Under CMS Review

ACITRETIN

Products Affected

- *acitretin*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Severely impaired liver or kidney function. Chronic abnormally elevated blood lipid values. Concomitant use of methotrexate or tetracyclines. Pregnancy. Females of child-bearing potential who intend to become pregnant during therapy or at any time for at least 3 years after discontinuing therapy. Females of child-bearing potential who will not use reliable contraception while undergoing treatment and for at least 3 years following discontinuation. Females of child-bearing potential who drink alcohol during treatment or for two months after cessation of therapy.
Required Medical Information	For diagnosis for severe, recalcitrant psoriasis (including plaque, guttate, erythrodermic palmar-plantar and pustular) AND must have contraindication or intolerance to at least 1 formulary first line agents per AAD psorasis guidelines (Topical Corticosteroids,Topical Calcipotriene/Calcitriol, Topical Calcipotriene,Topical Tazarotene)
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a dermatologist
Coverage Duration	12 months
Other Criteria	None

ACTEMRA

Products Affected

- ACTEMRA SUBCUTANEOUS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Patients with an ANC less than 2000/mm3, a platelet count less than 100,000/mm3, or an ALT or AST greater than 1.5 times the upper limit of normal. Patient is not receiving Actemra in combination with a biologic DMARD (Enbrel , Humira , Cimzia , Simponi) . Patient is not receiving Actemra in combination with a Janus kinase inhibitor (eg, Xeljanz).
Required Medical Information	Diagnosis of Chimeric antigen receptor (CAR) T cell-induced severe or life-threatening cytokine release syndrome (CRS), Giant cell arteritis, Polyarticular juvenile idiopathic arthritis, Rheumatoid arthritis, OR systemic juvenile idiopathic arthritis. For PAJIA, member needs trial or intolerance/contraindication to Humira. For RA, member needs trial or intolerance/contraindication to Humira and Enbrel. For diagnosis of systemic juvenile idiopathic arthritis, chimeric antigen receptor T cell-induced severe or life-threatening cytokine release syndrome, or Giant cell arteritis Actemra will be approved.
Age Restrictions	2 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

ADEMPAS

Products Affected

- ADEMPAS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Concomitant administration with nitrates or nitric oxide donors (such as amyl nitrate) in any form. Concomitant administration with phosphodiesterase inhibitors, including specific PDE-5 inhibitors (such as sildenafil, tadalafil, or vardenafil) or non-specific PDE inhibitors (such as dipyridamole or theophylline). Pregnancy.
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. For all indications female patients are enrolled in the ADEMPAS REMS program.
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	Initial: 6 months, Reauthorization: 12 months
Other Criteria	None

AFINITOR

Products Affected

- AFINITOR
- AFINITOR DISPERZ

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of advanced metastatic renal cell carcinoma and patient has failed therapy (disease progressed) with Sutent or Nexavar OR Diagnosis of pancreatic neuroendocrine tumors (pNET) that are unresectable, locally advanced, or metastatic OR Diagnosis of renal angiomyolipoma with tuberous sclerosis complex (TSC) and patient does not require immediate surgery OR Diagnosis of advanced hormone receptor-positive, HER2-negative breast cancer and patient is a postmenopausal woman and patient has failed treatment with Femara or Arimidex and the medication will be used in combination with Aromasin OR Diagnosis of subependymal giant cell astrocytoma (SEGA) associated with TSC that requires therapeutic intervention but is not a candidate for curative surgical resection OR diagnosis of adult patients with progressive, well-differentiated, non-functional, neuroendocrine tumors (NET) of gastrointestinal (GI) or lung origin with unresectable, locally advanced, or metastatic disease OR diagnosis of tuberous sclerosis complex (TSC) associated partial seizures.
Age Restrictions	18 years of age and older for RCC, pNET, and renal angiomyolipoma with TSC. 1 year of age and older for SEGA. 2 years of age and older for TSC associated partial seizures.
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or neurologist
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

ALECENSA

Products Affected

- ALECENSA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of metastatic anaplastic lymphoma kinase(ALK) positive non-small cell lung cancer detected with an FDA-approved test or Clinical Laboratory Improvement Amendments-approved facility
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

ALPHA-1 PROTEINASE INHIBITOR

Products Affected

- PROLASTIN-C INTRAVENOUS SOLUTION RECONSTITUTED 1000 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Patient has IgA deficiency with antibodies against IgA.
Required Medical Information	All of the following: A) Patient has an alpha-1 proteinase inhibitor (alpha-1 antitrypsin) deficiency AND B) Diagnosis of emphysema AND C) One of the following: 1) Patient has a high risk phenotype: PiZZ, PiZ(null), Pi(null)(null) OR 2) Patient has serum alpha-1 antitrypsin concentrations of less than 11 uM/L (80 mg/dL) AND D) One of the following: FEV1 level is between 30% and 65% of predicted OR the patient has experienced a rapid decline in lung function (i.e., reduction of FEV1 more than 120 mL/year) that warrants treatment.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Pulmonologist
Coverage Duration	12 months
Other Criteria	None

ALUNBRIG

Products Affected

- ALUNBRIG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of metastatic, ALK positive non-small cell lung cancer and have progressed or are intolerant to Xalkori (crizotinib)
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

AMPYRA

Products Affected

- AMPYRA
- *dalfampridine er*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	History of seizure. Moderate or severe renal impairment (creatinine clearance less than or equal to 50 mL/minute).
Required Medical Information	Diagnosis of multiple sclerosis. Patient must demonstrate sustained walking impairment, but with the ability to walk 25 feet (with or without assistance) prior to starting Ampyra and patient is currently on a disease modifying drug (interferon beta 1a, peginterferon beta 1a, interferon beta 1b, or glatiramer) to control disease progression, or has documented treatment failure, intolerance, or contraindication to any one of the following: interferon beta 1a, peginterferon beta 1a, interferon beta 1b, or glatiramer.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	Initial: 3 months, Reauthorization: 12 months
Other Criteria	None

APOKYN

Products Affected

- APOKYN SUBCUTANEOUS SOLUTION CARTRIDGE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	PD (Initial, reauth): Patient is using Apokyn with any 5-HT3 antagonist (eg, ondansetron, granisetron, dolasetron, palonosetron, alosetron)
Required Medical Information	Parkinson's disease (PD) (Initial): Diagnosis of advanced PD. Patient is experiencing acute intermittent hypomobility (defined as on/off episodes characterized by muscle stiffness, slow movements, or difficulty starting movements). Patient is receiving Apokyn in combination with other medications for the treatment of PD (e.g., carbidopa/levodopa, pramipexole, ropinirole, benztropine, etc.).
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

ARCALYST

Products Affected

- ARCALYST

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of cryopyrin-associated period syndromes (CAPS), including Familial Cold Auto-inflammatory Syndrome (FCAS) and/or Muckle-Wells Syndrome (MWS). The medication will not be used in combination with another biologic.
Age Restrictions	12 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with or recommendation of, an immunologist, allergist, dermatologist, rheumatologist, neurologist, or other medical specialist
Coverage Duration	12 months
Other Criteria	CAPS (Reauth): Patient has experienced disease stability or improvement in clinical symptoms while on therapy as evidence by one of the following: A) improvement in rash, fever, joint pain, headache, conjunctivitis, B) decreased number of disease flare days, C) normalization of inflammatory markers (CRP, ESR, SAA), D) corticosteroid dose reduction, OR E) improvement in MD global score or active joint count.

ARMODAFINIL

Products Affected

- *armodafinil*
- *modafinil*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following: A) excessive sleepiness associated with obstructive sleep apnea (OSA)/hypopnea syndrome confirmed by sleep lab evaluation, e.g., multiple sleep latency test, polysomnography), B) excessive sleepiness associated with narcolepsy confirmed by sleep lab evaluation and patient has tried and failed, is unable to tolerate, or has contraindication(s) to at least one other central nervous system stimulant (e.g., methylphenidate, mixed amphetamine salts, dextroamphetamine), OR C) excessive sleepiness associated with shift work disorder with a primary complaint of excessive sleepiness or insomnia which is temporally associated with a work period (usually night work) that occurs during the habitual sleep phase or polysomnography and the MSLT demonstrate loss of a normal sleep-wake pattern.
Age Restrictions	17 years of age and older
Prescriber Restrictions	None
Coverage Duration	OSA/hypopnea syndrome: 6 months (initial), 12 months (renewal). Other diagnoses: 12 months.
Other Criteria	None

AUBAGIO

Products Affected

- AUBAGIO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Severe hepatic impairment. Current treatment with leflunomide. Patients who are pregnant or women of childbearing potential not using reliable contraception.
Required Medical Information	Diagnosis of relapsing forms of multiple sclerosis (e.g., relapsing-remitting MS or progressive-relapsing MS) OR patient has experienced a first clinical episode and has MRI features consistent with multiple sclerosis AND Patient has tried and had an insufficient response to at least one other formulary MS disease modifying therapy (e.g., Avonex, Betaseron, Copaxone, Gilenya, Tecfidera)
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	For renewal, patient has experienced an objective response to therapy (i.e. no or slowed progression of disease)

AURYXIA

Products Affected

- AURYXIA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	For the management of hyperphosphatemia in patients with chronic kidney disease on dialysis
Age Restrictions	18 years and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

AUSTEDO

Products Affected

- AUSTEDO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Suicidal ideation and/or untreated or inadequately treated depression, hepatic impairment, or taking MAOIs, reserpine, or tetrabenazine.
Required Medical Information	Diagnosis of Chorea associated with Huntington's disease OR Diagnosis of Tardive dyskinesia
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in collaboration with a neurologist or psychiatrist
Coverage Duration	12 months
Other Criteria	Dosing will be approved per the FDA labeling based on CYP2D6 testing. For renewal, patient had an objective response to therapy.

BENLYSTA

Products Affected

- BENLYSTA SUBCUTANEOUS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Systemic lupus erythematosus (SLE) (init): 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)]).
Age Restrictions	None
Prescriber Restrictions	SLE (init): Prescribed by or in consultation with a rheumatologist
Coverage Duration	SLE (init, reauth): 6 months
Other Criteria	SLE (reauth): Documentation of positive clinical response to Benlysta therapy

BEXAROTENE

Products Affected

- *bexarotene*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Patient must meet one of following criteria: received prior systemic therapy for CTCL OR advanced-stage MF (stage IIB, III or IV) or SS OR early-stage MF (stage IA, IB or IIA) with folliculotropic/large cell transformation OR early-stage MF (stage IA, IB or IIA) refractory to skin directed therapy.
Age Restrictions	None
Prescriber Restrictions	Oncologist
Coverage Duration	12 months
Other Criteria	Female patients of child-bearing potential have a documented negative pregnancy test one week prior to the initiation of therapy. For renewal, Patient has not had disease progression while on therapy and female patients of child-bearing potential are not pregnant and are continuing to use adequate birth-control measures during therapy.

BOSULIF

Products Affected

- BOSULIF

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of Philadelphia chromosome-positive (Ph+) CML with resistance, relapse, or inadequate response to prior therapy with one of the following tyrosine kinase inhibitors (TKI): Gleevec [imatinib] OR Tasigna [nilotinib] OR newly diagnosed chronic phase Philadelphia chromosome-positive chronic myelogenous leukemia (Ph + CML)
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

BRIVIACT

Products Affected

- BRIVIACT ORAL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of partial-onset seizures, member must have history of inadequate response, contraindication, or intolerance to levetiracetam prior to approval.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

BUPRENORPHINE

Products Affected

- *buprenorphine hcl sublingual*
- *buprenorphine hcl-naloxone hcl sublingual tablet sublingual*
- *buprenorphine transdermal patch weekly 10 mcg/hr, 15 mcg/hr, 20 mcg/hr, 5 mcg/hr*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of opioid dependence
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	For renewal, patient meets all initial criteria

CABOMETYX

Products Affected

- CABOMETYX

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Patients who have or are at risk for severe hemorrhage and/or patients with a recent history of bleeding or hemoptysis.
Required Medical Information	Diagnosis of advanced renal cell carcinoma
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

CALQUENCE

Products Affected

- CALQUENCE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	MANTLE CELL LYMPHOMA (MCL) (1) Patient must have a diagnosis of MCL AND (2) Patient has tried one other therapy
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	Approve for continuation of therapy

CAPRELSA

Products Affected

- CAPRELSA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Congenital long QT syndrome
Required Medical Information	Diagnosis of medullary thyroid cancer (MTC), and disease is one of the following: A) unresectable, locally advanced, or B) metastatic AND one of the following: patient has symptomatic disease or patient has progressive disease.
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

CARBAGLU

Products Affected

- CARBAGLU

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of N-acetyl glutamate synthase (NAGS) deficiency AND patient is experiencing either acute or chronic hyperammonemia
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

CARIMUNE

Products Affected

- CARIMUNE NF INTRAVENOUS SOLUTION RECONSTITUTED 6 GM

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of a primary humoral immunodeficiency disorder such as: primary immunoglobulin deficiency syndrome X-linked immunodeficiency with hyperimmunoglobulin etc).Documented hypogammaglobulinemia (IgG less than 600mg/dl) Idiopathic/Immune Thrombocytopenia Purpura. Diagnosis of Acute ITP with any of the following: Management of acute bleeding due to severe thrombocytopenia (platelets less than 30 000/mcL). To increase platelet counts prior major surgical procedures. Severe thrombocytopenia (platelets less than 20 000/mcL) at risk for intracerebral hemorrhage. Diagnosis of Chronic ITP and ALL of the following are met: Prior treatment has included corticosteroids and splenectomy Duration of illness less than 6 months, no concurrent illness explaining thrombocytopenia, platelets persistently at or below 20 000/mcL. Chronic Lymphocytic Leukemia (CLL B-cell) with either of the following present: Hypogammaglobulinemia (IgG less than 600mg/dL) or Recurrent bacterial infections associated with B-cell CLL. Kawasaki Disease-Diagnosed with Kawasaki Syndrome within ten days of onset of disease manifestations or is diagnosed after ten days of disease onset and continues to exhibit manifestations of inflammation or evolving coronary artery disease. IVIG is used in combination with high dose aspirin for the prevention of coronary artery aneurysms. Bone Marrow Transplant (BMT). Member is hypogammaglobinemic (IgG less than 400mg/dL). Hematopoietic Stem Cell Transplantation (HSCT). Is within first 100 days of allogenic hematopoeietic stem cell transplantation. Is experiencing hypogammaglobulinemia (serum IgG level less than 400 mg/dL). AIDS/HIV- Has any of the following conditions: CD4+ T-cell counts greater than or equal 200/mm3, to prevent maternal transmission of HIV infection, IVIG is used in conjunction with zidovudine to prevent serious bacterial infections in HIV-infected members who have hypogammaglobulinemia (serum IgG less than 400 mg/dL).
Age Restrictions	None
Prescriber Restrictions	None

PA Criteria	Criteria Details
Coverage Duration	12 months
Other Criteria	None

CAYSTON

Products Affected

- CAYSTON

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of cystic fibrosis is confirmed by appropriate diagnostic or genetic testing. Confirmation of P. aeruginosa in cultures of the airways. For continuation of therapy, a clinical reason to continue therapy, such as symptomatic improvement or pulmonary function tests have not deteriorated more than 10% from baseline.
Age Restrictions	7 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	For renewal, Patient is benefiting from treatment (i.e. improvement in lung function [FEV1], decreased number of pulmonary exacerbations)

CIMZIA

Products Affected

- CIMZIA PREFILLED
- CIMZIA SUBCUTANEOUS KIT 2 X 200 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Active infection (including TB). Concurrent therapy with other biologics.
Required Medical Information	Screening for latent TB infection and assessment for Hep B risk. For positive latent TB, patient must have completed treatment or is currently receiving treatment for LTBI. HBV infection ruled out or treatment initiated for positive infection. Rheumatoid arthritis (RA) - Must have an inadequate response to one of following: 1) inadequate response to methotrexate, 2) inadequate response to another nonbiologic DMARD (e.g., leflunomide, hydroxychloroquine, sulfasalazine) if contraindicated or intolerant to MTX or, 3) intolerance or contraindication to at least 2 nonbiologic DMARDs. Crohn's Disease - Must have an inadequate response or contraindication/intolerance to at least one oral corticosteroid. For ankylosing spondylitis, psoriatic arthritis, plaque psoriasis, and/or rheumatoid arthritis member needs trial or intolerance/contraindication to Humira and Enbrel. For Crohn's, member needs trial or intolerance/contraindication to Humira.
Age Restrictions	18 years of age and older
Prescriber Restrictions	CD (init): Prescribed by or in consulation with a gastroenterologist. RA, AS (init): Prescribed by or in consulation with a rheumatologist. PsA (init): Prescribed by or in consulation with a dermatologist or rheumatologist.
Coverage Duration	Initial: 3 months for Crohn's disease, 1 year for all other indications. Renewal: Plan Year
Other Criteria	For re-authorization, patient's condition must have improved or stabilized.

