated thrombocytopenia: Prescribed by or in consultation with a hematologist/oncologist, gastroenterologist, hepatologist, or infectious disease specialist.
Coverage Duration	Hep.C thrombo(initial):3mo. SAA(initial):16wk. Chronic ITP,HepC(reauth), SAA(reauth):plan yr

Other Criteria	Chronic ITP: History of failure, contraindication, or intolerance to at least one of the following: corticosteroids, immunoglobulins, or splenectomy. SAA: History of failure, contraindication, or intolerance to at least one course of immunosuppressive therapy (eg, Atgam (antithymocyte globulin equine), Thymoglobulin (antithymocyte globulin rabbit), cyclosporine).

PROMETRIUM

Products Affected

- Progesterone ORAL CAPS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	One of the following: a) diagnosis of secondary amenorrhea, or b) diagnosis of endometrial hyperplasia and patient has not had a hysterectomy and patient is postmenopausal and patient is receiving conjugated estrogen tablets.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

PROPANTHELINE

Products Affected

- Propantheline Bromide TABS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For use as adjunctive therapy in the treatment of peptic ulcer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

PROVIGIL

Products Affected

- Modafinil

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Obstructive sleep apnea/hypopnea syndrome (OSAHS) (Initial): Diagnosis (dx) of OSAHS defined by one of the following: 15 or more obstructive respiratory events per hour of sleep confirmed by a sleep study (unless prescriber provides justification confirming that a sleep study is not feasible), or both of the following: 5 or more obstructive respiratory events per hour of sleep confirmed by a sleep study (unless prescriber provides justification confirming that a sleep study is not feasible), and 1 of the following symptoms: unintentional sleep episodes during wakefulness, daytime sleepiness, unrefreshing sleep, fatigue, insomnia, waking up breath holding/gasping/choking, loud snoring, or breathing interruptions during sleep. Shift-work sleep disorder (SWSD) (Initial):Dx of SWSD confirmed by symptoms of excessive sleepiness or insomnia for at least 3 months, which is associated with a work period (usually night work) that occurs during the normal sleep period, or sleep study demonstrating loss of a normal sleep-wake pattern (ie, disturbed chronobiologic rhythmicity). No other medical condition or medication accounts for the symptoms. Narcolepsy (initial): Dx of narcolepsy as confirmed by sleep study (unless prescriber provides justification confirming that a sleep study is not feasible). MS Fatigue (initial): Dx of multiple sclerosis (MS). Patient is experiencing fatigue. Idiopathic Hypersomnia (initial): Dx of idiopathic hypersomnia as confirmed by sleep study (unless prescriber provides justification confirming that a sleep study is not feasible). Depression (initial): Treatment-resistant depression defined as diagnosis of major depressive disorder (MDD) or bipolar depression, AND history of failure, contraindication, or intolerance to at least two antidepressants from different classes (eg, SSRIs, SNRIs, bupropion). Used as adjunctive therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A

Coverage Duration	OSAHS/MS/dep(init),SWSD(init,reauth):3mo. OSAHS/dep(reauth):plan yr. MS (reauth):6mo. Other:plan yr
Other Criteria	OSAHS (Reauth): Documentation of positive clinical response to prior therapy. SWSD (Reauth): Documentation of positive clinical response to prior therapy. Patient still requires treatment for SWSD. Narcolepsy (reauth): Documentation of positive clinical response to prior therapy. MS Fatigue (reauth): Patient is experiencing relief of fatigue with modafinil therapy. Idiopathic Hypersomnia (reauth): Documentation of positive clinical response to modafinil therapy. Depression (reauth): Documentation of positive clinical response to modafinil therapy. Used as adjunctive therapy.

QUALAQUIN

Products Affected

- Quinine Sulfate CAPS 324MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Excluded if used for treatment or prevention of nocturnal leg cramps.
Required Medical Information	Diagnosis (dx) of uncomplicated malaria and one of the following: treatment in areas of chloroquine-sensitive malaria or treatment in areas of chloroquine-resistant malaria.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	7 days
Other Criteria	Chloroquine-sensitive malaria: Failure, contraindication or intolerance to chloroquine or hydroxychloroquine.

RAGWITEK

Products Affected

- Ragwitek

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Initial: Excluded if patient has severe, unstable, or uncontrolled asthma.
Required Medical Information	Initial: Diagnosis of moderate to severe short ragweed pollen-induced allergic rhinitis. Diagnosis confirmed by in vitro testing for pollen-specific IgE antibodies for, or positive skin test to, short ragweed pollen. Treatment is started or will be started at least 12 weeks before the beginning of the short ragweed pollen season. Reauth: Documentation of positive clinical response to Ragwitek therapy.
Age Restrictions	N/A
Prescriber Restrictions	Initial: Prescribed by a specialist in allergy and immunology
Coverage Duration	Initial, Reauth: plan year
Other Criteria	Initial: History of failure, contraindication, or intolerance to both of the following: 1) an oral or intranasal antihistamine, and 2) an intranasal corticosteroid.

RASUVO

Products Affected

- Rasuvo

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid arthritis (RA): Diagnosis of severe, active RA. Polyarticular juvenile idiopathic arthritis (PJIA): Diagnosis of active PJIA. Psoriasis: Diagnosis of severe psoriasis. (Reauth): Documentation of positive clinical response to therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: plan year
Other Criteria	History of failure or intolerance to oral or injectable methotrexate.

RECLAST

Products Affected

- Zoledronic Acid INJ 5MG/100ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Paget's: (Initial) Dx of Paget's with 1 of the following: elevations in serum alk phosph of 2 or more times the upper limit of normal ref range provided by the physician's lab, symptoms associated with Paget's disease (eg, bone pain at a pagetic site, radicular or arthritic pain caused by bone involvement that affects nerve roots or joints, neurological symptoms arising in the setting of active pagetic bone impacting on neural tissues) , or at risk for complications (eg, active Paget's disease at skeletal sites: skull, spine, weight-bearing long bones, and bones adjacent to major joints such as hip or knee). (Reauth) Serum alkaline phosph conc fails to normalize after previous therapy or patient is experiencing symptoms. Treatment of postmenopausal osteoporosis (OP) or OP in men: Dx of postmenopausal OP or OP in men. Hx of vertebral compression fractures or fractures of the hip or distal radius resulting from minimal trauma, or T-score less than or equal to -2.5 (2.5 standard deviations or more below the mean for young adults). Prevention of postmenopausal osteoporosis: T-score of -1 to -2.5, or 10 year prob of hip fracture of 3% or more, or 10 year prob of a major OP-related fracture of 20% or more based on WHO Fracture Risk Algorithm. Glucocorticoid-induced OP: For treatment of glucocorticoid-induced OP, or prevention in patients who are initiating or continuing on 7.5 mg/day or more of oral prednisone or equivalent for at least 12 mo.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Paget's (all): One treatment. Osteoporosis:plan year
Other Criteria	N/A

REGRANEX

Products Affected

- Regranex

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diabetic Neuropathic Ulcers: Patient has a lower extremity diabetic neuropathic ulcer. Treatment will be given in combination with ulcer wound care (eg, debridement, infection control, and/or pressure relief).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Diabetic Neuropathic Ulcers: 5 months.
Other Criteria	N/A

RELISTOR

Products Affected

- Relistor

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Opioid-induced Constipation (OIC) (advanced illness): Diagnosis of OIC. Patient has advanced illness. OIC (non-cancer pain): Diagnosis of OIC. Patient has chronic non-cancer pain.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	OIC (advanced illness, non-cancer): Failure, contraindication, or intolerance to an osmotic laxative [eg, MiraLax/PEG3350 (polyethylene glycol (PEG)), Constulose (lactulose)]. OIC (non-cancer): Documentation of opioid use for at least 4 weeks prior to the proposed start of therapy.

REMICADE

Products Affected

- Remicade

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Crohn's Disease (CD) and Fistulizing Crohn's Disease (FCD) (initial): Dx of moderately to severely active CD or FCD. Ulcerative colitis (UC) (initial): Dx of moderately to severely active UC. Rheumatoid arthritis (RA) (initial): Diagnosis (Dx) of moderately to severely active RA. Ankylosing spondylitis (AS) (initial): Dx of active AS. Psoriatic arthritis (PsA) (initial): Dx of active PsA. Plaque psoriasis (initial): Dx of chronic severe (ie, extensive and/or disabling) plaque psoriasis. Reauthorization for all indications: Documentation of positive clinical response to Remicade therapy.
Age Restrictions	N/A
Prescriber Restrictions	RA, AS: Prescribed by or in consultation with a rheumatologist. PsA: Prescribed by or in consultation with a rheumatologist or dermatologist. Crohn's Disease, Fistulizing Crohn's Disease, UC: Prescribed by or in consultation with a gastroenterologist. Plaque Psoriasis: Prescribed by or in consultation with a dermatologist. Sarcoidosis: Prescribed by or in consultation with a pulmonologist, dermatologist, or ophthalmologist.
Coverage Duration	All indications (initial, reauth): plan year

Other Criteria	CD, FCD (initial): Failure, contraindication or intolerance to one of the following conventional therapies: 6-mercaptopurine (Purinethol), azathioprine (Imuran), corticosteroids (eg, prednisone, methylprednisolone), methotrexate (Rheumatrex, Trexall). UC (initial): Failure, contraindication or intolerance to one of the following conventional therapies: corticosteroids, aminosalicylate [eg, mesalamine (Asacol/Pentasa/Rowasa), olsalazine (Dipentum), sulfasalazine (Azulfidine/Sulfazine)], azathioprine (Imuran), 6-mercaptopurine (Purinethol). RA (initial): Receiving concurrent therapy with methotrexate (Rheumatrex/Trexall), or failure, contraindication or intolerance to methotrexate. AS (initial): Failure, contraindication or intolerance to two or more NSAIDs. Sarcoidosis (initial): Failure, contraindication or intolerance to one immunosuppressant [eg, Rheumatrex/Trexall (MTX), Cytoxan (cyclophosphamide), or Imuran (azathioprine)] and failure, contraindication or intolerance to corticosteroids (eg, prednisone). All indications (Initial and re-auth): Excluded if patient is receiving Remicade in combination with a Biologic Disease Modifying Antirheumatic Drug (DMARD) [eg, Enbrel (etanercept), Orencia (abatacept), Rituxan (rituximab), Kineret (anakinra), Cimzia (certolizumab)] or Janus kinase inhibitor [eg, Xeljanz (tofacitinib)].