CINRYZE

Products Affected

- CINRYZE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	History of life-threatening immediate hypersensitivity reactions, including anaphylaxis to the product.
Required Medical Information	Diagnosis of hereditary angioedema AND Medication will be used for routine prophylaxis against angioedema.
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with a hematologist, immunologist, or allergist
Coverage Duration	12 months
Other Criteria	None

COMETRIQ

Products Affected

- COMETRIQ (100 MG DAILY DOSE)
- COMETRIQ (140 MG DAILY DOSE)
- COMETRIQ (60 MG DAILY DOSE)

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Gastrointestinal perforation. Fistula. Severe hemorrhage.
Required Medical Information	Diagnosis of progressive, metastatic medullary thyroid cancer
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

COPAXONE

Products Affected

- COPAXONE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- *glatiramer acetate*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of relapsing-remitting multiple sclerosis OR diagnosis of first clinical episode with MRI features consistent with multiple sclerosis
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	For renewal, patient does not have progressive disease and responding to therapy.

CORLANOR

Products Affected

- CORLANOR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Decompensated acute heart failure, hypotension (i.e. blood pressure less than 90/50 mmHg), sick sinus syndrome, sinoatrial block, or 3rd degree AV block, unless a functioning demand pacemaker is present and bradycardia (i.e., resting heart rate less than 60 bpm prior to treatment)
Required Medical Information	Patients with stable, symptomatic chronic heart failure with left ventricular ejection fraction 35% or less, who are in sinus rhythm with resting heart rate 70 beats per minute or more and either are on maximally tolerated doses of beta-blockers or have a contraindication to beta-blocker use
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

COSENTYX

Products Affected

- COSENTYX 300 DOSE
- COSENTYX SENSOREADY 300 DOSE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Plaque psoriasis (Initial): Diagnosis of moderate to severe plaque psoriasis. One of the following: Failure, contraindication, or intolerance to Enbrel (etanercept) AND 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.
Age Restrictions	None
Prescriber Restrictions	Plaque psoriasis (Initial): Prescribed by or in consultation with a dermatologist. PsA (Initial): Prescribed by or in consultation with a rheumatologist or dermatologist. AS (Initial): Prescribed by or in consultation with a rheumatologist.
Coverage Duration	All indications (Initial, reauth): 12 months
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	None
Required Medical Information	Diagnosis of unresectable OR metastatic malignant melanoma with BRAF V600E OR V600K mutation. Documentation of combination therapy with vemurafenib (Zelboraf)
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

CYSTARAN

Products Affected

- CYSTARAN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Demonstrated cysteamine hypersensitivity or penicillamine hypersensitivity
Required Medical Information	Patient has a diagnosis of cystinosis AND patient has corneal cystine crystal accumulation
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

DALIRESP

Products Affected

- DALIRESP

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Moderate to severe liver impairment (Child-Pugh B or C)
Required Medical Information	Diagnosis of severe chronic obstructive pulmonary disease (COPD) (defined as FEV1 less than or equal to 50% of predicted and FEV1/forced vital capacity [FVC] less than 0.7) associated with chronic bronchitis AND history of COPD exacerbations which requires the use of systemic corticosteroids, antibiotics, or hospital admission AND Medication will be used with a long-acting inhaled bronchodilator (i.e. long-acting anticholinergic, or long-acting beta agonist in combination with inhaled corticosteroid) or patient is at high-risk of COPD exacerbation and is not a candidate for long-acting inhaled bronchodilator therapy.
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

DICLOFENAC TOPICAL

Products Affected

- *diclofenac sodium transdermal gel*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diclofenac 1%: Diagnosis of osteoarthritis, diclofenac 3% gel: Diagnosis of actinic keratosis
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

EMSAM

Products Affected

- EMSAM

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Pheochromocytoma. Patient is taking or will take any of the following: SSRIs, SNRIs, tricyclic antidepressants (TCAs), bupropion, buspirone, meperidine, tramadol, methadone, pentazocine, dextromethorphan, St. John's wort, mirtazapine, cyclobenzaprine, oral selegiline, other MAOIs, oxcarbazepine, carbamazepine, and/or sympathomimetic amines
Required Medical Information	Diagnosis of major depressive disorder AND Patient had adequate trial with at least 2 generic oral antidepressants from differing classes (at least one should be from the following list: selective serotonin reuptake inhibitors, serotonin and norepinephrine reuptake inhibitors, mirtazapine, or bupropion unless contraindicated), unless unable to take any oral medication AND Patient had an adequate washout period (for patients previously on agents requiring a washout period)
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	For renewal, the patient has improved or stabilized on Emsam.

ENBREL

Products Affected

- ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- ENBREL SUBCUTANEOUS SOLUTION RECONSTITUTED
- ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Active serious infection (including tuberculosis). Combined use with a biologic disease-modifying anti-rheumatic drugs or potent immunosuppressant (e.g., azathioprine or cyclosporine)
Required Medical Information	Diagnosis of moderate to severe rheumatoid arthritis and patient had an inadequate response to, intolerance to, or contraindication to one or more non-biologic disease modifying anti-rheumatic drugs for at least 3 consecutive months OR Diagnosis of moderate to severe polyarticular juvenile idiopathic arthritis and patient had an inadequate response, intolerance or contraindication to one or more non-biologic disease modifying anti-rheumatic drugs (DMARDs) for at least 3 consecutive months OR Diagnosis of psoriatic arthritis and patient had an inadequate response, intolerance, or contraindication to methotrexate OR Diagnosis of ankylosing spondylitis and patient had an inadequate response, intolerance or contraindication to one or more NSAIDs OR Diagnosis of moderate to severe chronic plaque psoriasis (affecting more than 5% of body surface area or affecting crucial body areas such as the hands, feet, face, or genitals) and patient had an inadequate response, intolerance or contraindication to conventional therapy with at least one of the following: phototherapy (including but not limited to Ultraviolet A with a psoralen [PUVA] and/or retinoids [RePUVA] for at least one continuous month or one or more oral systemic treatments (i.e. methotrexate, cyclosporine, acitretin, sulfasalazine) for at least 3 consecutive months.
Age Restrictions	2 years of age and older for JIA and JRA. 4 years of age and older for plaque psoriasis. 18 years of age and older for all other indications
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

ENDARI

Products Affected

- ENDARI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of acute sickle cell disease AND Must have A) trial history of Hydroxyurea OR B) intolerance to Hydroxyurea OR C) contraindication to Hydroxyurea
Age Restrictions	5 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

ENTRESTO

Products Affected

- ENTRESTO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	History of angioedema related to previous ACE inhibitor or ARB therapy, concomitant use or use within 36 hours of ACE inhibitors, concomitant use of aliskiren in patients with diabetes
Required Medical Information	Statement of diagnosis indicating Heart Failure (NYHA Class II through IV)
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

ERIVEDGE

Products Affected

- ERIVEDGE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of metastatic basal cell carcinoma OR Diagnosis of locally advanced basal cell carcinoma that has recurred following surgery or when the patient is not a candidate for surgery and radiation
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

ERLEADA

Products Affected

- ERLEADA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Pregnancy
Required Medical Information	Diagnosis of non-metastatic, castration-resistant prostate cancer
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or urologist
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

ESBRIET

Products Affected

- ESBRIET

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	1)Diagnosis of Idiopathic pulmonary fibrosis (IPF) as documented by all of the following: a) exclusion of other known causes of interstitial lung disease (ILD) (eg, domestic and occupational environmental exposures, connective tissue disease, drug toxicity), AND b) one of the following: i) in patients not subjected to surgical lung biopsy, the presence of a usual interstitial pneumonia (UIP) pattern on high-resolution computed tomography (HRCT) revealing IPF or probable IPF, OR ii) in patients subjected to a lung biopsy, both HRCT and surgical lung biopsy pattern revealing IPF or probable IPF, AND 2) not used in combination with Ofev (nintedanib).
Age Restrictions	None
Prescriber Restrictions	Pulmonologist
Coverage Duration	12 months
Other Criteria	None

ESRD THERAPY

Products Affected

- EPOGEN INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML
- MIRCERA INJECTION SOLUTION PREFILLED SYRINGE 100 MCG/0.3ML
- PROCRIT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Epoetin alfa therapy is not considered medically necessary for members with the following concomitant conditions: Concomitant use of another Recombinant Erythropoietin Product, anemia in cancer not related to chemotherapy OR anemia associated only with radiotherapy (without chemo). ESAs are not indicated in cancer patients receiving myelosuppressive chemotherapy when the anticipated outcome is cure (ESAs remain indicated when myelosuppressive chemotherapy is intended for palliation.
Required Medical Information	Pretreatment hemoglobin levels of less than 10g/dL. Dose reduction or interruption if hemoglobin exceeds 10 g/dL (CKD not on dialysis-adult, cancer), 11 g/dL (CKD on dialysis), 12 g/dL (pediatric CKD) in addition to supporting statement of diagnosis from physician.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	3 months
Other Criteria	None

EXJADE

Products Affected

- EXJADE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Creatinine clearance less than 40 mL/min or evidence of overt proteinuria, platelet count less than 50 x 10(9)/L, advanced malignancy, high-risk myelodysplastic syndrome (MDS) with poor performance status, or concurrent use of deferoxamine or iron-containing products.
Required Medical Information	The patient must meet all of the following criteria: 1) Diagnosis of transfusion-dependent anemia with chronic iron overload due to blood transfusions, 2) Patient will have baseline and monthly monitoring of serum ferritin, serum creatinine, creatinine clearance, serum transaminases, and bilirubin. OR For the treatment of chronic iron overload in patients 10 years and older with nontransfusion-dependent thalassemia syndromes
Age Restrictions	Covered for those 2 years of age and older with chronic iron overload due to blood transfusions
Prescriber Restrictions	None
Coverage Duration	3 months
Other Criteria	None

FARESTON

Products Affected

- FARESTON

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis. Must have previous inadequate response or intolerance to tamoxifen. For reauth: must have chart documentation from prescriber indicating improvement in condition.
Age Restrictions	None
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	6 months
Other Criteria	This criteria applies to new starts only

FARYDAK

Products Affected

- FARYDAK

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of Multiple Myeloma (MM) Used in combination with both of the following: 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	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist/hematologist
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

FENTANYL SL

Products Affected

- ABSTRAL SUBLINGUAL TABLET SUBLINGUAL 100 MCG, 600 MCG, 800 MCG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Management of acute or post-operative pain, including headache/migraine, dental pain, or use in the emergency room. Opioid non-tolerant patients.
Required Medical Information	Patient meets the following: A) Diagnosis of cancer and use is for breakthrough cancer pain, B) patient is opioid tolerant and taking at least 60 mg morphine/day, at least 25 mcg transdermal fentanyl/hour, at least 30 mg of oxycodone daily, at least 8 mg oral hydromorphone daily or an equianalgesic dose of another opioid for a week or longer, C) at least one other formulary short-acting strong narcotic analgesic alternatives (other than fentanyl) have been ineffective, not tolerated, or contraindicated, D) prescriber and patient are registered in the Transmucosal Immediate Release Fentanyl (TIRF) Risk Evaluation and Mitigation Strategy Access program, E) for brand requests, generic transmucosal fentanyl citrate has been ineffective or not tolerated.
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

FIRAZYR

Products Affected

- FIRAZYR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of hereditary angioedema AND medication will be used for the treatment of acute attacks.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed or overseen by a hematologist, immunologist, or allergist
Coverage Duration	12 months
Other Criteria	None

FIRMAGON

Products Affected

- FIRMAGON

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of advanced or metastatic prostate cancer
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

FORTEO

Products Affected

- FORTEO SUBCUTANEOUS SOLUTION
  600 MCG/2.4ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Patient has a diagnosis of one of the following: a) osteoporosis in a postmenopausal female, b) primary or hypogonadal osteoporosis in a male, or c) osteoporosis associated with sustained systemic glucocorticoid therapy AND patient is considered to be at high-risk for fracture by meeting one or more of the following: A) history of osteoporotic fracture, B) Low Bone Density less than 2.5 SD below normal, AND one or more of the following: i) failed one oral bisphosphonate and 1 injectable bisphosphonate, or ii) intolerant to one oral bisphosphonate and one injectable bisphosphonate. Patient has not received more than 2 years of therapy with Forteo.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Approve doses based on FDA labeling

GATTEX

Products Affected

- GATTEX

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Active gastrointestinal malignancy (gastrointestinal tract, hepatobiliary, pancreatic), colorectal cancer, or small bowel cancer
Required Medical Information	Diagnosis of short bowel syndrome AND patient is receiving specialized nutritional support (i.e. parenteral nutrition)
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	For renewal, patient has a reduced need for parenteral support (20% reduction) after at least 6 months of therapy.

GILENYA

Products Affected

- GILENYA ORAL CAPSULE 0.5 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Recent (within the last 6 months) occurrence of: myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, or Class III/IV heart failure. History or presence of Mobitz Type II 2nd degree or 3rd degree AV block or sick sinus syndrome, unless patient has a pacemaker. Baseline QTC interval greater than or equal to 500 miliseconds. Receiving concurrent treatment with Class Ia or Class III anti-arrhythmic drugs (quinidine, procainamide, amiodarone, sotalol).
Required Medical Information	Diagnosis of a relapsing form of multiple sclerosis or diagnosis of first clinical episode with MRI features consistent with MS AND Patient will be observed for signs and symptoms of bradycardia in a controlled setting for at least 6 hours after the first dose
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Initial: 6 months, Reauthorization: 12 months
Other Criteria	For renewal, the patient has experienced no or slowed disease progression.

GILOTRIF

Products Affected

- GILOTRIF

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Supporting statement of diagnosis from the physician in patients with: 1) metastatic non-small cell lung cancer (NSCLC) whose tumors have non-resistant epidermal growth factor receptor (EGFR) mutations as detected by an FDA-approved test or 2) metastatic squamous NSCLC, progressing after platinum-based chemotherapy.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

GLEOSTINE

Products Affected

- GLEOSTINE ORAL CAPSULE 10 MG, 100 MG, 40 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Statement of diagnosis indicating Hodgkin's disease, OR intracranial tumor, OR carcinoma of the breast, OR colorectal cancer, OR lung cancer, OR malignant melanoma, OR malignant tumor of the thymus, OR multiple myeloma, OR non-Hodgkin's lymphoma. AND monitoring of blood counts for evidence of Bone Marrow Suppression (thrombocytopenia or leukopenia).
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

GOCOVRI

Products Affected

- GOCOVRI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Patients with ESRD (CrCl below 15 ml/min/m2)
Required Medical Information	INITIAL: Diagnosis of Parkinsons disease AND (1) Patient is experiencing dyskinesia AND (2) Patient is receiving levodopa based therapy AND (3) Must have documented trial and failure to amantadine immediate release. RENEWAL: (1) must meet the initial criteria above AND (2) Documentation of positive clinical response to Gocovri (e.g., decreased off periods, decreased on time with troublesome dyskinesia)
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	12 months
Other Criteria	None

GROWTH HORMONE

Products Affected

- NORDITROPIN FLEXPRO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Acute critical illness due to complications following open heart or abdominal surgery, multiple accidental trauma or acute respiratory failure. Active malignancy. Active proliferative or severe non-proliferative diabetic retinopathy. For PWS only: severe obesity, history of upper airway obstruction or sleep apnea, or severe respiratory impairment.
Required Medical Information	Diagnosis of pediatric indication: A) GHD and bone age at least 1 year or 2 standard deviations (SD) delayed compared with chronological age and 2 stim tests with peak GH secretion below 10 ng/mL or IGF-1/IGFBP3 level more than 2 SDS below mean if CNS pathology, h/o irradiation, or proven genetic cause, B) SGA and birth weight or length 2 or more SDS below mean for gestational age and fails to manifest catch up growth by age 2 (height 2 or more SDS below mean for age and gender), C) CRI and nutritional status has been optimized, metabolic abnormalities have been corrected, and patient has not had renal transplant D) SHOX deficiency or Noonan syndrome E) PWS confirmed by genetic testing, F) Turner Syndrome confirmed by chromosome analysis. For GHD, CRI, SHOX deficiency, Noonan syndrome, and PWS one of the following: height more than 3 SDS below mean for age and gender, or height more than 2 SDS below mean with GV more than 1 SDS below mean, or GV over 1 year 2 SDS below mean. OR Diagnosis of an adult indication: A) childhood- or adult-onset GHD confirmed by 2 standard GH stim tests (provide assay): 1 test must be insulin tolerance test (ITT) with blood glucose nadir less than 40 mg/dL (2.2 mmol/L). If contraindicated, use a standardized stim test (i.e. arginine plus GH releasing hormone [preferred], glucagon, arginine), B) GHD with at least 1 other pituitary hormone deficiency and failed at least 1 GH stim test (ITT preferred), C) GHD with panhypopituitarism (3 or more pituitary hormone deficiencies), D) GHD with irreversible hypothalamic-pituitary structural lesions due to tumors, surgery or radiation of pituitary or hypothalamus region AND a subnormal IGF-1 (after at least 1 month off GH therapy) AND Objective evidence of GHD complications, such as: low bone density, increased visceral fat mass, or cardiovascular complications AND Completed linear growth (GV less than 2 cm/year) AND GH has been discontinued for at least 1 month (if previously receiving GH).
Age Restrictions	None

PA Criteria	Criteria Details
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

HEPATITIS B

Products Affected

- *adefovir dipivoxil*
- BARACLUDE ORAL SOLUTION
- *entecavir*
- VEMLIDY

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Patients that have immune-tolerant chronic hepatitis B per AASLD guidelines
Required Medical Information	Must submit documentation of immune-active chronic hepatitis B per AASLD guidelines.
Age Restrictions	None
Prescriber Restrictions	Prescriber must be a gastroenterologist, hepatologist, or infectious disease specialist
Coverage Duration	Duration of approval per AASLD Guidelines
Other Criteria	None

HEPATITIS C

Products Affected

- MAVYRET
- VOSEVI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Must submit documentation of chronic hepatitis C genotype (confirmed by HCV RNA level within the last 6 months). Must submit laboratory results within 6 weeks of initiating therapy including: 1) CBC w Platelets, 2) AST/ALT, 3) Total Bilirubin, 4) Serum Albumin, 5) PT/INR, 6) Serum Creatinine, and 7) GFR. FOR all GENOTYPES-Trial/failure, contraindication to, or intolerance to Mavyret required prior to the approval of Vosevi.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescriber must be a gastroenterologist, hepatologist, or infectious disease specialist
Coverage Duration	Duration of approval per AASLD Guidelines
Other Criteria	None

HEXALEN

Products Affected

- HEXALEN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Severe bone marrow depression-indicated by CBC. Severe neurologic toxicity-Seizure.
Required Medical Information	Diagnosis of persistent or recurrent ovarian cancer AND the medication will be used as palliative treatment AND the medication will be used as a single agent AND the medication will be used following first-line therapy with a cisplatin and/or alkylating agent-based combination.
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

HRM-ANALGESICS

Products Affected

- BUPAP ORAL TABLET 50-300 MG
- *butalbital-acetaminophen oral tablet 50-325 mg*
- *butalbital-apap-caff-cod oral capsule 50-325-40-30 mg*
- *butalbital-apap-caffeine oral capsule*
- *butalbital-apap-caffeine oral tablet 50-325-40 mg*
- *butalbital-asa-caff-codeine*
- *meperidine hcl injection solution 100 mg/ml, 25 mg/ml*
- *pentazocine-naloxone hcl*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation that risk outweighs benefit as to the medical necessity for using this high risk medication and anticipated treatment course/duration, and if formulary alternatives considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 2 alternative(s) - See OTHER criteria for alternatives.
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Mild pain: codeine. Moderate to severe pain: short-term NSAIDs, tramadol, tramadol/APAP, morphine sulfate, hydrocodone/APAP, oxycodone, oxycodone/APAP, fentanyl.

HRM-ANTICONVULSANTS

Products Affected

- *phenobarbital oral elixir*
- *phenobarbital oral tablet*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation that risk outweighs benefit as to the medical necessity for using this high risk medication and anticipated treatment course/duration, and if formulary alternatives considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 2 alternative(s) - See OTHER criteria for alternatives.
Age Restrictions	Less than and equal to 64 years old, claim for target drug automatically pays. Greater than and equal to 65 years old, priand authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Anticonvulsants: Aptiom,Banzel,carbamazepine,Celontin,Cerebyx,clonazepam,diazepam,Dilantin,divalproex,ethosuximide,felbamate,fosphenytoin,Fycompa,gabapentin,gabitril,lamotrigine,levetiracetam, Lyrica,Onfi,oxcarbazine,Oxtellar,Peganone,phenytoin,Potiga,Primidone,Qudexy XR,Sabril,Tegretol-XR, Tiagabine,topirimate,Trokendi-XR,valproate,Vimpat,zonisamide

HRM-ANTIDEMENTIA

Products Affected

- *ergoloid mesylates oral*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation that risk outweighs benefit as to the medical necessity for using this high risk medication and anticipated treatment course/duration, and if formulary alternatives considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 2 alternative(s) - See OTHER criteria for alternatives.
Age Restrictions	Less than and equal to 64 years old, claim for target drug automatically pays. Greater than and equal to 65 years old, priand authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Antidementia: donepezil,galantamine,memantine,rivastigmine oral

HRM-ANTIDEPRESSANTS

Products Affected

- *amitriptyline hcl oral*
- *chlordiazepoxide-amitriptyline*
- *clomipramine hcl oral*
- *desipramine hcl oral*
- *doxepin hcl oral*
- *imipramine hcl oral*
- *imipramine pamoate*
- *nortriptyline hcl oral capsule 25 mg, 50 mg*
- *nortriptyline hcl oral solution*
- *perphenazine-amitriptyline*
- *protriptyline hcl*
- *trimipramine maleate oral*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation that risk outweighs benefit as to the medical necessity for using this high risk medication and anticipated treatment course/duration, and if formulary alternatives considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 2 alternative(s) - See OTHER criteria for alternatives.
Age Restrictions	Less than and equal to 64 years old, claim for target drug automatically pays. Greater than and equal to 65 years old, priand authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Antidepressants: SSRI, SNRI, bupropion, mirtazapine, trazodone

HRM-ANTIHISTAMINES

Products Affected

- *carbinoxamine maleate oral tablet 4 mg*
- *cyproheptadine hcl oral*
- *hydroxyzine hcl oral syrup*
- *hydroxyzine hcl oral tablet*
- *hydroxyzine pamoate oral*
- *promethazine hcl oral syrup*
- *promethazine hcl oral tablet*
- *promethazine hcl rectal*
- PROMETHEGAN RECTAL SUPPOSITORY 25 MG, 50 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation that risk outweighs benefit as to the medical necessity for using this high risk medication and anticipated treatment course/duration.
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

HRM-ANTIINFLAMMATORY

Products Affected

- *indomethacin er*
- *indomethacin oral*
- *ketorolac tromethamine oral*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation that risk outweighs benefit as to the medical necessity for using this high risk medication and anticipated treatment course/duration, and if formulary alternatives considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 2 alternative(s) - See OTHER criteria for alternatives.
Age Restrictions	Less than and equal to 64 years old, claim for target drug automatically pays. Greater than and equal to 65 years old, priand authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Anti-inflammatories: celecoxib,diclofenac,diflunisal,etodolac,flurbiprofen,ibuprofen,ketoprofen,meclofenamate,meloxicam,nabumetone,naproxen,oxaprozin,piroxicam,sulindac,tolmetin

HRM-ANTINEOPLASTICS

Products Affected

- *megestrol acetate oral suspension 40 mg/ml, 625 mg/5ml*
- *megestrol acetate oral tablet*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation that risk outweighs benefit as to the medical necessity for using this high risk medication and anticipated treatment course/duration, and if formulary alternatives considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 2 alternative(s) - See OTHER criteria for alternatives.
Age Restrictions	Less than and equal to 64 years old, claim for target drug automatically pays. Greater than and equal to 65 years old, priand authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	For Megestrol: dronabinol

HRM-ANTIPARKINSONS

Products Affected

- *benztropine mesylate oral*
- *trihexyphenidyl hcl*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation that risk outweighs benefit as to the medical necessity for using this high risk medication and anticipated treatment course/duration, and if formulary alternatives considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 2 alternative(s) - See OTHER criteria for alternatives.
Age Restrictions	Less than and equal to 64 years old, claim for target drug automatically pays. Greater than and equal to 65 years old, priand authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Antiparkinsons': amantadine,Apokyn,Azilect,carbidopa/levodopa,entacapone,Neupro,pramipexole,ropinirole,selegiline

HRM-ANTIPLATELET

Products Affected

- *dipyridamole oral*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation that risk outweighs benefit as to the medical necessity for using this high risk medication and anticipated treatment course/duration, and if formulary alternatives considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 2 alternative(s) - See OTHER criteria for alternatives.
Age Restrictions	Less than and equal to 64 years old, claim for target drug automatically pays. Greater than and equal to 65 years old, priand authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Anti-platelets: Anagrelide, asa/dipyridamole, Brilinta, cilostazol, clopidogrel

HRM-ANTIPSYCHOTICS

Products Affected

- *chlorpromazine hcl oral*
- *perphenazine oral*
- *thioridazine hcl oral*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation that risk outweighs benefit as to the medical necessity for using this high risk medication and anticipated treatment course/duration, and if formulary alternatives considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 2 alternative(s) - See OTHER criteria for alternatives.
Age Restrictions	Less than and equal to 64 years old, claim for target drug automatically pays. Greater than and equal to 65 years old, priand authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Applies to New Starts only. Haloperidol, quetiapine, risperidone, aripiprazole, asenapine, iloperidone, lurasidone, olanzapine, paliperidone, ziprasidone

HRM-ANXIOLYTICS

Products Affected

- *meprobamate*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation that risk outweighs benefit as to the medical necessity for using this high risk medication and anticipated treatment course/duration, and if formulary alternatives considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 2 alternative(s) - See OTHER criteria for alternatives.
Age Restrictions	Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	SSRI, SNRI, buspirone.

HRM-CARDIOVASCULAR

Products Affected

- *guanfacine hcl er*
- *guanfacine hcl oral*
- *methyldopa oral*
- *methyldopa-hydrochlorothiazide*
- *nifedipine oral*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation that risk outweighs benefit as to the medical necessity for using this high risk medication and anticipated treatment course/duration, and if formulary alternatives considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 2 alternative(s) - See OTHER criteria for alternatives.
Age Restrictions	Less than and equal to 64 years old, claim for target drug automatically pays. Greater than and equal to 65 years old, priand authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Cardiovascular agents: acebutolol,amilor/hctz,amlod/benazp,amlod/valsar,amlodipine,atenol/chlorth,atenolol,benazep/hctz,benazepril,benicar,benicar hct,betaxolol,bisopr/hctz,bisoprolol,candesartan,candesartan/hctz,captopril/hctz,captopril,cartia xt,carvedilol,chlorothiazide,diltiazem,dilt-xr,doxazosin,enalapril,enalapril/hctz,eprosartan,felodipine,fosinopril,fosinopril/hctz, hctz,indapamide,irbesart/hctz,irbesartan,isradipine,labetalol,lisinopril,lisinopril/hctz,losartan/losartan/hctz,methylclothia,metolazone,metoprol/hctz,metoprolol,midodrine,moexipril/hctz,moexipril,nadolol,nadolol/bend,nicardipine,nifedical xl,nimodipine,nifedipine er,nisoldipine,perindopril,pindolol,prazosin,propran/hctz,propranolol,quinapril/quinapril/hctz,ramipril,spirono/hctz,taztia xt,telmis/amlod,telmis/hctz,telmisartan,terazosin,timolol,trandolapril,trandolapril/verapamil,triam/hctz,valsart/hctz,valsartan,verapamil

HRM-ORAL AND TRANSDERMAL ESTROGENS AND PROGESTINS

Products Affected

- DIVIGEL TRANSDERMAL GEL 1 MG/GM
- ELESTRIN
- *estradiol oral*
- *estradiol transdermal*
- *estropipate oral tablet 0.75 mg*
- EVAMIST
- MENEST ORAL TABLET 0.3 MG, 0.625 MG, 1.25 MG
- *norethindrone-eth estradiol*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation that risk outweighs benefit as to the medical necessity for using this high risk medication and anticipated treatment course/duration, and if formulary alternatives considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 2 alternative(s) - See OTHER criteria for alternatives.
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Bone Density: alendronate, risedronate, ibandronate, raloxifene (zoledronic acid for bed-bound patients or for post-hip fracture). Vaginal Symptoms: vaginal estrogen cream