REMODULIN

Products Affected

- Remodulin

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
Age Restrictions	N/A
Prescriber Restrictions	PAH (Initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH: Initial: 6 months. Reauth: plan year
Other Criteria	Subject to Part B vs. Part D review. PAH (Reauth): Documentation of positive clinical response to therapy.

REPATHA (UHCMR)

Products Affected

- Repatha
- Repatha Sureclick

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	HeFH/ASCVD (initial): Submission of medical records (eg, chart notes, laboratory values) documenting one of the following diagnoses: Heterozygous familial hypercholesterolemia (HeFH) as confirmed by one of the following: (1) Documented assessment of patient using Dutch Lipid Clinic Network diagnostic criteria with a cumulative score greater than or equal to 9 points (ie, definite FH), or (2) Presence of tendinous xanthomas in patient, first degree relative, or second degree relative, AND Untreated/pre-treatment LDL-C greater than 190 mg/dL in an adult, or (3) Genetic confirmation of a mutation in the LDL receptor, ApoB, or PCSK9. OR Atherosclerotic cardiovascular disease (ASCVD) as confirmed by acute coronary syndromes, history of myocardial infarction, stable or unstable angina, coronary or other arterial revascularization, stroke, transient ischemic attack, or peripheral arterial disease presumed to be of atherosclerotic origin. HoFH (initial): Submission of medical records (eg, chart notes, laboratory values) documenting diagnosis of homozygous familial hypercholesterolemia as confirmed by one of the following: (1) Genetic confirmation of 2 mutations in the LDL receptor, ApoB, PCSK9, or LDL receptor adaptor protein 1 (ie, LDLRAP1 or ARH), or (2) either untreated LDL-C greater than 500 mg/dL or treated LDL-C greater than 300 mg/dL, AND either xanthoma before 10 years of age or evidence of heterozygous familial hypercholesterolemia in both parents. HeFH/ASCVD/HoFH (initial): One of the following LDL-C values while on maximally tolerated lipid-lowering regimen within the last 30 days: (1) LDL-C greater than or equal to 100 mg/dL with ASCVD, or (2) LDL-C greater than or equal to 130 mg/dL without ASCVD.
Age Restrictions	N/A
Prescriber Restrictions	HeFH/ASCVD/HoFH (init, reauth): Prescribed by a cardiologist, endocrinologist, or lipid specialist
Coverage Duration	HeFH/ASCVD (init): 6 mon. HoFH (init): 3 mon. HeFH/ASCVD/HoFH (reauth): plan year

Other Criteria	HeFH/ASCVD (initial): History of failure after 12 consecutive weeks of Praluent 150 mg therapy or history of intolerance to Praluent therapy. One of the following: (1) Patient has been receiving at least 12 consecutive weeks of one maximally-tolerated statin therapy and will continue to receive a statin at maximally tolerated dose, or (2) Patient is unable to tolerate statin as evidenced by intolerable and persistent (ie, more than 2 weeks) myalgia (muscle symptoms without CK elevations) or myositis (muscle symptoms with CK elevations less than 10 times upper limit of normal [ULN]), or (3) Submission of medical records documenting patient has a labeled contraindication to all statins, or (4) Patient has experienced rhabdomyolysis on one statin therapy. HoFH (initial): One of the following: (1) Patient has been receiving at least 12 consecutive weeks of one maximally-tolerated statin therapy and will continue to receive a statin at maximally tolerated dose, or (2) both of the following: a) One of the following: 1. Patient is unable to tolerate statin as evidenced by intolerable and persistent (ie, more than 2 weeks) myalgia (muscle symptoms without CK elevations) or myositis (muscle symptoms with CK elevations less than 10 times upper limit of normal [ULN]), or 2. Submission of medical records documenting patient has a labeled contraindication to all statins, or 3. Patient has experienced rhabdomyolysis on one statin therapy, AND b) patient has been receiving at least 12 consecutive weeks of other LDL-C lowering prescription therapy and will continue to receive an LDL-C lowering prescription therapy. HeFH/ASCVD (reauth): Patient continues to receive statin at the maximally tolerated dose (unless patient has documented inability to take statins). HoFH (reauth): Patient continues to receive statin at the maximally tolerated dose (or other LDL-C lowering prescription therapy if patient is unable to take a statin). HeFH/ASCVD/HoFH (reauth): Submission of medical records (eg, laboratory values) documenting a sustained LDL-C reduction from pre-treatment baseline (ie, prior to Repatha therapy) while on Repatha therapy. HeFH/ASCVD/HoFH (Initial, reauth): Not used in combination with another proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor. HoFH (Initial, reauth): Not used in combination with Juxtapid (lomitapide) or Kynamro (mipomersen).

REVATIO

Products Affected

- Sildenafil TABS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
Age Restrictions	N/A
Prescriber Restrictions	PAH (Initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH: Initial: 6 months. Reauth: plan year
Other Criteria	PAH (Reauth): Documentation of positive clinical response to therapy

REVATIO INJECTION

Products Affected

- Sildenafil INJ

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH. Patient is temporarily unable to take oral medications.
Age Restrictions	N/A
Prescriber Restrictions	PAH (Initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH: Initial: 6 months. Reauth: plan year
Other Criteria	PAH (Reauth): Documentation of positive clinical response to therapy

REVATIO SUSPENSION

Products Affected

- Revatio SUSR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH. (initial, reauth): One of the following: A) History of intolerance to generic Revatio tablets, OR B) Patient is unable to ingest a solid dosage form (e.g., an oral tablet or capsule) due to one of the following: age, oral-motor difficulties, or dysphagia.
Age Restrictions	N/A
Prescriber Restrictions	PAH (Initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH: Initial: 6 months. Reauth: plan year
Other Criteria	PAH (Reauth): Documentation of positive clinical response to therapy.

REVLIMID

Products Affected

- Revlimid

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Multiple Myeloma: Diagnosis of multiple myeloma. Myelodysplastic syndrome (MDS) with a deletion 5q: Diagnosis of anemia due to MDS associated with a deletion 5q. MDS without deletion 5q: Diagnosis of anemia due to MDS without deletion 5q and one of the following: a) serum erythropoietin levels greater than 500 mU/mL, OR b) serum erythropoietin levels less than or equal to 500 mU/mL AND history of failure, contraindication, or intolerance to at least one erythropoietin agent [eg, Aranesp (darboepoetin), Epogen or Procrit (epoetin alfa)] AND history of failure, contraindication, or intolerance to initial treatment with at least one immunosuppressive therapy [eg, antithymocyte globulin (ATG), Neroal/Gengraf (cyclosporine modified), Sandimmune (cyclosporine)]. Mantle Cell Lymphoma (MCL): Diagnosis of relapsed, refractory, or progressed MCL and history of failure, contraindication, or intolerance to at least one prior MCL therapy (e.g., bortezomib, bendamustine, cladribine, rituximab).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist.
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

RITUXAN

Products Affected

- Rituxan INJ 500MG/50ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Excluded if patient is receiving Rituxan in combination with either of the following: Biologic DMARD [eg, Enbrel (etanercept), Orencia (abatacept), Kineret (anakinra)] or janus kinase inhibitor [eg, Xeljanz (tofacitinib)].
Required Medical Information	Non-Hodgkin's Lymphoma: As first-line treatment of diffuse large B-cell, CD20-positive, non-Hodgkin's lymphoma in combination with CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone) or other anthracycline-based chemotherapy regimens, or as first-line treatment of follicular, CD20-positive, B-cell non-Hodgkin's lymphoma in combination with chemotherapy, or as a single-agent maintenance therapy for the treatment of follicular, CD20-positive, B-cell non-Hodgkin's lymphoma in patients achieving a complete or partial response to Rituxan in combination with chemotherapy, or for the treatment of low-grade, CD20-positive, B-cell non-Hodgkin's lymphoma in patients with stable disease following first-line treatment with CVP (cyclophosphamide, vincristine, prednisolone/prednisone) chemotherapy or who achieve a partial or complete response following first-line treatment with CVP (cyclophosphamide, vincristine, prednisolone/prednisone) chemotherapy, or diagnosis of relapsed or refractory, low grade or follicular CD20-positive, B-cell non-Hodgkin’s lymphoma. Wegener’s Granulomatosis (WG) and Microscopic Polyangiitis (MPA): Patient is concurrently on glucocorticoids (eg, prednisone) OR contraindication or intolerance to glucocorticoids (eg, prednisone). Immune or idiopathic thrombocytopenic purpura (ITP): Diagnosis of immune or idiopathic thrombocytopenic purpura. Chronic Lymphocytic Leukemia (CLL): Diagnosis of CLL.
Age Restrictions	N/A
Prescriber Restrictions	ITP, NHL, CLL: Prescribed by or in consultation with a hematologist/oncologist. RA: Prescribed by or in consultation with a rheumatologist. WG, MPA: Prescribed by or in consultation with nephrologist, pulmonologist, or rheumatologist. NHL:
Coverage Duration	All uses except RA, WG, MPA: plan yr. RA, WG, MPA: 3 months

Other Criteria	Approve for continuation of prior therapy if within the past 120 days. ITP: Failure, contraindication, or intolerance to one of the following: corticosteroids, immunoglobulins, or splenectomy. Documented platelet count of less than 50x10^9 /L. RA: Concurrently on or contraindication, or intolerance to methotrexate. Failure, contraindication, or intolerance to a TNF antagonist (eg, adalimumab, etanercept, infliximab).

RUCONEST

Products Affected

- Ruconest

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of hereditary angioedema (HAE) and for the treatment of acute HAE attacks.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by an immunologist, allergist or rheumatologist
Coverage Duration	Plan year
Other Criteria	Not used in combination with other approved treatments for acute HAE attacks (eg, Berinert, Firazyr, or Kalbitor).

SABRIL

Products Affected

- Sabril

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Complex Partial Seizures (CPS): For use as adjunctive therapy. Infantile Spasms (IS): Diagnosis of infantile spasms.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days. CPS: Failure, contraindication, or intolerance (F/C/I) to two formulary anticonvulsants [eg, Lamictal (lamotrigine), Depakene (valproic acid), Dilantin (phenytoin)].