HRM-SEDATIVE HYPNOTICS

Products Affected

- BUTISOL SODIUM ORAL TABLET 30 MG
- *zaleplon*
- *zolpidem tartrate*
- *zolpidem tartrate er*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation that risk outweighs benefit as to the medical necessity for using this high risk medication and anticipated treatment course/duration, and if formulary alternatives considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 2 alternative(s) - See OTHER criteria for alternatives.
Age Restrictions	Less than and equal to 64 years old, claim for target drug automatically pays. Greater than and equal to 65 years old, priand authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Sleep disorder agents: estazolam, flurazepam, rozerem ,temazepam, triazolam

HRM-SKELETAL MUSCLE RELAXANTS

Products Affected

- *carisoprodol oral tablet 350 mg*
- *chlorzoxazone oral tablet 500 mg*
- *cyclobenzaprine hcl oral tablet 10 mg, 5 mg*
- *methocarbamol oral*
- *orphenadrine citrate er*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	High risk medication. Automatically approved for beneficiaries less than or equal to 64 years. Attestation that risk outweighs benefit as to the medical necessity for using this high risk medication and anticipated treatment course/duration.
Age Restrictions	Less than or equal to 64 years old, claim for target drug automatically pays. Greater than or equal to 65 years old, prior authorization exception request is required indicating medically accepted indication not otherwise excluded from Part D.
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

HUMIRA

Products Affected

- HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT
- HUMIRA PEN SUBCUTANEOUS PEN-INJECTOR KIT
- HUMIRA PEN-CD/UC/HS STARTER
- HUMIRA PEN-PS/UV STARTER
- HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Active serious infection (including tuberculosis). Combined use with a biologic disease-modifying anti-rheumatic drugs or potent immunosuppressant (e.g., azathioprine or cyclosporine)
Required Medical Information	Diagnosis of ONE of the following: A) moderate to severe rheumatoid arthritis OR moderate to severe polyarticular juvenile idiopathic arthritis and patient had inadequate response, intolerance, or contraindication to one or more non-biologic DMARDs for at least 3 consecutive months B) psoriatic arthritis and patient had inadequate response, intolerance, or contraindication to methotrexate C) ankylosing spondylitis and patient had inadequate response, intolerance, or contraindication to one or more NSAIDs D) moderate to severe chronic plaque psoriasis (affecting more than 5% of body surface area or affecting crucial body areas such as the hands, feet, face, or genitals) and patient had inadequate response, intolerance, or contraindication to conventional therapy with at least one of the following: phototherapy (including but not limited to UVA with a psoralen [PUVA] and/or retinoids [RePUVA] for at least one continuous month or one or more oral systemic treatments (Cyclosporine, acitretin, sulfasalazine, methotrexate, leflunomide, azathioprine) for at least 3 consecutive months E) moderate to severe Crohn's disease and patient had inadequate response, intolerance, or contraindication to conventional therapy with two or more of the following: corticosteroids or non-biologic DMARDs F) moderate to severe ulcerative colitis and patient had inadequate response, intolerance or contraindication to conventional therapy with two or more of the following: corticosteroids, 5-ASA (i.e. mesalamine, sulfasalazine, balsalazide) or non-biologic DMARDs (azathioprine, cyclosporine, hydroxychloroquine, leflunomide, penicillamine, sulfasalazine) G) non-infectious uveitis (including intermediate, posterior, and panuveitis) and patient had inadequate response, intolerance or contraindication to conventional therapy with one of the following following: systemic or topical corticosteroids or opthalmic antimuscarinics. OR H) moderate to severe hidradenitis suppurativa
Age Restrictions	2 years of age and older for JIA. 6 years of age and older for pediatric Crohn's disease, 18 years of age and older for all other indications

PA Criteria	Criteria Details
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

IBRANCE

Products Affected

- IBRANCE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of locally advanced or metastatic, hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative breast cancer AND One of the following: 1) Used in combination with Faslodex (fulvestrant) and disease has progressed following endocrine therapy OR 2) Used in combination with an aromatase inhibitor AND One of the following: 1) patient is a postmenopausal woman OR 2) both of the following: patient is a premenopausal or perimenopausal woman and patient is receiving a luteinizing hormone-releasing hormone (LHRH) agonist [eg, Zoladex (goserelin)].
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

ICLUSIG

Products Affected

- ICLUSIG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of chronic myelogenous leukemia (CML) AND One of the following: A) History of failure, resistance, relapse, contraindication, or intolerance to at least TWO other tyrosine kinase inhibitors (SPRYCEL, TASIGNA, and BOSULIF), or B) Patient has the T315I mutation. OR Diagnosis of Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ ALL) AND One of the following: A) History of failure, resistance relapse, contraindication, or intolerance to at least TWO other FDA-approved tyrosine kinase inhibitors (SPRYCEL, TASIGNA, BOSULIF), or B) Patient has the T315I mutation.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

IDHIFA

Products Affected

- IDHIFA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of relapsed or refractory acute myeloid leukemia with an isocitrate dehydrogenase 2 mutation as detected by an FDA approved test.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

IMATINIB

Products Affected

- *imatinib mesylate*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following: A) Philadelphia chromosome-positive chronic myelogenous leukemia (Ph+ CML), B) Ph+ acute lymphoblastic leukemia (ALL), C) Gastrointestinal tumor (GIST) where patient has documented c-KIT (CD117) positive unresectable or metastatic malignant GIST or patient had resection of c-KIT positive GIST and imatinib will be used as an adjuvant therapy, D) Dermatofibrosarcoma protuberans that is unresectable, recurrent, or metastatic, E) hypereosinophilic syndrome or chronic eosinophilic leukemia, F) myelodysplastic syndrome or myeloproliferative disease associated with platelet-derived growth factor receptor gene re-arrangements, G) aggressive systemic mastocytosis without the D816V c-KIT mutation or with c-KIT mutational status unknown
Age Restrictions	1 year of age and older - newly diagnosed CML in the chronic phase and newly diagnosed, Ph+ ALL. 18 years of age and older for other indications.
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

IMBRUVICA

Products Affected

- IMBRUVICA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of mantle cell lymphoma (MCL) who have received at least one prior therapy OR chronic lymphocytic leukemia (CLL)/Small lymphocytic lymphoma (SLL) OR chronic lymphocytic leukemia (CLL)/Small lymphocytic lymphoma (SLL) with 17p deletion OR Waldenstrom's macroglobulinemia (WM) OR marginal zone lymphoma who require systemic therapy and have received at least one prior anti-CD20-based therapy OR graft vs host disease after failure of a least one first-line corticosteroid therapy
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

INCRELEX

Products Affected

- INCRELEX

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Increlex is contraindicated in patients with allergies to mecasermin or any component of the Increlex formulation, for growth promotion in patients with closed epiphyses, for IV administration, in patients with active or suspected neoplasia. Increlex should be discontinued if neoplasia develops while on therapy.
Required Medical Information	Increlex (mecasermin [rDNA origin] injection) is indicated for the long-term treatment of growth failure in children with severe primary IGF-1 deficiency (Primary IGFD) or with growth hormone (GH) gene deletion who have developed neutralizing antibodies to GH. Child has one of the following conditions: Severe primary IGF-1 deficiency, OR Growth hormone gene deletion with developed neutralizing antibodies to growth hormone, OR Genetic mutation of GH receptor (i.e. Laron Syndrome), AND Child has severe growth retardation with height standard deviation score (SDS) more than 3 SDS below the mean for chronological age and sex, AND Child with IGF-1 level greater than or equal to 3 standard deviations below normal based on lab reference range for age and sex, AND Child with normal or elevated growth hormone (GH) levels based on at least one growth hormone stimulation test, AND Evidence of open epiphyses
Age Restrictions	2 years of age and older
Prescriber Restrictions	Pediatric or Endocrinologist
Coverage Duration	6 months
Other Criteria	For renewal, patient has experienced improvement

INHALED TOBRAMYCIN

Products Affected

- TOBI PODHALER
- *tobramycin inhalation*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of cystic fibrosis AND patient has evidence of P. aeruginosa in the lungs
Age Restrictions	6 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	For renewal, Patient is benefiting from treatment (i.e. improvement in lung function [FEV1], decreased number of pulmonary exacerbations).

INLYTA

Products Affected

- INLYTA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of advanced renal cell carcinoma AND patient failed one or more systemic therapies for renal cell carcinoma (e.g., sunitinib-, bevacizumab-, temsirolimus-, or cytokine-containing regimens)
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

INTRAROSA

Products Affected

- INTRAROSA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Vaginal bleeding or dysfunctional uterine bleeding of an undetermined origin, known or suspected estrogen-dependent neoplasia.
Required Medical Information	Diagnosis of moderate to severe dyspareunia or atrophic vaginitis AND A) Patient must be female, B) Patient must be menopausal or postmenopausal, C) Patient has tried and failed, has a contraindication or intolerance to a low dose vaginal estrogen preparation (e.g. Premarin vaginal cream, Estrace vaginal cream, Estring, Vagifem), D) Patient does not have renal or hepatic impairment.
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	Initial: 3 months, Reauthorization: 12 months
Other Criteria	None

INTRON A

Products Affected

- INTRON A

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Uncontrolled depression. Solid organ transplant other than liver. Autoimmune hepatitis or other autoimmune condition known to be exacerbated by interferon and ribavirin.
Required Medical Information	Diagnosis of hairy cell leukemia OR Diagnosis of Condylomata acuminata OR Diagnosis of AIDS-related Kaposi's sarcoma OR Clinically aggressive follicular lymphoma and the medication will be used concurrently with anthracycline-containing chemotherapy or is not a candidate for anthracycline-containing chemotherapy OR Malignant melanoma and the request for coverage is within 56 days of surgery and the patient is at high risk of disease recurrence OR Diagnosis of chronic hepatitis B with compensated liver disease and patient has evidence of hepatitis B viral replication and patient has been serum hepatitis B surface antigen-positive for at least 6 months OR Diagnosis of chronic hepatitis C with compensated liver disease and is receiving combination therapy with ribavirin, unless ribavirin is contraindicated, and the medication will not be used as part of triple therapy with a protease inhibitor and patient has a clinical reason for not using peginterferon
Age Restrictions	1 year of age and older for HBV. 3 years of age and older for HCV. 18 years of age and older for other indications.
Prescriber Restrictions	None
Coverage Duration	Condylomata: 3 mos. HBV e antigen pos: 16 wks, e antigen neg: 48 wks. KS: 16 wks. Others: 12 mos
Other Criteria	This criteria applies to new starts only

IRESSA

Products Affected

- IRESSA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of metastatic NSCLC AND Patient has known active epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations as detected by an FDA-approved test or Clinical Laboratory Improvement Amendments-approved facility
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

JAKAFI

Products Affected

- JAKAFI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Myelofibrosis: Diagnosis of primary myelofibrosis, OR 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	None
Prescriber Restrictions	None
Coverage Duration	6 months
Other Criteria	This criteria applies to new starts only

JUXTAPID

Products Affected

- JUXTAPID

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Moderate to severe liver impairment or active liver disease including unexplained persistent abnormal liver function tests. Pregnancy. Concomitant use with strong or moderate CYP3A4 inhibitors.
Required Medical Information	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 (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 PCSK9 inhibtor 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 (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 (ie. clarithromycin).
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	Initial: 6 months, Reauthorization: 12 months
Other Criteria	None

KALYDECO

Products Affected

- KALYDECO ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of cystic fibrosis AND the patient has 1 mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to ivacaftor potentiation based on clinical and/or in vitro assay data.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

KINERET

Products Affected

- KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Active infection, concurrent therapy with other biologics.
Required Medical Information	Must have one of following: 1) inadequate response to methotrexate (MTX), 2) inadequate response to another nonbiologic DMARD (e.g., leflunomide, hydroxychloroquine, sulfasalazine) if contraindicated or intolerant to MTX, 3) intolerance or contraindication to at least 2 nonbiologic DMARDs or, 4) use Kineret as first-line therapy with MTX for severely active RA. For diagnosis of CAPs, Kineret will be approved. For rheumatoid arthritis member needs trial or intolerance/contraindication to Humira and Enbrel.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	For re-authorization, patient's condition must have improved or stabilized.

KISQALI

Products Affected

- KISQALI 200 DOSE
- KISQALI 400 DOSE
- KISQALI 600 DOSE
- KISQALI FEMARA 200 DOSE
- KISQALI FEMARA 400 DOSE
- KISQALI FEMARA 600 DOSE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of hormone receptor (HR)-positive, HER2-negative advanced or metastatic breast cancer and intended to be used in combination with an aromatase inhibitor in pre/perimenopausal or postmenopausal women OR used in combination with fulvestrant in postmenopausal women.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or gastroenterologist
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

KORLYM

Products Affected

- KORLYM

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Pregnancy
Required Medical Information	Supporting statement of diagnosis and relevant medical information from physician
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

KUVAN

Products Affected

- KUVAN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of hyperphenylalaninemia (HPA) due to tetrahydrobiopterin (BH4)-responsive phenylketonuria (PKU). Appropriate for use in patients who: a) have been diagnosed with PKU, b) have a baseline blood Phe measured within 2 weeks prior to initiating therapy. Also require that the prescriber be a specialist with knowledge and expertise in metabolic diseases or genetic diseases or has consulted with a specialist in metabolic or genetic diseases. Initial approval will be for two months of therapy if the initial dose is 5 mg/kg/day to less than 20 mg/kg/day, it will be for one month if the initial dose is 20 mg/kg/day. Renewal for continued use will be for 6 months if patient response is seen based on prescriber determination.
Age Restrictions	1 month of age and older
Prescriber Restrictions	Specialist knowledgeable in the management of PKU
Coverage Duration	Initial Approval: 2 months. Extended Approval: 6 month intervals
Other Criteria	Blood Phe levels should be checked after 1 week of therapy and periodically up to one month during a therapeutic trial.

KYNAMRO

Products Affected

- KYNAMRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Moderate to severe liver impairment or active liver disease including unexplained persistent abnormal liver function tests.
Required Medical Information	Diagnosis of homozygous familial hypercholesterolemia as evidenced by one of the following: A) genetic confirmation of 2 mutant alleles at the LDL receptor, ApoB, PCSK9, or autosomal recessive hypercholesterolemia (ARH) adaptor protein gene locus OR B) untreated/pre-treatment LDL greater than 500 mg/dL with at least one of the following: cutaneous or tendonous xanthoma before age 10 years, history of early vascular disease (men younger than 55 years, women younger than 60 years) on both sides of the family if parenteral LDL levels are unknown, elevated LDL cholesterol levels before lipid-lowering therapy consistent with heterozygous FH in both parents AND Patient has tried and had an inadequate response to the maximum tolerated dose of a high potency statin (e.g., atorvastatin, rosuvastatin), unless all statins are contraindicated.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Initial: 6 months, Reauthorization: 12 months
Other Criteria	For renewal, patient has responded to therapy with a decrease in LDL levels from baseline AND patient does not have contraindications to therapy.