SANDOSTATIN

Products Affected

- Octreotide Acetate

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Acromegaly (initial): Diagnosis of acromegaly confirmed by one of the following: serum GH level greater than 1 ng/mL after a 2-hour oral glucose tolerance test at the time of diagnosis, or elevated serum IGF-1 levels (above the age and gender adjusted normal range as provided by the physician's lab) at the time of diagnosis. Inadequate response to surgery, radiotherapy, or dopamine agonist (eg, bromocriptine, cabergoline) therapy, or not a candidate for surgery. HIV/AIDS-Related Diarrhea (initial): Diagnosis of HIV/AIDS-related diarrhea. Carcinoid tumors, symptomatic treatment of diarrhea or flushing (initial): diagnosis of metastatic carcinoid tumor, for symptomatic treatment of severe diarrhea or flushing. Vasoactive Intestinal Peptide Tumors, symptomatic treatment of diarrhea (initial): Diagnosis of metastatic vasoactive intestinal peptide tumor, for symptomatic treatment of diarrhea associated with vasoactive intestinal peptide tumor. Cancer Chemotherapy- and/or Radiation- Induced Diarrhea (initial): Diagnosis of complicated diarrhea due to concurrent cancer chemotherapy and/or radiation or uncomplicated diarrhea due to concurrent cancer chemotherapy and/or radiation. Carcinoid tumor: diagnosis of carcinoid tumor. Reauthorization (all except carcinoid tumor): Documentation of positive clinical response to therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Carcinoid tumor: 6 mo. Acromegaly (initial): 6 mo, (Reauth): plan yr. Other uses (all): 6 mo.
Other Criteria	Uncomplicated diarrhea due to concurrent cancer chemotherapy and/or radiation (initial): Failure, contraindication, or intolerance (F/C/I) to standard therapy (e.g., loperamide). HIV/AIDS-related Diarrhea (initial): F/C/I to standard therapy (eg, loperamide, diphenoxylate with atropine). Carcinoid tumor: Approve for continuation of prior therapy.

SANDOSTATIN LAR

Products Affected

- Sandostatin Lar Depot

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Acromegaly (initial): Diagnosis of acromegaly confirmed by one of the following: serum GH level greater than 1 ng/mL after a 2-hour oral glucose tolerance test at the time of diagnosis, or elevated serum IGF-1 levels (above the age and gender adjusted normal range as provided by the physician's lab) at the time of diagnosis. Inadequate response to surgery or radiotherapy or dopamine agonist (eg, bromocriptine, cabergoline) therapy, or not a candidate for surgery. Carcinoid tumors, symptomatic treatment of diarrhea or flushing (initial): diagnosis of metastatic carcinoid tumor, for symptomatic treatment of severe diarrhea or flushing. Vasoactive Intestinal Peptide Tumors, symptomatic treatment of diarrhea (initial): Diagnosis of metastatic vasoactive intestinal peptide tumor, for symptomatic treatment of diarrhea associated with vasoactive intestinal peptide tumor. Carcinoid tumor: Diagnosis of carcinoid tumor. Re-auth (all except carcinoid tumor): Documentation of positive clinical response to therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Carcinoid tumor: 6 mo. Acromegaly (initial): 6 mo, (Reauth): plan yr. Other uses (all): 6 mo.
Other Criteria	Carcinoid tumor: Approve for continuation of prior therapy.

SEROSTIM

Products Affected

- Serostim INJ 4MG, 5MG, 6MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	HIV wasting (Initial): Diagnosis of HIV-associated wasting syndrome or cachexia, and one of the following: unintentional weight loss greater than 10% over the last 12 months, or unintentional weight loss greater than 7.5% over the last 6 months, or loss of 5% body cell mass (BCM) within 6 months, or body mass index (BMI) less than 20 kg/m2, or patient is male and has BCM less than 35% of total body weight (TBW) and BMI less than 27 kg/m2, or patient is female and has BCM less than 23% of TBW and BMI less than 27 kg/m2. Nutritional evaluation since onset of wasting first occurred. Anti-retroviral tx has been optimized to decrease the viral load. Patient has not had weight loss as a result of other underlying treatable conditions (eg, depression, mycobacterium avium complex, chronic infectious diarrhea, or malignancy with the exception of Kaposi's sarcoma limited to skin or mucous membranes). HIV wasting (reauthorization): Evidence of positive response to therapy. One of the following targets or goals has not been achieved: weight, BCM, BMI.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 3 months, Reauth: 6 months
Other Criteria	N/A

SIGNIFOR

Products Affected

- Signifor

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Cushing's disease (initial): Diagnosis of endogenous Cushing's disease (i.e, hypercortisolism is not a result of chronic administration of high dose glucocorticoids). Either pituitary surgery has not been curative for the patient OR patient is not a candidate for pituitary surgery. (Reauthorization): Documentation of positive clinical response to Signifor therapy.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist.
Coverage Duration	Initial: 3 months. Reauth: plan year
Other Criteria	N/A

SIGNIFOR LAR

Products Affected

- Signifor Lar

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Initial Authorization: Diagnosis of acromegaly. Diagnosis of acromegaly has been confirmed by one of the following: serum GH level greater than 1 ng/mL after a 2 hour oral glucose tolerance test (OGTT) at the time of diagnosis OR elevated serum IGF-1 levels (above the age and gender adjusted normal range as provided by the physician's lab) at the time of diagnosis. One of the following: Inadequate response to surgery OR Patient is not a candidate for surgery. Reauthorization: documentation of positive clinical response to Signifor LAR therapy
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months. Reauth: plan year
Other Criteria	N/A

SIMPONI (EH)

Products Affected

- Simponi

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (initial): Diagnosis of moderately to severely active rheumatoid arthritis. One of the following: Receiving concurrent therapy with methotrexate (Rheumatrex/Trexall) OR failure, contraindication, or intolerance to methotrexate (Rheumatrex/Trexall). One of the following: Failure, contraindication, or intolerance to both Enbrel (etanercept) and Humira (adalimumab), OR for continuation of prior Simponi therapy. Psoriatic Arthritis (PsA) (initial): Diagnosis of active PsA. One of the following: Failure, contraindication, or intolerance to both Enbrel (etanercept) and Humira (adalimumab), OR for continuation of prior Simponi therapy. Ankylosing Spondylitis (AS) (initial): Diagnosis of active AS. One of the following: Failure, contraindication, or intolerance to both Enbrel (etanercept) and Humira (adalimumab), OR for continuation of prior Simponi therapy. Ulcerative Colitis (UC) (initial): Diagnosis of moderately to severely active UC. Patient is corticosteroid dependent (ie, an inability to successfully taper corticosteroids without a return of the symptoms of UC), OR history of failure, contraindication, or intolerance to one of the following: oral aminosalicylate, oral corticosteroid, azathioprine, 6-mercaptopurine. One of the following: Failure, contraindication, or intolerance to Humira (adalimumab), OR for continuation of prior Simponi therapy. All indications (Initial, reauth): Patient is not receiving Simponi in combination with a biologic DMARD [eg, Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Orencia (abatacept)]. Patient is not receiving Simponi in combination with a Janus kinase inhibitor [eg, Xeljanz (tofacitinib)]. For a diagnosis of PsA, Patient is not receiving Simponi in combination with a phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)].
Age Restrictions	N/A
Prescriber Restrictions	RA, AS (Initial): Prescribed by or in consultation with a rheumatologist. PsA (Initial): Prescribed by or in consultation with a rheumatologist or dermatologist. UC (Initial): Prescribed by or in consultation with a gastroenterologist.

Coverage Duration	UC (Initial): 12 weeks. UC (Reauthorization): plan year. RA, AS, PsA (initial, reauth): plan year
Other Criteria	All indications (Reauth): Documentation of positive clinical response to Simponi therapy.

SIMPONI ARIA (EH)

Products Affected

- Simponi Aria

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. One of the following: Receiving concurrent therapy with methotrexate (Rheumatrex/Trexall), OR failure, contraindication, or intolerance to methotrexate (Rheumatrex/Trexall). One of the following: Failure, contraindication, or intolerance to both Enbrel (etanercept) and Humira (adalimumab), OR for continuation of prior Simponi Aria therapy. RA (initial, reauth): Patient is not receiving Simponi Aria in combination with a biologic DMARD [eg, Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Orencia (abatacept)]. Patient is not receiving Simponi Aria in combination with a Janus kinase inhibitor [eg, Xeljanz (tofacitinib)].
Age Restrictions	N/A
Prescriber Restrictions	RA (Initial): Prescribed by or in consultation with a rheumatologist.
Coverage Duration	Initial and reauth: plan year
Other Criteria	RA (Reauth): Documentation of positive clinical response to Simponi Aria therapy.

SOLARAZE

Products Affected

- Diclofenac Sodium TRANSDERMAL GEL 3%

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Actinic Keratosis (initial): Diagnosis of Actinic Keratosis. Actinic Keratosis (reauthorization): Documentation of positive clinical response to diclofenac sodium 0.3 % topical gel therapy. At least 30 days have elapsed since cessation of diclofenac sodium 0.3 % topical gel therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	90 days
Other Criteria	N/A

SOMATULINE

Products Affected

- Somatuline Depot

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Acromegaly (Initial): Diagnosis of acromegaly by one of the following: serum growth hormone (GH) level greater than 1 ng/mL after a 2-hour oral glucose tolerance test (OGTT) at time of diagnosis, or elevated serum IGF-1 levels (above the age and gender adjusted normal range as provided by the physician's lab) at time of diagnosis. Inadequate response to one of the following: surgery or radiotherapy, or not a candidate for surgery. Acromegaly (Reauth): Documentation of positive clinical response to Somatuline Depot therapy. Gastroenteropancreatic neuroendocrine tumors (GEP-NET): Diagnosis of GEP-NET, and disease is unresectable, locally advanced, metastatic, or well- or moderately-differentiated.
Age Restrictions	N/A
Prescriber Restrictions	GEP-NET: Prescribed by or in consultation with one of the following: oncologist, neuro-oncologist.
Coverage Duration	Acromegaly (Initial): 6 months. (Reauth): plan year. GEP-NET: plan year
Other Criteria	GEP-NET: Approve for continuation of prior therapy.

SOMAVERT

Products Affected

- Somavert

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Acromegaly (Initial): Diagnosis of acromegaly by one of the following: serum growth hormone (GH) level greater than 1 ng/mL after a 2 hour oral glucose tolerance test (OGTT) at time of diagnosis, or elevated serum IGF-1 levels (above the age and gender adjusted normal range as provided by the physician's lab) at time of diagnosis. Inadequate response to one of the following: surgery, radiotherapy, or dopamine agonist (eg, bromocriptine, cabergoline) therapy or not a candidate for surgery, or dopamine agonist (eg, bromocriptine, cabergoline) therapy. History of failure, contraindication, or intolerance to one of the following somatostatin analogs: Sandostatin (octreotide) or Sandostatin LAR (octreotide) or Somatuline Depot (lanreotide) , or Patient has extremely high IGF-1 values defined as greater than 900 ng/mL. Acromegaly (Reauth): Documentation of positive clinical response to Somavert therapy.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist
Coverage Duration	Acromegaly (Initial): 12 weeks. Reauth: plan year
Other Criteria	N/A

SOVALDI

Products Affected

- Sovaldi

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Criteria will be applied consistent with current AASLD/IDSA guideline. For genotype 1 patients and Sovaldi used in combination with Olysio: Patient is without decompensated liver disease (defined as Child-Pugh Class B or C). For genotype 3 patients without decompensated cirrhosis (defined as Child-Pugh Class B or C), using Sovaldi in combination with ribavirin: Patient is peginterferon ineligible*. For genotype 3 patients with cirrhosis, using Sovaldi in combination with Daklinza: Patient is peginterferon ineligible*. All genotype 1 (except Sovaldi plus Olysio therapy) and 4: history of intolerance or contraindication to Harvoni and Zepatier therapy OR patient is currently on Sovaldi therapy. All Sovaldi plus Olysio therapy: one of the following: a) history of failure, intolerance or contraindication to Harvoni and Zepatier therapy OR b) both of the following: 1. history of failure to Harvoni OR Zepatier AND 2. the patient has NS5A inhibitor resistant-associated variants detected using commercially available assays, OR c)patient is currently on Sovaldi therapy. All Sovaldi plus Daklinza therapy: One of the following: 1) Patient has not failed a prior HCV NS5A-containing regimen (eg, Daklinza) therapy, OR 2) patient has failed prior therapy with an NS5A-containing regimen AND submission of medical records (eg, chart notes) documenting that the patient does not have NS5A inhibitor resistance-associated variants detected using commercially available assays.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with one of the following: Hepatologist, Gastroenterologist, Infectious disease specialist, HIV specialist certified through the American Academy of HIV Medicine
Coverage Duration	12 to 48 wks. Criteria will be applied consistent with current AASLD/IDSA guideline

Other Criteria	*Peginterferon ineligibility confirmed by medical record documentation (eg, chart note, lab values) of one of the following: intolerance to interferon, autoimmune hepatitis or other autoimmune disorders, hypersensitivity to peginterferon or any of its components, major uncontrolled depressive illness, baseline neutrophil count below 1500/uL, baseline platelet count below 90,000/uL, baseline hemoglobin below 10 g/dL, decompensated hepatic disease or history of preexisting cardiac disease.

SPORANOX (CAPSULES)

Products Affected

- Itraconazole CAPS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Systemic Fungal Infections: Diagnosis of blastomycosis, histoplasmosis, or aspergillosis. Onychomycosis (initial): Diagnosis of fingernail or toenail onychomycosis confirmed by one of the following: KOH test, fungal culture, or nail biopsy. (retreatment): One of the following: Nine months has elapsed since completion of initial therapy for toenail onychomycosis or three months have elapsed since completion of initial therapy for fingernail onychomycosis. Documentation of positive clinical response to therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Systemic Fungal infxns: plan year. Onychomycosis: (Fingernail) 2 mo. (Toenail) 3 mo.
Other Criteria	N/A

SPORANOX (SOLUTION)

Products Affected

- Sporanox SOLN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Fungal Infections: Diagnosis of oropharyngeal or esophageal candidiasis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

SPRYCEL

Products Affected

- Sprycel

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Chronic Myelogenous/Myeloid Leukemia (CML): Diagnosis (dx) of Philadelphia chromosome-positive chronic myelogenous/myeloid leukemia (Ph+ CML). Acute Lymphoblastic Leukemia/Acute Lymphoblastic Lymphoma (ALL): Diagnosis of Philadelphia chromosome-positive acute lymphoblastic leukemia/acute lymphoblastic lymphoma (Ph+ ALL).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist and/or hematologist
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

STELARA (EH)

Products Affected

- Stelara INJ 45MG/0.5ML, 90MG/ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Plaque psoriasis (Initial - 45mg/0.5mL): Diagnosis of moderate to severe plaque psoriasis. Plaque psoriasis (Initial - 90mg/1mL): Diagnosis of moderate to severe plaque psoriasis. Patient's weight is greater than 100 kg (220 lbs). Psoriatic arthritis (PsA) (Initial - 45mg/0.5mL): Diagnosis of active PsA. PsA (Initial - 90mg/1mL): Diagnosis of active PsA. Patient's weight is greater than 100 kg (220 lbs). Diagnosis of co-existent moderate to severe psoriasis. Plaque psoriasis (Initial): One of the following: a) History of failure, contraindication, or intolerance (F/C/I) to Enbrel (etanercept) OR Humira (adalimumab) OR b) for continuation of prior Stelara therapy. PsA (Initial): One of the following: a) History of failure, contraindication, or intolerance (F/C/I) to both Enbrel (etanercept) and Humira (adalimumab) OR b) for continuation of prior Stelara therapy. All indications (initial, reauth): Patient is not receiving Stelara in combination with either of the following: Biologic DMARD [eg, Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab), Otezla (apremilast)] or a Janus Kinase Inhibitor [eg, Xeljanz (toficitinib)].Patient is not receiving Stelara in combination with a phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)].
Age Restrictions	N/A
Prescriber Restrictions	Plaque psoriasis (Initial): Prescribed by or in consultation with a dermatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist.
Coverage Duration	All indications (initial and reauth): plan year
Other Criteria	Reauthorization (all indications): Documentation of positive clinical response to Stelara therapy.

STIVARGA

Products Affected

- Stivarga

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Metastatic Colorectal Cancer (mCRC): Diagnosis of advanced or metastatic colorectal cancer. One of the following: a) history of failure, contraindication, or intolerance to FOLFOXIRI (fluorouracil, leucovorin, oxaliplatin, and irinotecan)], OR b) history of failure, contraindication, or intolerance to oxaliplatin-based chemotherapy and irinotecan-based chemotherapy, OR c) disease that has progressed through all available regimens. Gastrointestinal stromal tumor (GIST): Diagnosis of progressive, locally advanced, unresectable or metastatic GIST. History of failure, contraindication, or intolerance to Gleevec (imatinib mesylate) or Sutent (sunitinib malate).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

STRENSIQ

Products Affected

- Strensiq INJ 40MG/ML, 80MG/0.8ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of perinatal/infantile or juvenile-onset hypophosphatasia (HPP).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist or a specialist experienced in the treatment of inborn errors of metabolism.
Coverage Duration	Plan year
Other Criteria	80mg/0.8 mL strength: Patient’s weight is greater than or equal to 40 kg

SUTENT

Products Affected

- Sutent

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Gastrointestinal stromal tumor (GIST): Diagnosis of GIST. History of failure, contraindication, or intolerance to imatinib. Renal Cell Carcinoma (RCC): Diagnosis of RCC and one of the following: (1) relapse, or (2) both of the following: medically or surgically unresectable tumor and Stage IV disease. Islet Cell Tumors/Pancreatic Neuroendocrine Tumors (pNET): Diagnosis of islet cell tumors/progressive pNET.
Age Restrictions	N/A
Prescriber Restrictions	pNET: Prescribed by or in consultation with an oncologist or neuro-oncologist. GIST, RCC: Prescribed by or in consultation with an oncologist.
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

SYLATRON

Products Affected

- Sylatron

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Melanoma: For the adjuvant treatment of melanoma with microscopic or gross nodal involvement. Administered within 84 days of surgical resection including complete lymphadenectomy.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

SYLVANT

Products Affected

- Sylvant INJ 100MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Multicentric Castleman's disease (MCD) (initial): Diagnosis of MCD. Patient is human immunodeficiency virus (HIV) negative and human herpesvirus-8 (HHV-8) negative. MCD (reauth): Documentation of positive clinical response to Sylvant therapy.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hematologist/oncologist or rheumatologist.
Coverage Duration	MCD (initial and reauth): 6 months
Other Criteria	N/A

SYMLIN

Products Affected

- Symlinpen 120
- Symlinpen 60

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diabetes Mellitus (DM): Type 1 or type 2 diabetes. Concurrent use of insulin therapy.
Age Restrictions	DM: 18 years and older.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

SYNAGIS

Products Affected

- Synagis INJ 50MG/0.5ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prophylaxis of respiratory syncytial virus (RSV) One of the following: (criteria 1) all of the following: born before 29 weeks, 0 days gestation, age less than 12 months of age at start of RSV season. (criteria 2) all of the following: chronic lung disease (CLD) of prematurity (born before 32 weeks, 0 days gestation), and one of the following: require at least 21% oxygen for at least first 28 days after birth if age less than 12 months, or require at least 21% oxygen for at least 28 days after birth and requires supplemental oxygen, diuretics, or chronic systemic corticosteroid therapy within 6 months of the start of second RSV season. (criteria 3) all of the following: hemodynamically significant congenital heart disease, and one of the following: age less than 12 months with one of the following: acyanotic heart disease receiving medication to control congestive heart failure and will require cardiac surgical procedures, moderate to severe pulmonary hypertension, cyanotic heart defects in the first year of life with documentation of decision for prophylaxis made in consultation with a pediatric cardiologist. Or will be allowed one additional postoperative dose if still requires prophylaxis for age less than 24 months, with one of the following: undergone cardiac transplantation, cardiac bypass, or after extracorporeal membrane oxygenation during the RSV season. (criteria 4): all of the following: pulmonary abnormalities or neuromuscular disease that impairs the ability to clear secretions from the lower airways because of ineffective cough, age less than 12 months. (criteria 5) all of the following: profoundly immunocompromised, age less than 24 months. (criteria 6) all of the following: diagnosis of cystic fibrosis, and one of the following: clinical evidence of CLD and/or nutritional compromise if age less than 12 months, or severe lung disease or weight for length less than 10th percentile on pediatric growth chart if age at least 12 to less than 24 months.
Age Restrictions	N/A
Prescriber Restrictions	N/A

Coverage Duration	5 months (5 doses) during RSV season.
Other Criteria	One additional postoperative dose allowed for patients undergoing cardiac transplantation, cardiac bypass or extracorporeal membrane oxygenation.