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	None
Required Medical Information	Diagnosis of locally recurrent or metastatic, progressive, radioactive iodine-refractory differentiated thyroid cancer OR advanced renal cell carcinoma following one prior anti-angiogenic therapy in combination with everolimus
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

LETAIRIS

Products Affected

- LETAIRIS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of pulmonary arterial hypertension that was confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.) AND Patient has WHO Group I PAH AND pregnancy must be excluded prior to the start of therapy and will be prevented thereafter with two forms of reliable contraception in female patients of reproductive potential.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Initial: 6 months, Reauthorization: 12 months
Other Criteria	None

LEUKINE

Products Affected

- LEUKINE INTRAVENOUS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Concurrent use with myelosuppresive chemotherapy or radiation or excessive (greater than or equal to 10%) leukemic myeloid blasts in bone marrow or peripheral blood
Required Medical Information	Diagnosis of one of the following: A) Patient has undergone allogeneic or autologous bone marrow transplant (BMT) and engraftment is delayed or failed OR B) Patient is undergoing autologous peripheral-blood progenitor cell transplant to mobilize progenitor cells for collection by leukapheresis OR C) Medication will be used for myeloid reconstitution after an autologous or allogeneic BMT OR D) Patient has acute myeloid leukemia and administration will be after completion of induction chemotherapy
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

LEUPROLIDE

Products Affected

- ELIGARD
- *leuprolide acetate injection*
- LUPRON DEPOT (1-MONTH)
- LUPRON DEPOT (3-MONTH)
- LUPRON DEPOT (4-MONTH)
- LUPRON DEPOT (6-MONTH)

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following: A) advanced or metastatic prostate cancer, B) Diagnosis of central precocious puberty and patient had early onset of secondary sexual characteristics (male: earlier than 9 years of age. female: earlier than 8 years of age) and advanced bone age of at least one year compared with chronological age and has undergone gonadotropin-releasing hormone agonist (GnRHa) testing with peak luteinizing hormone (LH) level above pre-pubertal range or random LH level in pubertal range and Patient had the following diagnostic evaluations to rule out tumors, when suspected: diagnostic imaging of the brain (MRI or CT scan), Pelvic/testicular/adrenal ultrasound, Human chorionic gonadotropin levels, Adrenal steroids to rule out congenital adrenal hyperplasia, C) the medication will be used for stimulation testing to confirm the diagnosis of central precocious puberty or D) management of endometriosis E) anemia caused by uterina leiomyomata
Age Restrictions	None
Prescriber Restrictions	CPP - Prescribed by or in consultation with a pediatric endocrinologist
Coverage Duration	12 months. CPP testing: one time dose.
Other Criteria	For renewal of CPP, LH levels have been suppressed to pre-pubertal levels and consideration for discontinuation of therapy when the patient is 11 years of age for girls and 12 years of age for boys.

LIDOCAINE PATCH

Products Affected

- *lidocaine external patch 5 %*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of pain associated with diabetic neuropathy OR pain associated with cancer-related neuropathy OR post-herpetic neuralgia.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

LINEZOLID

Products Affected

- *linezolid intravenous solution 600 mg/300ml*
- *linezolid oral tablet*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Not covered with concomitant use of MAOI therapy
Required Medical Information	Supporting statement of diagnosis from the physician
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	VRE: 4 weeks. Nosocomial and community acquired pneumonia: 3 weeks. All other indications: 2 weeks
Other Criteria	None

LONSURF

Products Affected

- LONSURF

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of metastatic colorectal cancer, previously treated with fluoropyrimidine, oxaliplatin, and irinotecan-based regimens, an anti-VEGF therapy, and if RAS wild-type, an anti-EGFR therapy
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	For initial treatment: Absolute neutrophil count 1,500/mm(3) or greater or febrile neutropenia resolved, platelet count 75,000/mm(3) or greater, and grade 3 or 4 nonhematological reactions resolved to grade 0 or 1

LYNPARZA

Products Affected

- LYNPARZA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Appropriate diagnosis and testing for BRCA mutation (deleterious or suspected deleterious germline BRCA mutated (as detected by an FDA approved test) advanced ovarian cancer that has been treated with 3 or more prior lines of chemotherapy)
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

MEKINIST

Products Affected

- MEKINIST

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of locally advanced or metastatic anaplastic thyroid cancer with documented positive BRAF V600E or V600K mutation as detected by an FDA-approved test as single agent or used in combination with Tafinlar OR Diagnosis of metastatic or unresectable melanoma and metastatic non-small cell lung cancer (NSCLC) with BRAF V600E mutation as detected by an FDA-approved test OR Diagnosis of BRAF V600K mutation-positive unresectable or metastatic melanoma or use as adjuvant treatment of BRAF V600K mutation-positive melanoma
Age Restrictions	None
Prescriber Restrictions	Oncologist
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

MS INTERFERONS

Products Affected

- AVONEX
- AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT
- AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT
- BETASERON SUBCUTANEOUS KIT
- PLEGRIDY
- PLEGRIDY STARTER PACK SUBCUTANEOUS SOLUTION PEN-INJECTOR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of relapsing form of multiple sclerosis OR diagnosis of first clinical episode and MRI features consistent with multiple sclerosis.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	For renewal, patient has experienced an objective response to therapy (i.e. no or slowed progression of disease)

MYTESI

Products Affected

- MYTESI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Clinical notes to support a diagnosis of chronic diarrhea, defined as diarrhea persisting for more than four weeks, caused by their medication regimen or hiv enteropathy proven by biopsy, and not a virus, parasite or bacterium as evidenced by stool sample taken in the previous 3 months. Patient must have tried and failed or had intolerance to loperamide or diphenoxylate-atropine trials of a minimum of 30 days.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Infectious Disease Specialist or GI Consult for new starts
Coverage Duration	12 months
Other Criteria	None

NATPARA

Products Affected

- NATPARA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of hypocalcemia due to chronic hypoparathyroidism AND NATPARA is not being used in the setting of acute post-surgical hypoparathyroidism AND Patient does not have a known calcium-sensing receptor mutation AND Patient has a documented parathyroid hormone concentration that is inappropriately low for the level of calcium, recorded on at least two occasions within the previous 12 months AND Patient has normal thyroid-stimulating hormone concentrations if not on thyroid hormone replacement therapy (or if on therapy, the dose had to have been stable for 3 months or longer) AND Patient has normal magnesium and serum 25-hydroxyvitamin D concentrations AND Creatinine clearance is at least 30 mL/min on two separate measurements, or greater than 60 mL/min (one measurement) with an accompanying serum creatinine concentration of less than 1.5 mg/dL AND Prescriber is certified in the NATPARA REMS program
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

NERLYNX

Products Affected

- NERLYNX

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of early stage HER2- overexpressed breast cancer. Must be used after trastuzumab therapy.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

NEUPOGEN

Products Affected

- NEUPOGEN INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6ML
- NEUPOGEN INJECTION SOLUTION PREFILLED SYRINGE
- ZARXIO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following: A) congenital, cyclic, or idiopathic neutropenia, B) severe febrile neutropenia (FN) with the following: Has not received prophylactic pegfilgrastim and Used as adjunct to appropriate antibiotics in high-risk patients and any one of the following: 65 years or older, Uncontrolled primary disease, Pneumonia, Hypotension and multiorgan dysfunction (sepsis syndrome), Invasive fungal infection, Hospitalization when developed fever, Prior FN, Severe (ANC less than 100/mcL) or anticipated prolonged (more than 10 days) neutropenia, C) Autologous peripheral-blood progenitor cell transplant to mobilize progenitor cells for collection by leukapheresis, D) Undergoing myeloablative chemotherapy followed by autologous or allogeneic BMT, E) Acute myeloid leukemia and will be given after completion of induction or consolidation chemotherapy, F) Acute lymphoblastic leukemia and will be given after completion of the first few days of chemotherapy of the initial induction or first post-remission course, G) Myelodysplastic syndrome with severe neutropenia and recurrent infection, H) Receiving radiation therapy, not on chemotherapy, and expected to have prolonged delays in treatment due to neutropenia, I) Neutropenia associated with HIV infection and antiretroviral therapy, J) Aplastic anemia, K)Primary prophylaxis of FN in one of the following patients: 20% or higher risk of FN based on chemotherapy regimen OR Less than 20% risk of FN based on chemotherapy regimen with one of the following: 65 years or older, Poor performance status, Poor nutritional status, Previous FN, Extensive prior treatment including large radiation ports, Cytopenias due to bone marrow involvement by tumor, Administration of combined chemoradiotherapy, Presence of open wounds or active infections, Other serious comorbidities (including renal or liver dysfunction) or Receiving dose-dense chemotherapy regimen in breast or small cell lung cancer or non-Hodgkins lymphoma.
Age Restrictions	None

PA Criteria	Criteria Details
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

NEXAVAR

Products Affected

- NEXAVAR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Squamous cell lung cancer being treated with carboplatin and paclitaxel.
Required Medical Information	Diagnosis of unresectable hepatocellular carcinoma OR Diagnosis of advanced renal cell carcinoma OR Diagnosis of locally recurrent or metastatic, progressive, differentiated thyroid carcinoma refractory to radioactive iodine treatment
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

NINLARO

Products Affected

- NINLARO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of multiple myeloma, documentation of combination therapy with lenalidomide and dexamethasone. History of 1 prior therapy.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

NORTHERA

Products Affected

- NORTHERA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Request will be approved for the following indication(s): orthostatic dizziness, light-headedness, or the feeling that you are about to black out in adults with neurogenic orthostatic hypotension (NOH) caused by primary autonomic failure (i.e., Parkinson disease, multiple system atrophy, pure autonomic failure), dopamine beta-hydroxylase deficiency, and non-diabetic autonomic neuropathy).
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

NOXAFIL

Products Affected

- NOXAFIL ORAL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Concomitant treatment with sirolimus, CYP 3A4 substrates that prolong QT interval (pimozide, quinidine), HMG-CoA Reductase inhibitors primarily metabolized through CYP 3A4, or ergot alkaloids
Required Medical Information	Diagnosis of oropharyngeal candidiasis and patient tried itraconazole and/or fluconazole OR Medication will be used as prophylaxis of invasive Aspergillus and Candida infections and the patient is at high risk of developing these infections due to being severely immunocompromised, such as hematopoietic stem cell transplant (HSCT) recipients with graft-versus-host disease (GVHD) or those with hematologic malignancies with prolonged neutropenia from chemotherapy.
Age Restrictions	13 years of age and older for prophylaxis of invasive aspergillus and candidal infection
Prescriber Restrictions	None
Coverage Duration	12 weeks
Other Criteria	None

NUCALA

Products Affected

- NUCALA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of severe asthma (eosinophilic phenotype) OR eosinophilic granulomatosis with polyangiitis (EGPA)
Age Restrictions	12 years of age and older for severe asthma eosinophilic phenotype and 18 years of age and older for granulomatosis with polyangiitis (EGPA)
Prescriber Restrictions	Must be prescribed by a pulmonologist or immunologist
Coverage Duration	12 months
Other Criteria	None

NUEDEXTA

Products Affected

- NUEDEXTA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Patient diagnosis of pseudobulbar affect.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

NUPLAZID

Products Affected

- NUPLAZID ORAL TABLET 17 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of Parkinson disease psychosis including hallucinations and/or delusions
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

ODOMZO

Products Affected

- ODOMZO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of locally advanced basal cell carcinoma of the skin and specific documentation of negative pregnancy status
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

OPSUMIT

Products Affected

- OPSUMIT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Pregnancy
Required Medical Information	Diagnosis of pulmonary arterial hypertension WHO group I AND diagnosis was confirmed by right heart catheterization AND female patients are enrolled in the OPSUMIT REMS program.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Initial: 6 months, Reauthorization: 12 months
Other Criteria	None

ORENCIA

Products Affected

- ORENCIA CLICKJECT
- ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Active infection (including TB). Concurrent therapy with other biologics.
Required Medical Information	Screening for latent TB infection and assessment for Hep B risk. For positive latent TB, patient must have completed treatment or is currently receiving treatment for LTBI. HBV infection ruled out or treatment initiated for positive infection. Rheumatoid arthritis - Must have one of following: 1) inadequate response to methotrexate (MTX), 2) inadequate response to another nonbiologic DMARD (e.g., leflunomide, hydroxychloroquine, sulfasalazine) if contraindicated or intolerant to MTX, 3) intolerance or contraindication to at least 2 nonbiologic DMARDs or, 4) use Orencia as first-line therapy with MTX for severely active RA. Polyarticular JIA - Must have an inadequate response to at least one nonbiologic DMARD or intolerance/contraindication to at least 2 nonbiologic DMARDs. For PAJIA, member needs trial or intolerance/contraindication to Humira. For RA, member needs trial or intolerance/contraindication to Humira and Enbrel.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	For re-authorization, patient's condition must have improved or stabilized.

ORKAMBI

Products Affected

- ORKAMBI ORAL TABLET 200-125 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Initial Therapy: Diagnosis of cystic fibrosis (CF) with documented homozygous F508del mutation confirmed by FDA-approved CF mutation test AND if less than 18 years of age, baseline ophthalmological exam completed. Continuation of therapy: Documentation patient is tolerating and responding to medication (i.e. improved FEV1, weight gain, decreased exacerbations, etc.)
Age Restrictions	Must be greater than and equal to 12 years of age
Prescriber Restrictions	Must be prescribed by, or in conjunction with, a pulmonologist or is from a CF center accredited by the Cystic Fibrosis Foundation
Coverage Duration	12 months
Other Criteria	None

OSPHENA

Products Affected

- OSPHENA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Vaginal bleeding or dysfunctional uterine bleeding of an undetermined origin, known or suspected estrogen-dependent neoplasia, acute thromboembolism or a past history of thromboembolic disease (including patients with a history of DVT, pulmonary embolism, retinal vein thrombosis, stroke, or myocardial infarction, known or suspected pregnancy.
Required Medical Information	Diagnosis of moderate to severe dyspareunia or atrophic vaginitis AND A) Patient must be female, B) Patient must be menopausal or postmenopausal, C) Patient has tried and failed, has a contraindication or intolerance to a low dose vaginal estrogen preparation (Premarin vaginal cream, Estrace vaginal cream, Estring, Vagifem), D) Dose must not exceed 1 tablet per day, E) Patient does not have hepatic impairment.
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

OTREXUP

Products Affected

- OTREXUP SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.4ML, 12.5 MG/0.4ML, 15 MG/0.4ML, 20 MG/0.4ML, 22.5 MG/0.4ML, 25 MG/0.4ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Pregnancy, breastfeeding, alcoholism, alcoholic liver disease or other chronic liver disease, immunodeficiency syndrome, or preexisting blood dyscrasias
Required Medical Information	Diagnosis of Psoriasis or Rheumatoid Arthritis, including polyarticular juvenile idiopathic arthritis, AND documented trial and failure, contraindication, or intolerance to oral methotrexate.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