SYNRIBO

Products Affected

- Synribo

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Chronic myeloid leukemia (CML): Diagnosis of chronic phase CML or accelerated phase CML or post-transplant relapse CML chronic myeloid leukemia (CML). History of failure, contraindication, or intolerance to two prior tyrosine kinase inhibitor therapies [eg, Gleevec (imatinib), Sprycel (dasatinib), Tasigna (nilotinib), Bosulif (bosutinib)].
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hematologist/oncologist.
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

SYPRINE

Products Affected

- Syprine

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	(initial) Diagnosis of Wilson's disease (i.e., hepatolenticular degeneration). History of failure, contraindication, or intolerance to Depen (penicillamine).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	(reauthorization) Documentation of positive clinical response to therapy.

TAFINLAR

Products Affected

- Tafinlar

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Melanoma: Unresectable melanoma or metastatic melanoma. Cancer is BRAFV600 mutant type (MT).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

TAGRISSO

Products Affected

- Tagrisso

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of NSCLC. Tumors are positive for epidermal growth factor receptor (EGFR) T790M mutation. History of failure, contraindication, or intolerance to at least one prior EGFR tyrosine kinase inhibitor (TKI) therapy [e.g., Iressa (gefitinib), Tarceva (erlotinib), Gilotrif (afatinib)].
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

TARCEVA

Products Affected

- Tarceva

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Non-Small Cell Lung Cancer (NSCLC): 1) Diagnosis of NSCLC. Disease is metastatic or recurrent. Tumors are positive for epidermal growth factor receptor (EGFR) exon 19 deletion mutations or exon 21 (L858R) substitution mutations. OR 2) Diagnosis of locally advanced NSCLC, metastatic NSCLC, or recurrent NSCLC. Maintenance treatment in patients whose disease has not progressed after 4 cycles of platinum based first line chemotherapy (eg, cisplatin, carboplatin) or failure of at least one prior chemotherapy regimen. Pancreatic cancer: Diagnosis of locally advanced, unresectable or metastatic pancreatic cancer. Used in combination with Gemzar (gemcitabine).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

TARGRETIN

Products Affected

- Bexarotene
- Targretin GEL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Cutaneous T-cell lymphoma (CTCL): Diagnosis of cutaneous T-cell lymphoma (CTCL).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or dermatologist
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

TASIGNA

Products Affected

- Tasigna

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Chronic Myelogenous/Myeloid Leukemia (CML): Diagnosis of Philadelphia chromosome-positive chronic myelogenous/myeloid leukemia (Ph+ CML).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist and/or hematologist.
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

TECFIDERA

Products Affected

- Tecfidera
- Tecfidera Starter Pack

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Multiple Sclerosis: Diagnosis of a relapsing form of multiple sclerosis (MS) (eg, relapsing-remitting MS, secondary-progressive MS with relapses, progressive-relapsing MS with relapses).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

TESTOSTERONE (ORAL)

Products Affected

- Methitest
- Methyltestosterone CAPS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Hypogonadism (HG) (Initial): Diagnosis (dx) of HG in a male patient. 1) Two pre-treatment serum total testosterone (T) levels less than 280 ng/dL (9.7 nmol/L) or less than reference range for the lab OR 2) Both of the following: Has a condition that may cause altered sex-hormone binding globulin (SHBG) (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and one pre-treatment calculated free or bioavailable T level less than 5 ng/dL (0.17 nmol/L) or less than reference range for the lab, OR 3) History of bilateral orchiectomy, panhypopituitarism, or a genetic disorder known to cause HG (eg, congenital anorchia, Klinefelter's syndrome). (Reauth): 1) Total serum T level within or below the normal limits of the reporting lab, or 2) Total serum T level outside of upper limits of normal for the reporting lab and the dose is adjusted, OR 3) Has a condition that may cause altered SHBG (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and one of the following: Calculated free or bioavailable T level within or below the normal limits of the reporting lab, or calculated free or bioavailable T level outside of upper limits of normal for the reporting lab and the dose is adjusted . Delayed puberty (DP): Dx of DP in males. Breast cancer (BC): Dx for the palliative treatment of inoperable BC in women.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	HG(init): New to tx:6mo. New to plan and cont tx:plan yr, (reauth): plan yr. BC: plan yr. DP: 6mo.
Other Criteria	BC: Approve for continuation of prior therapy.

TESTOSTERONE, BUCCAL (STRIANT)

Products Affected

- Striant

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Hypogonadism (HG) (Initial): Diagnosis (dx) of HG in a male patient. 1) Two pre-treatment serum total testosterone (T) levels less than 280 ng/dL (9.7 nmol/L) or less than reference range for the lab OR 2) Both of the following: Has a condition that may cause altered sex-hormone binding globulin (SHBG) (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and one pre-treatment calculated free or bioavailable T level less than 5 ng/dL (0.17 nmol/L) or less than reference range for the lab, OR 3) History of bilateral orchiectomy, panhypopituitarism, or a genetic disorder known to cause HG (eg, congenital anorchia, Klinefelter's syndrome). (Reauth): 1) Total serum T level within or below the normal limits of the reporting lab, or 2) Total serum T level outside of upper limits of normal for the reporting lab and the dose is adjusted, OR 3) Has a condition that may cause altered SHBG (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and one of the following: Calculated free or bioavailable T level within or below the normal limits of the reporting lab, or calculated free or bioavailable T level outside of upper limits of normal for the reporting lab and the dose is adjusted .
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: New to T tx: 6 mo. New to plan and cont T tx: plan yr. Reauth: plan yr
Other Criteria	N/A

TESTOSTERONE, TOPICAL (ANDRODERM)

Products Affected

- Androderm TRANSDERMAL PT24 2MG/24HR, 4MG/24HR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Hypogonadism (HG) (Initial): Diagnosis (dx) of HG in a male patient. 1) Two pre-treatment serum total testosterone (T) levels less than 280 ng/dL (9.7 nmol/L) or less than reference range for the lab OR 2) Both of the following: Has a condition that may cause altered sex-hormone binding globulin (SHBG) (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and one pre-treatment calculated free or bioavailable T level less than 5 ng/dL (0.17 nmol/L) or less than reference range for the lab, OR 3) History of bilateral orchiectomy, panhypopituitarism, or a genetic disorder known to cause HG (eg, congenital anorchia, Klinefelter's syndrome). (Reauth): 1) Total serum T level within or below the normal limits of the reporting lab, or 2) Total serum T level outside of upper limits of normal for the reporting lab and the dose is adjusted, OR 3) Has a condition that may cause altered SHBG (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and one of the following: Calculated free or bioavailable T level within or below the normal limits of the reporting lab, or calculated free or bioavailable T level outside of upper limits of normal for the reporting lab and the dose is adjusted .
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: New to T tx: 6 mo. New to plan and cont T tx: plan yr. Reauth: plan yr
Other Criteria	N/A

TESTOSTERONE, TOPICAL (ANDROGEL)

Products Affected

- Androgel TRANSDERMAL GEL 20.25MG/1.25GM, 40.5MG/2.5GM
- Androgel Pump GEL 1.62%

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Hypogonadism (HG) (Initial): Diagnosis (dx) of HG in a male patient. 1) Two pre-treatment serum total testosterone (T) levels less than 280 ng/dL (9.7 nmol/L) or less than reference range for the lab OR 2) Both of the following: Has a condition that may cause altered sex-hormone binding globulin (SHBG) (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and one pre-treatment calculated free or bioavailable T level less than 5 ng/dL (0.17 nmol/L) or less than reference range for the lab, OR 3) History of bilateral orchiectomy, panhypopituitarism, or a genetic disorder known to cause HG (eg, congenital anorchia, Klinefelter's syndrome). (Reauth): 1) Total serum T level within or below the normal limits of the reporting lab, or 2) Total serum T level outside of upper limits of normal for the reporting lab and the dose is adjusted, OR 3) Has a condition that may cause altered SHBG (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and one of the following: Calculated free or bioavailable T level within or below the normal limits of the reporting lab, or calculated free or bioavailable T level outside of upper limits of normal for the reporting lab and the dose is adjusted .
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: New to T tx: 6 mo. New to plan and cont T tx: plan yr. Reauth: plan yr
Other Criteria	N/A

TESTOSTERONE, TOPICAL (NON-PREFERRED)

Products Affected

- Natesto

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Hypogonadism (HG) (Initial): Diagnosis (dx) of HG in a male patient. 1) Two pre-treatment serum total testosterone (T) levels less than 280 ng/dL (9.7 nmol/L) or less than reference range for the lab OR 2) Both of the following: Has a condition that may cause altered sex-hormone binding globulin (SHBG) (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and one pre-treatment calculated free or bioavailable T level less than 5 ng/dL (0.17 nmol/L) or less than reference range for the lab, OR 3) History of bilateral orchiectomy, panhypopituitarism, or a genetic disorder known to cause HG (eg, congenital anorchia, Klinefelter's syndrome). (Reauth): 1) Total serum T level within or below the normal limits of the reporting lab, or 2) Total serum T level outside of upper limits of normal for the reporting lab and the dose is adjusted, OR 3) Has a condition that may cause altered SHBG (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and one of the following: Calculated free or bioavailable T level within or below the normal limits of the reporting lab, or calculated free or bioavailable T level outside of upper limits of normal for the reporting lab and the dose is adjusted .
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: New to T tx: 6 mo. New to plan and cont T tx: plan yr. Reauth: plan yr
Other Criteria	History of failure or intolerance to Androgel or Androderm (not applicable to Tier 1 products).