OXANDROLONE

Products Affected

- *oxandrolone oral*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Breast or prostate cancer in men. Breast cancer in women with hypercalcemia. Pregnancy. Nephrosis or nephrotic phase of nephritis. Hypercalcemia.
Required Medical Information	Patient is receiving treatment as an adjunct therapy to promote weight gain and has one of the following: Extensive surgery, Chronic infections, Severe trauma, Failure to gain or maintain at least 90% of ideal body weight without definite pathophysiologic reasons OR Oxandrin (oxandrolone) will be used to counterbalance protein catabolism associated with chronic corticosteroid administration OR Patient has bone pain associated with osteoporosis.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Osteoporosis bone pain: 1 month. Other diagnoses: 3 months
Other Criteria	For renewal, patient has experienced an objective improvement (i.e. weight gain, increase in lean body mass, or reduction in muscle pain/weakness)

PCSK9 INHIBITOR

Products Affected

- PRALUENT SUBCUTANEOUS SOLUTION PEN-INJECTOR
- REPATHA
- REPATHA PUSHTRONEX SYSTEM
- REPATHA SURECLICK

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	For PRALUENT: MUST MEET CRITERIA #1 OR #3. For REPATHA: MUST MEET CRITERIA #1, #2, OR #3. 1. Diagnosis of heterozygous familial hypercholesterolemia (HeFH) confirmed by genotyping OR Simon Broome criteria: Total cholesterol greater than 290mg/dL or LDL cholesterol greater than 190mg/dL, PLUS ONE OF THE FOLLOWING: Tendon xanthomas in patient or 1st degree relative (parent, sibling, child) or 2nd degree relative (grandparent, uncle, aunt) OR DNA-based evidence of LDL receptor mutation, familial defective apo B-100, or PCSK9 mutation. 2a. Myocardial infarction prophylaxis, stroke prophylaxis, and to reduce risk of coronary revascularization in patients with established CVD OR 2b. Diagnosis of homozygous familial hypercholesterolemia (HoFH) confirmed by genotyping OR diagnosis based on the following: a. History of untreated LDL-C greater than 500 mg/dL AND xanthoma before 10 years of age OR b. Documentation of HeFH in both parents. 3. Diagnosis of clinical atherosclerotic cardiovascular disease as defined as one of the following: a. acute coronary syndrome, b. history of myocardial infarction, c. stable/unstable angina, d. coronary or other arterial revascularization, e. stroke, f. transient ischemic stroke, g. peripheral arterial disease presumed to be atherosclerotic region AND MEETS CRITERIA #4, #5, and #6. 4. Provide baseline and current LDL-C. 5. LDL-C greater than or equal to 70mg/dL. 6. Used in combination with maximally tolerated high-intensity statin OR MEETS CRITERIA #7 AND #8. 7. Statin intolerant 8. LDL-C greater than or equal to 70mg/dL. CONTINUING THERAPY: 1. Documented response to Praluent or Repatha, defined as ONE of the following: a. The patient is tolerating medication b. Will continue to be used in combination with maximally tolerated statin (unless statin intolerant).
Age Restrictions	Repatha: 13 years of age and older for diagnosis HoFM, Diagnosis CVD and HeFH AND Praluent and Repatha : 18 years of age and older
Prescriber Restrictions	Must be prescribed by, or in consultation with, a cardiologist, endocrinologist, or lipid specialist
Coverage Duration	Initial approval: 8 weeks, Renewal approval: 12 months

PA Criteria	Criteria Details
Other Criteria	None

PEGYLATED INTERFERON

Products Affected

- PEGASYS PROCLICK SUBCUTANEOUS SOLUTION 180 MCG/0.5ML
- PEGASYS SUBCUTANEOUS SOLUTION

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Uncontrolled depression. Autoimmune hepatitis or other autoimmune condition known to be exacerbated by interferon.
Required Medical Information	Chronic Hepatitis C: Criteria will be applied consistent with current AASLD-IDSA guidance OR Chronic Hepatitis B: Diagnosis of HBeAg-positive or HBeAg-negative infection
Age Restrictions	5 years of age and older. Hepatitis B: 3 years of age and older.
Prescriber Restrictions	Prescribed by or in consultation with a hepatologist, gastroenterologist, oncologist or infectious disease specialist
Coverage Duration	HepC: Initial: 28 wks. Reauth: 20 wks. HepB: 48 weeks
Other Criteria	None

POMALYST

Products Affected

- POMALYST

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Documentation of ALL of the following: 1. Disease has progressed within 60 days of completion of the last therapy 2. If female of reproductive potential ALL of the below: Two negative pregnancy tests obtained prior to initiating therapy with Pomalyst, monthly negative pregnancy tests during therapy 3. Patient has been counseled about the use of reliable contraception before, during, and 1 month after initiation of therapy with Pomalyst 4. Patient assessment to determine if prophylactic aspirin or antithrombic treatment (warfarin, clopidogrel) will need to be taken to reduce the risk of VTE (embolism, stroke) 5. Registered and certified to be compliant with Pomalyst REMS (Risk Evalutation and Mitigation Strategy) program
Age Restrictions	None
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	12 months
Other Criteria	A documented diagnosis of multiple myeloma and received at least two prior therapies including lenalidomide (Revlimid) and bortezomib (Velcade)

PROMACTA

Products Affected

- PROMACTA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following: A) Relapsed/refractory chronic immune (idiopathic) thrombocytopenic purpura (ITP) for greater than 6 months AND Baseline platelet count is less than 50,000/mcL AND Degree of thrombocytopenia and clinical condition increase the risk of bleeding AND Patient had an insufficient response, intolerance, contraindication to corticosteroids or immune globulin or inadequate response or contraindication to splenectomy, B)Chronic hepatitis C and patient has thrombocytopenia defined as platelets less than 90,000/mcL for initiation (pre-treatment) of interferon therapy, C) Severe aplastic anemia in patients who have had an insufficient response to immunosuppressive therapy.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	For renewal of ITP, after at least 4 weeks of therapy at the maximum weekly dose (10 mcg/kg) the platelet count increased to a sufficient level to avoid clinically important bleeding. For renewal of Hepatitis C, platelets less than 75,000/mcL for maintenance of optimal interferon-based therapy.

PULMONARY FIBROSIS

Products Affected

- OFEV

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of idiopathic pulmonary fibrosis
Age Restrictions	None
Prescriber Restrictions	Prescriber must be a pulmonologist
Coverage Duration	12 months
Other Criteria	None

PULMOZYME

Products Affected

- PULMOZYME

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of cystic fibrosis
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	For renewal, Patient is benefiting from treatment (i.e. improvement in lung function [FEV1], decreased number of pulmonary exacerbations). Part D if patient in long term care (defined by customer location code on claim) otherwise Part B.

RANEXA

Products Affected

- RANEXA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Hepatic cirrhosis. Pre-existing QT prolongation. Concurrent therapy with a strong CYP3A4 inhibitor. Concurrent therapy with a CYP3A4 inducer.
Required Medical Information	Diagnosis of chronic angina AND patient has tried at least 2 combined anti-anginal therapies such as nitrates, beta-blockers, and calcium channel blockers OR unable to take full doses of conventional angina drugs due to low blood pressure and heart rate.
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	For renewal, patient had an objective response to therapy

RASUVO

Products Affected

- RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.2ML, 12.5 MG/0.25ML, 15 MG/0.3ML, 17.5 MG/0.35ML, 20 MG/0.4ML, 22.5 MG/0.45ML, 25 MG/0.5ML, 30 MG/0.6ML, 7.5 MG/0.15ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Pregnancy or treatment of neoplastic diseases
Required Medical Information	Diagnosis of severe, active rheumatoid arthritis, polyarticular juvenile idiopathic arthritis or severe, recalcitrant, disabling psoriasis AND Failure or clinically significant adverse effects to generic methotrexate injection
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

REGRANEX

Products Affected

- REGRANEX

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diabetic Neuropathic Ulcers: Diabetic patient with ulcer wound. Treatment will be given in combination with ulcer wound care (debridement, infection control, and/or pressure relief).
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Diabetic Neuropathic Ulcers: Maximum 5 months.
Other Criteria	None

REVLIMID

Products Affected

- REVLIMID

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Pregnancy
Required Medical Information	Diagnosis of multiple myeloma and medication will be used in combination with dexamethasone OR diagnosis of multiple myeloma (maintenance therapy) following autologous hematopoietic stem cell transplantation OR diagnosis of transfusion-dependent anemia due to low- or intermediate-1-risk myelodysplastic syndromes associated with a deletion 5q cytogenetic abnormality with or without additional cytogenetic abnormalities OR diagnosis of mantle cell lymphoma whose disease has relapsed or progressed after two prior therapies, one of which included bortezomib AND patient is enrolled in the Revlimid REMS Program
Age Restrictions	12 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

RILUTEK

Products Affected

- *riluzole*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of amyotrophic lateral sclerosis (ALS)
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

RUBRACA

Products Affected

- RUBRACA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of deleterious BRCA mutation (germline and/or somatic)-associated epithelial ovarian, fallopian tube, or primary peritoneal cancer and all of the following criteria: 1. BRCA mutation detected by an approved FDA laboratory test, 2. Previous trial/failure with two or more chemotherapy regimens, 3. Used as monotherapy, 4. Agreement of provider to perform a complete blood count (CBC) at baseline and monthly thereafter, 5. Women of reproductive potential must use an effective method of contraception during therapy and for 6 months after the last dose OR Diagnosis of recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer and all of the following: 1. Complete or partial response to platinum-based chemotherapy 2. Used as monotherapy 3. Agreement of provider to perform a complete blood count (CBC) at baseline and monthly thereafter, 4. Women of reproductive potential must use an effective method of contraception during therapy and for 6 months after the last dose.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Hematologist or Oncologist
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

RYDAPT

Products Affected

- RYDAPT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Angioedema
Required Medical Information	Diagnosis of treatment naive FLT3 mutation-positive acute myelogenous leukemia (AML) and must be used in combination with standard cytarabine and daunorubicin induction and consolidation therapy or diagnosis of systemic mastocytosis.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

SABRIL

Products Affected

- SABRIL ORAL TABLET
- *vigabatrin*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of one of the following: A) infantile spasms B) complex partial seizures and patient had an inadequate response to at least one generic first-line agents (carbamazepine, lamotrigine, levetiracetam, oxcarbazepine, valproic acid, divalproex sodium) and at least one adjunctive agent (carbamazepine, clobazam, gabapentin, lamotrigine, levitiracetam, oxcarbazepine, valproic acid, divalproex sodium, topiramate) AND patient and prescriber are enrolled in the SHARE restricted distribution program.
Age Restrictions	Seizures - 10 years of age and older. Infantile spasms - at least one month to 2 years of age
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

SAMSCA

Products Affected

- SAMSCA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Supporting statement of diagnosis from the physician
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

SANDOSTATIN

Products Affected

- *octreotide acetate injection solution 100 mcg/ml, 1000 mcg/ml, 200 mcg/ml, 50 mcg/ml, 500 mcg/ml*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of acromegaly and patient had an inadequate response or cannot be treated with surgical resection, pituitary irradiation, and/or bromocriptine mesylate at maximally tolerated doses OR Diagnosis of metastatic carcinoid tumor requiring symptomatic treatment of severe diarrhea and flushing episodes OR Diagnosis of vasoactive intestinal peptide tumor requiring treatment of profuse watery diarrhea.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	For renewal of acromegaly, IGF-1 level has normalized or improved. For renewal of metastatic carcinoid tumor, patient has improvement in diarrhea and flushing episodes. For renewal of vasoactive intestinal peptide tumor, improvement in diarrhea episodes.

SIGNIFOR

Products Affected

- SIGNIFOR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Acromegaly (initial): Diagnosis of acromegaly AND History of failure to surgery or patient is not a candidate for surgery. 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	None
Prescriber Restrictions	None
Coverage Duration	Initial: 6 months, Reauthorization: 12 months
Other Criteria	Cushing's disease (reauth): a clinically meaningful reduction in 24-hour urinary free cortisol levels or improvement in signs or symptoms of the disease. Acromegaly (reauth): patient's growth hormone (GH) level or insulin-like growth factor 1 (IGF-1) level for age and gender has normalized/improved

SILDENAFIL

Products Affected

- *sildenafil citrate oral tablet 20 mg*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Supporting statement of diagnosis from the physician
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

SIMPONI

Products Affected

- SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
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 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	None
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.

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

SOLTAMOX

Products Affected

- SOLTAMOX

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis for use. Documentation of inability to swallow tablet formulation.
Age Restrictions	None
Prescriber Restrictions	Oncologist
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

SOMATULINE DEPOT

Products Affected

- SOMATULINE DEPOT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of acromegaly AND Inadequate response to surgery and/or radiation therapy or patient cannot be treated with surgery and/or radiotherapy OR diagnosis of carcinoid syndrome OR diagnosis of unresectable, locally advanced or metastatic, gastroenteropancreatic neuroendocrine tumors (GEP-NETs)
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	For renewal, patient's IGF-1 levels has normalized or improved.

SOMAVERT

Products Affected

- SOMAVERT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	IV administration of Somavert, concomitant use of Sandostatin or Somatuline.
Required Medical Information	Diagnosis of acromegaly was confirmed by an elevated IGF-1 level or elevated GH level with a glucose tolerance test. Patient has tried and failed at least a 3 month trial of Sandostatin or Somatuline. For renewal, reduction in IGF-1 level from baseline.
Age Restrictions	None
Prescriber Restrictions	Endocrinologist
Coverage Duration	12 months
Other Criteria	None

SPORANOX

Products Affected

- *itraconazole oral capsule*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Ventricular dysfunction. Congestive heart failure (CHF). History of CHF. Concurrent therapy with a CYP3A4 inhibitor (e.g., cisapride, lovastatin, methadone, etc.)
Required Medical Information	Patient meets one of the following conditions: A) Diagnosis of systemic fungal infection (e.g., aspergillosis, histoplasmosois, blastomycosis) OR B) Diagnosis of onychomycosis confirmed by one of the following: positive potassium hydroxide (KOH) preparation, culture, or histology and the patient has extensive nail involvement causing significant pain and/or debilitation and Patient has tried or had a contraindication or intolerance to oral terbinafine OR C) Diagnosis of one of the following: tinea corporis (ringworm), tinea cruris (jock itch), tinea pedis (athlete's foot), tinea capitis (scalp ringworm), pityriasis versicolor and the patient is resistant to topical treatment OR D) All labeled FDA indicated uses.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Systemic infection: 6 months. Onychomycosis 2 months (fingernail), 3 months (toenail)
Other Criteria	None

SPRYCEL

Products Affected

- SPRYCEL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of Philadelphia chromosome-positive chronic myelogenous leukemia (Ph+ CML) that is newly diagnosed in the chronic phase OR Ph+ CML with resistance or intolerance to prior therapy, including imatinib OR Diagnosis of Ph+ acute lymphoblastic leukemia with resistance or intolerance to prior therapy OR Gastrointestinal stromal tumors (GIST) after disease progression on imatinib or Sutent (sunitinib)
Age Restrictions	None
Prescriber Restrictions	Oncologist
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

STELARA

Products Affected

- STELARA SUBCUTANEOUS SOLUTION 45 MG/0.5ML
- STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
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) and 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 Enbrel (etanercept) and Humira (adalimumab) OR b) for continuation of prior Stelara therapy. For Crohn's disease, history of failure, contraindication, or intolerance (F/C/I) to Humira (adalimumab).
Age Restrictions	None
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 uses (Initial, reauth): 12 months
Other Criteria	Reauthorization (all indications): Documentation of positive clinical response to 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 (tofacitinib)].Patient is not receiving Stelara in combination with a phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)].

STIVARGA

Products Affected

- STIVARGA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of metastatic colorectal cancer AND documentation of prior therapy with ALL of the following per the indication: 1. fluoropyrimidine, oxaliplatin, and irinotecan-based chemotherapy 2. bevacizumab (Avastin) 3. panitumumab (Vectibix) OR cetuximab (Erbitux) (for KRAS mutation-negative patients only) OR a documented diagnosis of locally advanced, unresectable or metastatic gastrointestinal stromal tumor (GIST) who have been previously treated with imatinib mesylate (Gleevec) and sunitinib malate (Sutent) OR a documented diagnosis of hepatocellular carcinoma in patients previously treated with sorafenib (Nexavar).
Age Restrictions	None
Prescriber Restrictions	Oncologist
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

SUTENT

Products Affected

- SUTENT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of advanced/metastatic renal cell carcinoma OR Diagnosis of gastrointestinal stromal tumors after disease progression on or intolerance to Gleevec OR Diagnosis of progressive, well-differentiated pancreatic neuroendocrine tumors in a patient with unresectable locally advanced or metastatic disease OR Diagnosis of high risk recurrent renal cell carcinoma following nephrectomy, used as adjuvant therapy.
Age Restrictions	None
Prescriber Restrictions	Oncologist
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

SYLATRON

Products Affected

- SYLATRON SUBCUTANEOUS KIT 200 MCG, 300 MCG, 600 MCG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Autoimmune hepatitis. Hepatic decompensation (Child-Pugh score greater than 6 [Class B or C])
Required Medical Information	Melanoma: Diagnosis of melanoma with microscopic or gross nodal involvement AND The prescribed medication will be used as adjuvant therapy within 84 days of definitive surgical resection, including complete lymphadenectomy.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

SYMDEKO

Products Affected

- SYMDEKO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of cystic fibrosis and patient is homozygous for the F508del mutation OR have at least one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to tezacaftor/ivacaftor verified by an FDA-cleared CF mutation test
Age Restrictions	12 years of age and older
Prescriber Restrictions	None
Coverage Duration	Initial: 6 months, Reauthorization: 12 months
Other Criteria	None

SYMLIN

Products Affected

- SYMLINPEN 120 SUBCUTANEOUS SOLUTION PEN-INJECTOR
- SYMLINPEN 60 SUBCUTANEOUS SOLUTION PEN-INJECTOR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Confirmed diagnosis of gastroparesis. Concurrent use of drugs that stimulate gastrointestinal motility. Recurrent severe hypoglycemia requiring assistance during the past 6 months. Presence of hypoglycemia unawareness. Poor compliance with current insulin regimen. Poor compliance with prescribed self-blood glucose monitoring. Hemoglobin A1c level higher than 9%.
Required Medical Information	Diagnosis of type 1 or type 2 diabetes mellitus AND Patient is taking concurrent mealtime insulin therapy (e.g., Humulin, Humalog, Novolin, Novolog)
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	For renewal, the patient had an objective response to therapy.

SYNAREL

Products Affected

- SYNAREL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Synarel should not be administered to patients who are hypersensitive to GnRH, GnRH agonist analogues or any of the excipients of SYNAREL, have undiagnosed vaginal bleeding, are pregnant or may become pregnant as major fetal abnormalities were observed in rats (not applicable when used in invitro fertilization programs), are breast feeding.
Required Medical Information	Diagnosis of central precocious puberty or endometriosis
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

SYNRIBO

Products Affected

- SYNRIBO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of chronic myelogenous leukemia AND patient has tried and failed or has a contraindication or intolerance to 2 tyrosine kinase inhibitors
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

SYPRINE

Products Affected

- *trientine hcl*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of Wilson's disease and intolerance to penicillamine
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

TAFINLAR

Products Affected

- TAFINLAR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of locally advanced or metastatic anaplastic thyroid cancer with documented positive BRAF V600E or V600K mutation as detected by an FDA-approved test as single agent or used in combination with Mekinist OR Diagnosis of metastatic or unresectable melanoma and metastatic non-small cell lung cancer (NSCLC) with BRAF V600E mutation as detected by an FDA-approved test
Age Restrictions	None
Prescriber Restrictions	Oncologist
Coverage Duration	12 months
Other Criteria	Tafinlar should not be used in patients with wild-type BRAF melanoma due to the potential risk of tumor promotion in these patients

TAGRISSO

Products Affected

- TAGRISSO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of metastatic, non-small cell lung cancer with one of the following- confirmed presence of T790M EGFR tumor mutation OR confirmed presence of epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R tumor mutations, as detected by an FDA-approved test.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

TARCEVA

Products Affected

- TARCEVA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of locally advanced, unresectable, or metastatic pancreatic cancer and Tarceva will be used in combination with gemcitabine OR Diagnosis of locally advanced or metastatic (stage III or IV) non-small cell lung cancer with one of the following: A) failure with at least one prior chemotherapy regimen and Tarceva will be used as monotherapy, or B) no evidence of disease progression after four cycles of first-line platinum-based chemotherapy and Tarceva will be used as maintenance treatment and Tarceva will be used as monotherapy, or C) Patient has known active epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutation as detected by an FDA-approved test or Clinical Laboratory Improvement Amendments-approved facility.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Oncologist
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

TASIGNA

Products Affected

- TASIGNA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Long QT syndrome. Uncorrected hypokalemia. Uncorrected hypomagnesemia. Concomitant use with a drug known to prolong the QT interval or strong cytochrome P450 3A4 inhibitors
Required Medical Information	Diagnosis of newly diagnosed Philadelphia chromosome-positive chronic myelogenous leukemia (Ph+ CML) in the chronic phase OR Diagnosis of Ph+ CML with resistance or intolerance to prior therapy that include imatinib.
Age Restrictions	None
Prescriber Restrictions	Oncologist
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

TAZORAC

Products Affected

- *tazarotene external*
- TAZORAC EXTERNAL CREAM 0.05 %
- TAZORAC EXTERNAL GEL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Pregnancy
Required Medical Information	Diagnosis of acne vulgaris and patient has tried an adequate trial with at least one other topical acne product (e.g., benzoyl peroxide, salicylic acid, clindamycin, erythromycin, adapalene, azelaic acid, and/or tretinoin) OR Diagnosis of stable moderate to severe plaque psoriasis and 20% or less body surface area involvement and patient has a contraindication or tried adequate trial with at least one other topical psoriasis product (e.g., medium to high potency corticosteroid and/or vitamin D analogs) AND females of child-bearing potential are using adequate birth control measures during therapy.
Age Restrictions	12 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

TECFIDERA

Products Affected

- TECFIDERA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of relapsing forms of multiple sclerosis (relapsing-remitting MS or progressive-relapsing MS, or secondary-progressive MS) OR patient has experienced a first clinical episode and has MRI features consistent with multiple sclerosis.
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

TESTOSTERONE

Products Affected

- ANDROGEL PUMP TRANSDERMAL GEL 20.25 MG/ACT (1.62%)
- ANDROGEL TRANSDERMAL GEL 20.25 MG/1.25GM (1.62%), 40.5 MG/2.5GM (1.62%)
- *testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml*
- *testosterone enanthate intramuscular solution*
- *testosterone transdermal gel 10 mg/act (2%), 12.5 mg/act (1%), 50 mg/5gm (1%)*
- *testosterone transdermal solution*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of hypogonadism (primary or hypogonadotropic) AND patient is male AND patient's serum testosterone (total or free) value and the laboratory reference value range reported by laboratory service AND diagnosis has been confirmed by a low-for-age serum testosterone (total or free) level defined by the normal laboratory reference value OR diagnosis of inoperable, metastatic breast cancer AND patient is female
Age Restrictions	12 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	For renewal, patient experienced an objective response to therapy.

TETRABENAZINE

Products Affected

- *tetrabenazine*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Actively suicidal. Untreated or inadequately treated depression. Impaired hepatic function. Concomitant use of monoamine oxidase inhibitors. Concomitant use of reserpine or within 20 days of discontinuing reserpine.
Required Medical Information	Diagnosis of chorea associated with Huntington's disease AND any medication possibly contributing to the underlying symptoms of chorea has been discontinued (e.g., antipsychotics, metoclopramide, amphetamines, methylphenidate, dopamine agonists, etc.) unless cessation would be detrimental to the underlying condition AND patient has been genotypes to CYP2D6 to determine whether the patient is a poor, intermediate or extensive metabolizer.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Dosing will be approved per the FDA labeling based on CYP2D6 testing. For renewal, patient had an objective response to therapy.

TOPICAL RETINOIDS

Products Affected

- *adapalene external cream*
- *adapalene external gel*
- *tretinoin external cream*
- *tretinoin external gel 0.01 %, 0.025 %*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of mild to moderate acne vulgaris
Age Restrictions	PA applies to patients older than 26 years of age
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	For renewal, medication has been effective in treating the patient's condition.

TRACLEER

Products Affected

- TRACLEER

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Receiving concomitant cyclosporine A or glyburide therapy. Aminotransferase elevations are accompanied by signs or symptoms of liver dysfunction or injury or increases in bilirubin at least 2 times the upper limit of normal.
Required Medical Information	Diagnosis of pulmonary arterial hypertension that was confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.) AND Patient has WHO Group I PAH AND Patient has New York Heart Association (NYHA) Functional Class II-IV AND pregnancy must be excluded prior to the start of therapy and will be prevented thereafter with two forms of reliable contraception in female patients of reproductive potential.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Initial: 6 months, Reauthorization: 12 months
Other Criteria	Liver aminotransferases will be measured prior to initiation of treatment and then monthly.

TRELSTAR

Products Affected

- TRELSTAR MIXJECT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of FDA approved indications not otherwise excluded from Part D AND palliative treatment of advanced prostate cancer, central precocious puberty, endometrial hyperplasia, endometriosis, fibrocystic disease of breast, uterine leiomyoma
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

TYKERB

Products Affected

- TYKERB

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of breast cancer with tumors that overexpress human epidermal growth factor receptor 2 (HER2) AND a) the medication will be used in combination with Xeloda in a patient with advanced or metastatic disease and the patient has received prior therapy including an anthracycline, a taxane, and trastuzumab or b) The medication will be used in combination with Femara for the treatment of a postmenopausal woman with hormone receptor-positive metastatic disease for whom hormonal therapy is indicated.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Oncologist
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

TYMLOS

Products Affected

- TYMLOS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Patients at increased risk of osteogenic sarcoma.
Required Medical Information	Diagnosis of osteoporosis in post-menopausal women at high risk for fracture. Member must have failed therapy with a bisphosphonate (defined by a fracture while on therapy or worsening bone density) unless such a trial is shown to be inappropriate or contraindicated (i.e., presence of severe osteoporosis [T-scores -3.0 or worse in lumbar spine, femoral neck, or total hip region], history of major osteoporotic fracture, presence of renal insufficiency, etc) AND member has at least one of the following: T-score equal to or worse than -2.5 in the lumbar spine, femoral neck, or total hip region OR a FRAX calculator based 10-year risk of at least 20% for a major osteoporotic fracture (spine, shoulder, hip, or wrist), or a 10-year risk of at least 3% for a hip fracture OR presence or history of osteoporotic fracture.
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	Initial: 12 months, Renewal: Total duration not to exceed 24 months during patient's lifetime.
Other Criteria	None

UPTRAVI

Products Affected

- UPTRAVI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of pulmonary arterial hypertension (WHO Group 1) confirmed by right heart catheterization AND patient has tried and had an insufficient response to at least one other PAH agent (e.g., sildenafil) therapy and one other ERA agent (e.g. letairis, opsumit, tracleer).
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

VALCHLOR

Products Affected

- VALCHLOR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of mycosis fungoides-type cutaneous T-cell lymphoma AND patient has early stage disease (defined as Stage 1A or 1B) AND patient has received prior skin-directed therapy (e.g., very high potency class I topical corticosteroids for at least 3 months (i.e. clobetasol, diflorasone, halobetasol, augmented betamethasone diproprionate), phototherapy, topical nitrogen mustard, or a topical retinoid (e.g., bexarotene)).
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

VARIZIG

Products Affected

- VARIZIG INTRAMUSCULAR SOLUTION

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	History of hypersensitivity (including anaphylaxis or severe systemic reaction) to immune globulin or any component of the preparation. Severe thrombocytopenia or coagulation disorder where IM injections are contraindicated.
Required Medical Information	To be used for post-exposure varicella infection prophylaxis to reduce varicella severity in high-risk patients defined as premature neonates, neonates and infants less than 1 year old, pregnant women, newborns of women with varicella shortly before or after delivery, immunocompromised children and adults without a past history of varicella unless the patient is undergoing a bone marrow transplantation, and adults without evidence of immunity.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	6 months
Other Criteria	None

VENCLEXTA

Products Affected

- VENCLEXTA
- VENCLEXTA STARTING PACK

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of chronic lymphocytic leukemia (CLL) OR small lymphocytic lymphoma, with or without 17p deletion and patient has had at least 1 prior therapy
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

VERZENIO

Products Affected

- VERZENIO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	BREAST CANCER (1) Patient must have a diagnosis of advanced or metastatic breast cancer AND (2a) must be used in combination with fulvestrant for the treatment of disease progression following endocrine therapy OR (2b) used as monotherapy for treatment of disease progression following endocrine therapy and patient has already received at least one prior chemotherapy regimen of Ibrance or Kisqali OR (2c) used as initial endocrine-based treatment in combination with an aromatase inhibitor AND (3) disease is hormone receptor positive AND human epidermal growth factor 2 (HER2)- negative
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	Approve for continuation of therapy

VOTRIENT

Products Affected

- VOTRIENT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of advanced/metastatic renal cell carcinoma OR Diagnosis of advanced soft tissue sarcoma and patient received at least one prior chemotherapy (doxorubicin, dacarbazine, ifosfamide, epirubicin, docetaxel, or vinorelbine).
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

XALKORI

Products Affected

- XALKORI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of locally advanced or metastatic (stage III or IV) non-small cell lung cancer AND patient has non-squamous cell histology AND Patient has anaplastic lymphoma kinase (ALK)-positive disease as detected with an FDA-approved test or Clinical Laboratory Improvement Amendments-approved facility or are ROS1-positive
Age Restrictions	18 years of age and older
Prescriber Restrictions	Must be prescribed by an oncologist
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

XELJANZ

Products Affected

- XELJANZ
- XELJANZ XR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Psoriatic arthritis (PsA) or Rheumatoid arthritis (RA) or Ulcerative Colitis-(Initial): Diagnosis of psoriatic arthritis or moderately to severely active RA and an inadequate response or intolerance to methotrexate. One of the following: Failure, contraindication, or intolerance to both Enbrel (etanercept) and Humira (adalimumab) (for Ulcerative Colitis only Humira will be required), 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. Patient is not receiving tofacitinib in combination with a biologic DMARD [eg, Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)]. Patient is not receiving tofacitinib in combination with a potent immunosuppressant (eg, azathioprine, cyclosporine).
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with a rheumatologist or gastroenterologist
Coverage Duration	12 months
Other Criteria	Documentation of positive clinical response to tofacitinib therapy. Patient is not receiving tofacitinib in combination with a biologic DMARD [eg, Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)]. Patient is not receiving tofacitinib in combination with a potent immunosuppressant (eg, azathioprine, cyclosporine).