THALOMID

Products Affected

- Thalomid

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Erythema Nodosum Leprosum (ENL): Diagnosis (Dx) of moderate to severe ENL. One of the following: used for acute treatment OR used as maintenance therapy for prevention & suppression of cutaneous manifestations of ENL recurrence. Multiple Myeloma (MM): Dx of multiple myeloma.
Age Restrictions	N/A
Prescriber Restrictions	MM: Prescribed by or in consultation with an oncologist/ hematologist.
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

TOBI PODHALER

Products Affected

- Tobi Podhaler

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	Plan year
Other Criteria	N/A

TOPICAL RETINOIDS

Products Affected

- Avita
- Retin-a Micro Pump GEL 0.08%
- Tazorac
- Tretinoin EXTERNAL CREA
- Tretinoin EXTERNAL GEL
- Tretinoin Microsphere
- Tretin-x CREA 0.038%
- Veltin
- Ziana

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	All indications: Excluded if treatment for cosmetic purposes.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

TOPIRAMATE ER

Products Affected

- Topiramate Er
- Trokendi Xr

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	One of the following: a) diagnosis of partial onset or primary generalized tonic-clonic seizures, or b) diagnosis of Lennox-Gastaut Syndrome.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

TRACLEER

Products Affected

- Tracleer

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH AND PAH is symptomatic AND One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH
Age Restrictions	N/A
Prescriber Restrictions	PAH (Initial): Prescribed by or in consultation with a pulmonologist or cardiologist
Coverage Duration	PAH: Initial: 6 months. Reauth: plan year
Other Criteria	PAH (Reauth): Documentation of positive clinical response to therapy

TREANDA

Products Affected

- Treanda INJ 100MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of indolent B-cell non-Hodgkin's lymphoma, chronic lymphocytic leukemia, or small lymphocytic lymphoma.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hematologist or oncologist.
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

TYKERB

Products Affected

- Tykerb

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Breast Cancer: One of the following: A) Diagnosis of recurrent or stage IV estrogen receptor positive (ER+), human epidermal growth factor receptor 2-positive (HER2+) breast cancer. a) Patient is a postmenopausal female or b) patient is a male receiving testicular steroidogenesis suppression. Used in combination with an aromatase inhibitor [eg, Aromasin (exemestane), Femara (letrozole), Arimedex (anastrozole)]. OR B) Diagnosis of recurrent or metastatic HER2+ breast cancer. Patient has been previously treated with Herceptin (trastuzumab). Used in combination with Herceptin (trastuzumab) or Xeloda (capecitabine).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

TYSABRI

Products Affected

- Tysabri

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Multiple Sclerosis (MS): Diagnosis of a relapsing form of MS (eg, relapsing-remitting MS, secondary-progressive MS with relapses, progressive-relapsing MS with relapses). Crohn's Disease (CD) (Initial): Diagnosis of moderate to severe CD with evidence of inflammation (eg, elevated C-reactive protein [CRP], elevated erythrocyte sedimentation rate, presence of fecal leukocytes). CD (Reauthorization): Documentation of positive clinical response (eg, improved disease activity index) to Tysabri therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	MS: plan year. CD (initial): 3 months. CD (Reauth): plan year.

Other Criteria	MS: Failure, contraindication, or intolerance (F/C/I) to one of the following: Aubagio (teriflunomide), Avonex (interferon beta-1a), Betaseron (interferon beta-1b), Copaxone or Glatopa (glatiramer acetate), Extavia (interferon beta-1b), Gilenya (fingolimod), Plegridy (peginterferon beta-1a), Rebif (interferon beta-1a), or Tecfidera (dimethyl fumarate). Patient is not taking Tysabri in combination with another disease-modifying therapy for MS [eg, Aubagio (teriflunomide), Avonex (interferon beta-1a), Betaseron (interferon beta-1b), Copaxone or Glatopa (glatiramer acetate), Extavia (interferon beta-1b), Gilenya (fingolimod), Lemtrada (alemtuzumab), Plegridy (peginterferon beta-1a), Rebif (interferon beta-1a), or Tecfidera (dimethyl fumarate). CD (Initial): History of inadequate response or intolerance to one of the following conventional therapies: corticosteroids, 6-mercaptopurine (6MP [Purinethol], azathioprine (Imuran), methotrexate, aminosalicylates (eg, sulfasalazine, mesalamine, olsalazine). History of inadequate response or intolerance to a TNF-inhibitor (eg, Cimzia [certolizumab pegol], Humira [adalimumab], Remicade [infliximab]). CD (initial and reauth): Patient is not taking Tysabri in combination with an immunosuppressant (eg, 6-MP, azathioprine, cyclosporine, or methotrexate) or a TNF-inhibitor (eg, Enbrel [etanercept], Humira [adalimumab], or Remicade [infliximab]).

TYVASO

Products Affected

- Tyvaso

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
Age Restrictions	N/A
Prescriber Restrictions	PAH (Initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH: Initial: 6 months. Reauth: plan year
Other Criteria	Subject to Part B vs D review. PAH (Reauth): Documentation of positive clinical response to therapy.

UPTRAVI

Products Affected

- Uptravi

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (initial): Diagnosis of PAH AND Patient is symptomatic AND One of the following: a) Diagnosis of PAH was confirmed by right heart catheterization OR b) patient is currently on any therapy for the diagnosis of PAH. One of the following: a) History of inadequate response, contraindication, or intolerance to a PDE5 inhibitor (ie, Adcirca, Revatio) or Adempas (riociguat), and History of inadequate response, contraindication, or intolerance to an endothelin receptor antagonist [e.g. Letairis (ambrisentan), Opsumit (macitentan), or Tracleer (bosentan)] OR b) For continuation of prior Uptravi therapy. Not taken in combination with a prostanoid/prostacyclin analogue (eg, epoprostenol, iloprost, treprostinil).
Age Restrictions	N/A
Prescriber Restrictions	PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist
Coverage Duration	PAH: Initial: 6 months. Reauth: plan year
Other Criteria	PAH (Reauth): Documentation of positive clinical response to Uptravi therapy. Not taken in combination with a prostanoid/prostacyclin analogue (eg, epoprostenol, iloprost, treprostinil)

VALCHLOR

Products Affected

- Valchlor

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Mycosis fungoides (MF): Diagnosis of MF. Disease is not stage IVA1, IVA2 or IVB.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or dermatologist
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

VANDETANIB

Products Affected

- Caprelsa

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Thyroid Cancer: Diagnosis of unresectable locally advanced or metastatic medullary thyroid cancer, and one of the following: patient has symptomatic disease or patient has progressive disease.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or endocrinologist.
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

VECAMYL

Products Affected

- Vecamyl

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Hypertension: Diagnosis of one of the following: moderately severe to severe hypertension, or uncomplicated malignant hypertension. Off-label supported diagnosis: nicotine dependence.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Moderately severe to severe hypertension: History of failure, contraindication, or intolerance to (F/C/I) two of the following: Angiotensin converting enzyme (ACE)-inhibitor (eg, benazepril, captopril, lisinopril), Angiotensin receptor blocker (ARB) (eg, losartan, candesartan, irbesartan), Diuretic (eg, hydrochlorothiazide, chlorthalidone), Calcium channel blocker (eg, amlodipine, diltiazem), Beta blocker (eg, atenolol, carvedilol).

VELCADE

Products Affected

- Velcade

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Multiple Myeloma: Diagnosis of multiple myeloma. Mantle Cell Lymphoma: Diagnosis of mantle cell lymphoma.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist.
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

VENTAVIS

Products Affected

- Ventavis

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
Age Restrictions	N/A
Prescriber Restrictions	PAH (Initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH: Initial: 6 months. Reauth: plan year
Other Criteria	Subject to Part B vs D review. PAH (Reauth): Documentation of positive clinical response to therapy.

VIBERZI

Products Affected

- Viberzi

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Irritable bowel syndrome (IBS) (initial): Diagnosis of IBS with diarrhea. History of failure, contraindication, or intolerance to an antidiarrheal agent (eg, loperamide). (reauthorization): Documentation of positive clinical response to Viberzi therapy
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	IBS (Initial): 12 weeks. IBS (Reauthorization): 6 months.
Other Criteria	N/A

VIVITROL

Products Affected

- Vivitrol

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Alcohol dependence, opioid dependence (initial): One of the following: History of alcohol dependence and confirmed abstinence at treatment initiation OR history of opioid dependence and confirmed opioid detoxification at treatment initiation. Alcohol dependence, opioid dependence (Reauthorization): Confirmation of clinical benefit to the patient.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Alcohol dependence, opioid dependence (initial, reauthorization): 24 weeks
Other Criteria	N/A

VOTRIENT

Products Affected

- Votrient

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Renal Cell Carcinoma (RCC): Diagnosis of RCC and one of the following: (1) relapse following surgical excision, or (2) both of the following: medically or surgically unresectable tumor and Stage IV disease. Soft tissue sarcoma (STS): Diagnosis of advanced STS.
Age Restrictions	N/A
Prescriber Restrictions	RCC, STS: Prescribed by or in consultation with an oncologist.
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

VPRIV

Products Affected

- Vpriv

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Gaucher disease: Diagnosis of Type 1 Gaucher disease. Patient has evidence of symptomatic disease (eg, moderate to severe anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

XALKORI

Products Affected

- Xalkori

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Non-small Cell Lung Cancer (NSCLC): Diagnosis of metastatic or recurrent NSCLC. One of the following: Anaplastic lymphoma kinase (ALK)-positive tumor, tumor is ROS1-positive, tumor is positive for mesenchymal-epithelial transition (MET) amplification, or tumor is positive for MET exon 14 skipping mutation.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

XANAX XR

Products Affected

- Alprazolam Er ORAL TB24 1MG, 2MG, 3MG
- Alprazolam Xr TB24 0.5MG

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	Plan year
Other Criteria	N/A

XELJANZ (EH)

Products Affected

- Xeljanz
- Xeljanz Xr

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. History of failure, contraindication, or intolerance (F/C/I) to both Enbrel (etanercept) and Humira (adalimumab) or patient has a documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-IV-TR 300.29 for specific phobia diagnostic criteria) or for continuation of prior tofacitinib therapy. RA: (initial and reauth): Patient is not receiving tofacitinib in combination with a biologic DMARD [eg, Actemra (tocilizumab), Enbrel (etanercept), Orencia (abatacept), Rituxan (rituximab), Kineret (anakinra)]. Patient is not receiving tofacitinib in combination with a potent immunosuppressant (eg, azathioprine, cyclosporine).
Age Restrictions	N/A
Prescriber Restrictions	RA (initial): Prescribed by or in consultation with a rheumatologist
Coverage Duration	All indications (initial/reauth): plan year
Other Criteria	RA (Reauthorization): Documentation of positive clinical response to tofacitinib therapy.

XENAZINE

Products Affected

- Tetrabenazine

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Huntington's Disease (initial): Diagnosis of chorea in patients with Huntington's disease. (Reauthorization): Documented clinical response and benefit from therapy. Tardive dyskinesia and Tourette's syndrome(initial): Patient has stereotypes associated with tardive dyskinesia or patient has tics associated with Tourette's syndrome. (Reauthorization): Documented clinical response and benefit from therapy.
Age Restrictions	Tardive dyskinesia: Age greater than or equal to 18 years.
Prescriber Restrictions	Huntington: Prescribed by a neurologist. Tardive dyskinesia, Tourette: Prescribed by neurologist or psychiatrist.
Coverage Duration	Initial: 3 months. Reauth: 12 months.
Other Criteria	Tics associated with Tourette's syndrome: Failure, contraindication, or intolerance to Haldol (haloperidol).

XEOMIN

Products Affected

- Xeomin INJ 50UNIT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Cervical Dystonia (CD) (init): Diagnosis of CD (also known as spasmodic torticollis). Blepharospasm (initial): Diagnosis of blepharospasm. History of previous use of Botox (onabotulinumtoxinA) for the treatment of blepharospasm. Upper limb spasticity (ULS) (init): Diagnosis of upper limb spasticity.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All indications (init, reauth): 3 months (for 1 dose)
Other Criteria	All indications (reauth): Confirmed improvement in symptoms with initial Xeomin treatment. At least 3 months have elapsed since the last treatment with Xeomin

XERESE

Products Affected

- Xerese

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Herpes labialis: Diagnosis of recurrent herpes labialis (cold sores)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

XGEVA

Products Affected

- Xgeva

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prevention of skeletal-related events in patients with bone metastases from solid tumors: Diagnosis of solid tumors (eg, breast cancer, kidney cancer, lung cancer, prostate cancer, thyroid cancer) and documented evidence of one or more metastatic bone lesions. Giant cell tumor of bone (GCTB): Diagnosis of giant cell tumor of bone. Tumor is unresectable or surgical resection is likely to result in severe morbidity. Hypercalcemia of malignancy (initial): Diagnosis of hypercalcemia of malignancy and history of failure, contraindication, or intolerance to one intravenous bisphosphonate (eg, Aredia (pamidronate), Zometa (zoledronic acid). Hypercalcemia of malignancy (reauthorization): Documentation of positive clinical response to Xgeva therapy.
Age Restrictions	N/A
Prescriber Restrictions	GCTB, Hypercalcemia of malignancy (initial): Prescribed by or in consultation with an oncologist
Coverage Duration	Bone metastasis solid tumor: plan year. GCTB: 6 mo. Hypercalcemia of malignancy (all): 2 months.
Other Criteria	Giant cell tumor of bone : Approve for continuation of prior therapy.

XIFAXAN

Products Affected

- Xifaxan

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Traveler's Diarrhea (TD) (only 200 mg strength): Diagnosis of traveler's diarrhea. Hepatic Encephalopathy (only 550 mg strength): Used for the prophylaxis of hepatic encephalopathy recurrence. Irritable Bowel Syndrome with Diarrhea (Initial) (only 550 mg strength): Diagnosis of irritable bowel syndrome with diarrhea (IBS-D). History of failure, contraindication or intolerance to dicyclomine. Reauthorization (only 550 mg strength): Patient experiences IBS-D symptom recurrence and patient has not already received 3 treatment courses of Xifaxan for IBS-D in their lifetime.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	TD: 1 time only. Hepatic encephalopathy: 6 months. IBS-D (initial/reauth): 2 weeks
Other Criteria	TD: History of failure, contraindication, or intolerance to one of the following: Cipro (ciprofloxacin), Levaquin (levofloxacin), ofloxacin, Zithromax (azithromycin) OR resistance to all of the following: Cipro (ciprofloxacin), Levaquin (levofloxacin), ofloxacin, Zithromax (azithromycin).

XOLAIR

Products Affected

- Xolair

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Asthma (Initial): Diagnosis of moderate to severe persistent uncontrolled asthma defined by one of the following: daily asthmatic symptoms, daily use of inhaled short-acting beta2-agonist, exacerbations affect/limit activity, exacerbations (requiring oral systemic corticosteroids) greater than or equal to two times a year, nighttime awakenings more than once a week, forced expiratory volume in one second or peak expiratory flow less than or equal to 80% of predicted level, or measures of asthma control indicate uncontrolled asthma (eg, Asthma Control Test [ACT] score 19 or less).Baseline (pre-Xolair treatment) serum total IgE level greater than or equal to 30 IU/mL and less than or equal to 700 IU/mL. Positive skin test or in vitro reactivity to a perennial aeroallergen. Chronic Idiopathic Urticaria (CIU) (Initial): Diagnosis of CIU. Asthma, CIU (Reauthorization): Documentation of positive clinical response to Xolair therapy.
Age Restrictions	N/A
Prescriber Restrictions	Asthma (Initial): Prescribed by or in consultation with a pulmonologist or allergist/immunologist. CIU (Initial): Prescribed by or in consultation with an allergist/immunologist, or dermatologist.
Coverage Duration	Asthma (Initial): 6 months. CIU (Initial): 3 months. Asthma, CIU (Reauth): 6 months

Other Criteria	Asthma (Initial): Documented failure (eg, emergency room visit or hospitalization for asthma exacerbation, need for oral steroid burst) of at least 3 months to regular/routine treatment with one of the following: one combination inhaled corticosteroid/long-acting beta2-agonist [eg, Advair (fluticasone propionate/salmeterol), Dulera (mometasone/formoterol), Symbicort (budesonide/formoterol)] or combination therapy with one inhaled corticosteroid at the maximum dosage [eg, Flovent (fluticasone propionate), Pulmicort (budesonide), QVAR (beclomethasone dipropionate)] and one long-acting beta2-agonist [eg, Foradil (formoterol fumarate), Serevent (salmeterol xinafoate)]. CIU (Initial): Patient remains symptomatic despite at least a 2-week trial of, or history of contraindication or intolerance to a) two H1-antihistamines [eg, Allegra (fexofenadine), Benadryl (diphenhydramine), Claritin (loratadine)] OR b) both of the following taken in combination: Second generation H1-antihistamine [eg, Allegra (fexofenadine), Claritin (loratadine), Zyrtec (cetirizine)] AND one of the following: Different second generation H1-antihistamine [eg, Allegra (fexofenadine), Claritin (loratadine), Zyrtec (cetirizine)], or first generation H1-antihistamine [eg, Benadryl (diphenhydramine), Chlor-Trimeton (chlorpheniramine), Vistaril (hydroxyzine)], or H2-antihistamine [eg, Pepcid (famotidine), Tagamet HB (cimetidine), Zantac (ranitidine)], or Leukotriene modifier [eg, Accolate (zafirlukast), Singulair (montelukast), Zyflo (zileuton)].

XTANDI

Products Affected

- Xtandi

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Metastatic castration-resistant prostate cancer (mCRPC): Diagnosis of metastatic, castration-resistant or castration-recurrent prostate cancer. History of failure, contraindication or intolerance to Zytiga (abiraterone).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or urologist
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

XYREM

Products Affected

- Xyrem

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Narcolepsy with cataplexy (Narcolepsy Type 1)(initial): Diagnosis of narcolepsy as confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible), AND symptoms of cataplexy are present, AND symptoms of excessive daytime sleepiness (eg, irrepressible need to sleep or daytime lapses into sleep) are present. Narcolepsy without cataplexy (Narcolepsy Type 2)(initial): Diagnosis of narcolepsy as confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible), AND symptoms of cataplexy are absent, AND symptoms of excessive daytime sleepiness (eg, irrepressible need to sleep or daytime lapses into sleep) are present, AND history of failure, contraindication, or intolerance to one of the following: 1) amphetamine-based stimulant (eg, amphetamine, dextroamphetamine), OR 2) methylphenidate-based stimulant.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial: 6 months. Reauth: plan year
Other Criteria	Narcolepsy Type 1 (reauth): Documentation demonstrating a reduction in the frequency of cataplexy attacks associated with Xyrem therapy, OR documentation demonstrating a reduction in symptoms of excessive daytime sleepiness associated with Xyrem therapy. Narcolepsy Type 2 (reauth): Documentation demonstrating a reduction in symptoms of excessive daytime sleepiness associated with Xyrem therapy.

YERVOY

Products Affected

- Yervoy INJ 50MG/10ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Unresectable or metastatic melanoma: Diagnosis of unresectable, metastatic melanoma. Cutaneous melanoma: For adjuvant treatment of cutaneous melanoma with pathologic involvement of regional lymph nodes of more than 1 mm. Patient has undergone resection, including total lymphadenectomy.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

ZALTRAP

Products Affected

- Zaltrap INJ 100MG/4ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Metastatic colorectal cancer (mCRC): Diagnosis of mCRC. Use in combination with one of the following: FOLFIRI (fluorouracil, leucovorin, irinotecan) regimen OR irinotecan. History of failure to an Eloxatin (oxaliplatin)-containing regimen.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

ZAVESCA

Products Affected

- Zavesca

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Gaucher disease: Diagnosis of mild to moderate Type 1 Gaucher disease. Patient is unable to receive enzyme replacement therapy due to one of the following conditions: allergy or hypersensitivity to enzyme replacement therapy, poor venous access, or unavailability of enzyme replacement therapy (e.g. Cerezyme, VPRIV).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

ZELBORAF

Products Affected

- Zelboraf

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Melanoma: Diagnosis of unresectable or metastatic melanoma. Patient is positive for BRAF V600 mutation.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

ZEPATIER

Products Affected

- Zepatier

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	All of the following: A) Criteria will be applied consistent with current AASLD/IDSA guideline AND B) Patient is not receiving Zepatier in combination with another HCV direct acting antiviral agent, AND D) patient does not have moderate to severe hepatic impairment (eg, Child-Pugh Class B or C), AND E) For genotype 1a, patient has been tested for the presence of NS5A resistance-associated polymorphisms (ie, polymorphisms at amino acid positions 28, 30, 31, or 93).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with one of the following: Hepatologist, Gastroenterologist, Infectious disease specialist, HIV specialist certified through the American Academy of HIV Medicine
Coverage Duration	12 to 16 wks. Criteria will be applied consistent with current AASLD/IDSA guideline
Other Criteria	N/A

ZOLINZA

Products Affected

- Zolinza

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Cutaneous T-cell lymphoma (CTCL): Diagnosis of CTCL. History of failure, contraindication, or intolerance to at least two systemic therapies.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hematologist/oncologist
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

ZONTIVITY

Products Affected

- Zontivity

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	(initial): Used for the reduction of thrombotic cardiovascular events in patients with a history of one of the following: at least 2 weeks post-myocardial infarction (MI) or peripheral arterial disease (PAD). Used in combination with aspirin and/or clopidogrel therapy (reauthorization): Documentation of positive clinical response to Zontivity therapy. Used in combination with aspirin and/or clopidogrel therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	(initial and reauth): Excluded if patient has a history of any of the following: stroke, transient ischemic attack (TIA), intracranial hemorrhage (ICH)

ZORBTIVE

Products Affected

- Zorbtive

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Short Bowel Syndrome (SBS): Diagnosis of SBS. Patient is currently receiving specialized nutritional support (eg, intravenous parenteral nutrition, fluid, and micronutrient supplements). Patient has not previously received 4 weeks of treatment with Zorbtive.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	SBS: 4 weeks.
Other Criteria	N/A

ZORTRESS

Products Affected

- Zortress

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Transplant: Patient received a renal (kidney) or hepatic (liver) transplant.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Subject to Part B vs. Part D review. Approve for continuation of prior therapy if within the past 120 days if Part D.

ZOSTAVAX

Products Affected

- Zostavax

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Vaccine is used for prevention of herpes zoster (shingles).
Age Restrictions	Approve for age 50 and older.
Prescriber Restrictions	N/A
Coverage Duration	1 vaccination per lifetime.
Other Criteria	N/A

ZYDELIG

Products Affected

- Zydelig

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL): Diagnosis of CLL or SLL, disease is relapsed or refractory, used in combination with Rituxan (rituximab), and candidate for Rituxan (rituximab) monotherapy due to presence of other comorbidities (eg, coronary artery disease, peripheral vascular disease, diabetes mellitus, pulmonary disease [COPD], etc.). Follicular B-cell non-Hodgkin Lymphoma (FL): Diagnosis of follicular B-cell non-Hodgkin lymphoma (FL). Disease is relapsed, refractory, or progressive. History of failure, contraindication, or intolerance to at least one prior systemic therapy [eg, Gazyva (obinutuzumab) + Leukeran (chlorambucil), Fludara (fludarabine) + Rituxan (rituximab), Leustatin (cladribine)].
Age Restrictions	N/A
Prescriber Restrictions	All indications: Prescribed by or in consultation with an oncologist/hematologist
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

ZYKADIA

Products Affected

- Zykadia

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of metastatic or recurrent non-small cell lung cancer (NSCLC), tumor is anaplastic lymphoma kinase (ALK)-positive, and history of failure or intolerance to Xalkori (crizotinib).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

ZYTIGA

Products Affected

- Zytiga

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prostate cancer: Confirmed diagnosis of metastatic castration-resistant or castration-recurrent prostate cancer, and used in combination with prednisone.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or urologist
Coverage Duration	Plan year
Other Criteria	Approve for continuation of prior therapy if within the past 120 days.

PART B VERSUS PART D

Products Affected

- Abelcet
- Acetylcysteine INHALATION SOLN
- Acyclovir Sodium INJ 50MG/ML
- Adrucil INJ 500MG/10ML
- Albuterol Sulfate INHALATION NEBU
- Ambisome
- Aminosyn 7%/electrolytes
- Aminosyn 8.5%/electrolytes
- Aminosyn II INJ 50.3MEQ/L; 695MG/100ML; 713MG/100ML; 490MG/100ML; 517MG/100ML; 350MG/100ML; 210MG/100ML; 462MG/100ML; 700MG/100ML; 735MG/100ML; 120MG/100ML; 209MG/100ML; 505MG/100ML; 371MG/100ML; 31.3MEQ/L; 280MG/100ML; 140MG/100ML; 189MG/100ML; 350MG/100ML, 71.8MEQ/L; 993MG/100ML; 1018MG/100ML; 700MG/100ML; 738MG/100ML; 500MG/100ML; 300MG/100ML; 660MG/100ML; 1000MG/100ML; 1050MG/100ML; 172MG/100ML; 298MG/100ML; 722MG/100ML; 530MG/100ML; 44.4MEQ/L; 400MG/100ML; 200MG/100ML; 270MG/100ML; 500MG/100ML
- Aminosyn II 8.5%/electrolytes
- Aminosyn-hbc
- Aminosyn-pf INJ 46MEQ/L; 698MG/100ML; 1227MG/100ML; 527MG/100ML; 820MG/100ML; 385MG/100ML; 312MG/100ML; 760MG/100ML; 1200MG/100ML; 677MG/100ML; 180MG/100ML; 427MG/100ML; 812MG/100ML; 495MG/100ML; 3.4MEQ/L; 70MG/100ML; 512MG/100ML; 180MG/100ML; 44MG/100ML; 673MG/100ML
- Aminosyn-pf 7%
- Aminosyn-rf
- Amphotericin B INJ
- Anzemet ORAL TABS
- Argatroban INJ 125MG/125ML; 0.9%, 250MG/2.5ML
- Azasan
- Azathioprine INJ
- Azathioprine TABS
- Bethkis
- Bleomycin Sulfate INJ 30UNIT
- Brovana
- Budesonide INHALATION SUSP 0.25MG/2ML, 0.5MG/2ML, 1MG/2ML
- Calcitriol INJ 1MCG/ML
- Calcitriol ORAL CAPS
- Calcitriol ORAL SOLN
- Chlorothiazide Sodium
- Cladribine
- Cromolyn Sodium NEBU
- Cyclophosphamide ORAL CAPS
- Cyclosporine ORAL CAPS
- Cyclosporine Modified
- Cytarabine Aqueous
- Dextrose 5%/potassium Chloride 0.15%
- Diphenhydramine Hcl INJ 50MG/ML
- Doxercalciferol
- Doxorubicin Hcl INJ 2MG/ML
- Engerix-b
- Fluorouracil INJ 2.5GM/50ML
- Freamine Hbc 6.9%
- Furosemide INJ
- Gablofen INJ 10000MCG/20ML, 40000MCG/20ML, 50MCG/ML
- Ganciclovir INJ
- Gengraf ORAL CAPS 100MG, 25MG
- Gengraf SOLN
- Granisetron Hcl TABS

- Heparin Sodium INJ 10000UNIT/ML, 1000UNIT/ML, 20000UNIT/ML, 5000UNIT/ML
- Heparin Sodium/d5w
- Hepatamine
- Hyperrab S/d
- Ibandronate Sodium INJ
- Imovax Rabies (h.d.c.v.)
- Intralipid INJ 20GM/100ML, 30GM/100ML
- Ipratropium Bromide INHALATION SOLN 0.02%
- Ipratropium Bromide/albuterol Sulfate
- Levalbuterol NEBU
- Levalbuterol Hcl INHALATION NEBU 0.31MG/3ML, 0.63MG/3ML
- Levocarnitine ORAL SOLN
- Levocarnitine TABS
- Lidocaine Hcl INJ 0.5%, 2%
- Lioresal Intrathecal INJ 0.05MG/ML, 10MG/20ML, 10MG/5ML
- Mycophenolic Acid Dr
- Nebupent
- Nephramine
- Nutrilipid
- Ondansetron Hcl ORAL SOLN
- Ondansetron Hcl ORAL TABS
- Ondansetron Odt
- Pamidronate Disodium INJ 30MG/10ML, 6MG/ML, 90MG/10ML
- Paricalcitol
- Perforomist
- Plenamine
- Potassium Chloride INJ 10MEQ/100ML, 20MEQ/100ML, 2MEQ/ML, 40MEQ/100ML
- Potassium Chloride 0.15% /nacl 0.45% Viaflex
- Potassium Chloride 0.15%/nacl 0.9%
- Potassium Chloride 0.3%/ Nacl 0.9%
- Potassium Chloride 0.3%/d5w
- Premasol
- Procalamine
- Prosol
- Pulmozyme
- Rabavert
- Rapamune SOLN
- Recombivax Hb
- Sandimmune SOLN
- Sirolimus ORAL TABS
- Tobramycin NEBU
- Travasol INJ 52MEQ/L; 1760MG/100ML; 880MG/100ML; 34MEQ/L; 1760MG/100ML; 372MG/100ML; 406MG/100ML; 526MG/100ML; 492MG/100ML; 492MG/100ML; 526MG/100ML; 356MG/100ML; 356MG/100ML; 390MG/100ML; 34MG/100ML; 152MG/100ML
- Trophamine INJ 97MEQ/L; 0.54GM/100ML; 1.2GM/100ML; 0.32GM/100ML; 0; 0; 0.5GM/100ML; 0.36GM/100ML; 0.48GM/100ML; 0.82GM/100ML; 1.4GM/100ML; 1.2GM/100ML; 0.34GM/100ML; 0.48GM/100ML; 0.68GM/100ML; 0.38GM/100ML; 5MEQ/L; 0.025GM/100ML; 0.42GM/100ML; 0.2GM/100ML; 0.24GM/100ML; 0.78GM/100ML
- Varubi
- Vinblastine Sulfate INJ 1MG/ML
- Vincasar Pfs
- Vincristine Sulfate INJ
- Zemplar INJ
- Zoledronic Acid INJ 4MG/5ML
- Zuplenz

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.