XGEVA

Products Affected

- XGEVA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of hypercalcemia of malignancy, refractory to bisphosphonate therapy OR diagnosis of giant cell tumor of bone that is unresectable or where surgical resection is likely to result in severe morbidity OR treatment used for prevention of skeletal-related events in patients with multiple myeloma or bone metastases from solid tumors.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

XOLAIR

Products Affected

- XOLAIR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Documentation of the following: A)moderate to severe chronic idiopathic urticaria and has remained symptomatic despite at least 2 weeks of H1 antihistamine therapy OR intolerance or contraindication of H1 antihistamine therapy OR B)Mod-severe persistent asthma (NHLBI definition) meeting all the following criteria: Evidence of reversible disease (12% or greater improvement in FEV1 with at least a 200ml increase or 20% or greater improvement in PEF as a result of a short-acting bronchodilator challenge). Evidence of specific allergic sensitivity to a perennial aeroallergen (+ skin test or in vitro test). Failure of an adequate trial of standard therapy as defined by a trial of at least a 3 month course of high-dose inhaled corticosteroids and long-acting beta2-agonists OR maximally tolerated doses of standard therapy OR intolerance or contraindication to standard therapy. Extended approval for 6 months if demonstrated benefit, meeting at least 2 of the following criteria: PEF improvement (12% or greater from baseline (prior to start of Xolair)), OR FEV1 improvement (12% or greater from baseline (prior to start of Xolair)), OR reduction in symptoms (wheezing, sob, cough, chest tightness), OR reduction in systemic corticosteroids and rescue drug use, OR reduction of asthma-related hospitalizations and other medical contacts.
Age Restrictions	6 years of age and older
Prescriber Restrictions	Allergist, immunologist, pulmonologist or dermatologist
Coverage Duration	Initial: 6 months trial. Extended approval: 6 months if demonstrated benefit
Other Criteria	If this medication is administered by a physician incident to a physicians visit this would be covered by Medicare Part B

XTANDI

Products Affected

- XTANDI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Metastatic castration-resistant prostate cancer (mCRPC): Diagnosis of mCRPC. History of failure, contraindication or intolerance to Zytiga OR Diagnosis of Non-metastatic castration-resistant prostate cancer (Zytiga will not be required)
Age Restrictions	None
Prescriber Restrictions	Prescribed or in consultation with an oncologist or urologist
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

XURIDEN

Products Affected

- XURIDEN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of Hereditary orotic aciduria
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with a specialist that treats metabolic defects
Coverage Duration	12 months
Other Criteria	None

XYREM

Products Affected

- XYREM

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Concomitant treatment with sedative hypnotic agents. Succinic semialdehyde dehydrogenase deficiency.
Required Medical Information	Diagnosis of narcolepsy with excessive daytime sleepiness, confirmed by sleep lab evaluation (e.g., multiple sleep latency test, polysomnography) and for patients with excessive daytime sleepiness, patient has had a previous trial with or has a contraindication, intolerance, or allergy to modafinil, armodafinil, methylphenidate, dextroamphetamine, or mixed amphetamine salts. For diagnosis of cataplexy alone, request will be approved.
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	For renewal, the patient had a positive response to the medication (increased sleep quality for patients with narcolepsy)

YONSA

Products Affected

- YONSA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of metastatic castration-resistant prostate cancer, and used in combination with methylprednisolone AND Documented history of trial with, inadequate treatment response, adverse event, or contraindication to Zytiga
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or urologist
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

ZAVESCA

Products Affected

- *miglustat*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of mild to moderate type 1 Gaucher disease and patient is not a candidate for enzyme replacement therapy.
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

ZEJULA

Products Affected

- ZEJULA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of recurrent epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer and patient had a complete or partial response to platinum-based chemotherapy.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or gynecologist
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

ZELBORAF

Products Affected

- ZELBORAF

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of unresectable or metastatic melanoma OR Erdheim-Chester disease. Patient has positive BRAF-V600E mutation documented by an FDA-approved test or Clinical Laboratory Improvement Amendments-approved facility.
Age Restrictions	None
Prescriber Restrictions	Oncologist
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

ZOLINZA

Products Affected

- ZOLINZA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of cutaneous T-cell lymphoma AND progressive, persistent or recurrent disease or patient is not a candidates for or following 2 systemic therapies (bexarotene, romidepsin, etc.)
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

ZORTRESS

Products Affected

- ZORTRESS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Medication is being used for: A) Prevention of kidney transplant organ rejection AND patient is at low-to-moderate immunologic risk AND member is prescribed concurrent therapy with reduced doses of cyclosporine and corticosteroids, or B) Prevention of liver transplant organ rejection AND 30 or more days have passed since the transplant procedure AND the member is prescribed concurrent therapy with reduced doses of tacrolimus and corticosteroids
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescriber is experienced in immunosuppressive therapy and management of transplant patients.
Coverage Duration	12 months
Other Criteria	Part B if transplant covered by Medicare. otherwise Part D

ZYDELIG

Products Affected

- ZYDELIG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	The patient has one of the following diagnoses: A) chronic lymphocytic leukemia AND The medication will be used in combination with rituximab AND The patient has relapsed on at least one prior therapy (purine analogues [fludarabine, pentostatin, cladribine], alkylating agents [chlorambucil, cyclophosphamide], or monoclonal antibodies [rituximab]) AND the patient does not have any co-morbidities that prevents the use of cytotoxic chemotherapy (severe neutropenia or thrombocytopenia, creatinine clearance less than 60 mL/minute), B) follicular lymphoma AND the patient has relapsed on at least two prior systemic therapies (rituximab, alkylating agents [cyclophosphamide, chlorambucil], anthracyclines [doxorubicin, daunorubicin], purine analogs [fludarabine]), or C) small lymphocytic lymphoma AND The patient has relapsed on at least two prior systemic therapies (rituximab, alkylating agents [cyclophosphamide, chlorambucil], anthracyclines [doxorubicin, daunorubicin], purine analogs [fludarabine]).
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

ZYKADIA

Products Affected

- ZYKADIA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer (NSCLC).
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

ZYTIGA

Products Affected

- ZYTIGA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of metastatic prostate cancer AND Patient has castration-resistant disease (defined by tumor growth/disease progression, risk in PsA levels, new metastases) OR high-risk castration-sensitive prostate cancer AND Zytiga will be used in combination with prednisone.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	This criteria applies to new starts only

PART B VERSUS PART D

Products Affected

- ABELCET INTRAVENOUS SUSPENSION 5 MG/ML
- *acetylcysteine inhalation solution 10 %, 20 %*
- *acyclovir sodium intravenous solution 50 mg/ml*
- *albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, (5 mg/ml) 0.5%, 0.63 mg/3ml, 1.25 mg/3ml*
- AMBISOME INTRAVENOUS SUSPENSION RECONSTITUTED 50 MG
- *amikacin sulfate injection solution 500 mg/2ml*
- AMINOSYN II INTRAVENOUS SOLUTION 10 %, 8.5 %
- AMINOSYN II/ELECTROLYTES INTRAVENOUS SOLUTION 8.5 %
- AMINOSYN/ELECTROLYTES INTRAVENOUS SOLUTION 7 %, 8.5 %
- AMINOSYN-HBC INTRAVENOUS SOLUTION 7 %
- AMINOSYN-PF INTRAVENOUS SOLUTION 10 %, 7 %
- AMINOSYN-RF INTRAVENOUS SOLUTION 5.2 %
- *amphotericin b injection solution reconstituted 50 mg*
- *ampicillin sodium injection solution reconstituted 1 gm, 125 mg*
- *ampicillin-sulbactam sodium injection solution reconstituted 1.5 (1-0.5) gm, 15 (10-5) gm, 3 (2-1) gm*
- *aprepitant oral capsule 125 mg, 40 mg, 80 & 125 mg, 80 mg*
- ASTAGRAF XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 0.5 MG, 1 MG, 5 MG
- AZACTAM INJECTION SOLUTION RECONSTITUTED 1 GM, 2 GM
- AZASAN ORAL TABLET 100 MG, 75 MG
- *azathioprine oral tablet 50 mg*
- *azithromycin intravenous solution reconstituted 500 mg*
- *budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml, 1 mg/2ml*
- *calcitonin (salmon) nasal solution 200 unit/act*
- *calcitriol oral capsule 0.25 mcg, 0.5 mcg*
- *calcitriol oral solution 1 mcg/ml*
- *caspofungin acetate intravenous solution reconstituted 50 mg, 70 mg*
- *cefazolin sodium injection solution reconstituted 1 gm, 10 gm, 500 mg*
- *cefepime hcl injection solution reconstituted 1 gm, 2 gm*
- *cefoxitin sodium injection solution reconstituted 10 gm*
- *cefoxitin sodium intravenous solution reconstituted 1 gm, 2 gm*
- *ceftriaxone sodium injection solution reconstituted 1 gm, 2 gm, 250 mg, 500 mg*
- *ceftriaxone sodium intravenous solution reconstituted 10 gm*
- *cefuroxime sodium injection solution reconstituted 7.5 gm, 750 mg*
- *cefuroxime sodium intravenous solution reconstituted 1.5 gm*
- *ciprofloxacin in d5w intravenous solution 200 mg/100ml*
- *clindamycin phosphate injection solution 300 mg/2ml, 600 mg/4ml, 900 mg/6ml*
- CLINIMIX E/DEXTROSE (2.75/10) INTRAVENOUS SOLUTION 2.75 %
- CLINIMIX E/DEXTROSE (2.75/5) INTRAVENOUS SOLUTION 2.75 %
- CLINIMIX E/DEXTROSE (4.25/10) INTRAVENOUS SOLUTION 4.25 %
- CLINIMIX E/DEXTROSE (4.25/25) INTRAVENOUS SOLUTION 4.25 %
- CLINIMIX E/DEXTROSE (4.25/5) INTRAVENOUS SOLUTION 4.25 %
- CLINIMIX E/DEXTROSE (5/15) INTRAVENOUS SOLUTION 5 %
- CLINIMIX E/DEXTROSE (5/20) INTRAVENOUS SOLUTION 5 %
- CLINIMIX E/DEXTROSE (5/25) INTRAVENOUS SOLUTION 5 %
- CLINIMIX/DEXTROSE (2.75/5) INTRAVENOUS SOLUTION 2.75 %
- CLINIMIX/DEXTROSE (4.25/10) INTRAVENOUS SOLUTION 4.25 %
- CLINIMIX/DEXTROSE (4.25/20) INTRAVENOUS SOLUTION 4.25 %

- CLINIMIX/DEXTROSE (4.25/25) INTRAVENOUS SOLUTION 4.25 %
- CLINIMIX/DEXTROSE (4.25/5) INTRAVENOUS SOLUTION 4.25 %
- CLINIMIX/DEXTROSE (5/15) INTRAVENOUS SOLUTION 5 %
- CLINIMIX/DEXTROSE (5/20) INTRAVENOUS SOLUTION 5 %
- CLINIMIX/DEXTROSE (5/25) INTRAVENOUS SOLUTION 5 %
- CLINISOL SF INTRAVENOUS SOLUTION 15 %
- *colistimethate sodium (cba) injection solution reconstituted 150 mg*
- *cromolyn sodium inhalation nebulization solution 20 mg/2ml*
- *cyclophosphamide oral capsule 25 mg, 50 mg*
- *cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg*
- *cyclosporine modified oral solution 100 mg/ml*
- *cyclosporine oral capsule 100 mg, 25 mg*
- *daptomycin intravenous solution reconstituted 500 mg*
- DEPO-PROVERA INTRAMUSCULAR SUSPENSION 400 MG/ML
- *dextrose intravenous solution 10 %, 5 %*
- *dextrose-nacl intravenous solution 10-0.2 %, 10-0.45 %, 2.5-0.45 %, 5-0.2 %, 5-0.225 %, 5-0.33 %, 5-0.45 %, 5-0.9 %*
- *diphtheria-tetanus toxoids dt intramuscular suspension 25-5 lfu/0.5ml*
- *doripenem intravenous solution reconstituted 500 mg*
- DOXY 100 INTRAVENOUS SOLUTION RECONSTITUTED 100 MG
- *dronabinol oral capsule 10 mg, 2.5 mg, 5 mg*
- *duramorph injection solution 0.5 mg/ml, 1 mg/ml*
- ENGERIX-B INJECTION SUSPENSION 10 MCG/0.5ML, 20 MCG/ML
- ENVARSUS XR ORAL TABLET EXTENDED RELEASE 24 HOUR 0.75 MG, 1 MG, 4 MG
- ERAXIS INTRAVENOUS SOLUTION RECONSTITUTED 100 MG, 50 MG
- ERYTHROCIN LACTOBIONATE INTRAVENOUS SOLUTION RECONSTITUTED 500 MG
- FLEBOGAMMA DIF INTRAVENOUS SOLUTION 5 GM/50ML
- *fluconazole in sodium chloride intravenous solution 200-0.9 mg/100ml-%, 400-0.9 mg/200ml-%*
- FREAMINE HBC INTRAVENOUS SOLUTION 6.9 %
- *furosemide injection solution 10 mg/ml, 10 mg/ml (4ml syringe)*
- GAMMAGARD INJECTION SOLUTION 2.5 GM/25ML
- GAMMAGARD S/D LESS IGA INTRAVENOUS SOLUTION RECONSTITUTED 10 GM, 5 GM
- GAMMAPLEX INTRAVENOUS SOLUTION 10 GM/100ML, 10 GM/200ML, 20 GM/200ML, 5 GM/50ML
- GENGRAF ORAL CAPSULE 100 MG, 25 MG
- GENGRAF ORAL SOLUTION 100 MG/ML
- *gentamicin sulfate injection solution 40 mg/ml*
- *granisetron hcl oral tablet 1 mg*
- *heparin sodium (porcine) injection solution 1000 unit/ml, 10000 unit/ml, 20000 unit/ml, 5000 unit/ml*
- HEPATAMINE INTRAVENOUS SOLUTION 8 %
- *imipenem-cilastatin intravenous solution reconstituted 250 mg, 500 mg*
- IMOVAX RABIES INTRAMUSCULAR INJECTABLE 2.5 UNIT/ML
- INTRALIPID INTRAVENOUS EMULSION 20 %, 30 %
- INVANZ INJECTION SOLUTION RECONSTITUTED 1 GM
- *ipratropium bromide inhalation solution 0.02 %*
- *ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml*
- ISOLYTE-S INTRAVENOUS SOLUTION
- *kcl in dextrose-nacl intravenous solution 10-5-0.45 meq/l-%-%, 20-5-0.2 meq/l-%-%, 20-5-0.33 meq/l-%-%, 20-5-0.45 meq/l-%-%, 20-5-0.9 meq/l-%-%, 30-5-0.45 meq/l-%-%, 40-5-0.45 meq/l-%-%, 40-5-0.9 meq/l-%-%*
- *kcl-lactated ringers-d5w intravenous solution 20 meq/l*
- *levocarnitine oral solution 1 gm/10ml*

- *levocarnitine oral tablet 330 mg*
- *levofloxacin in d5w intravenous solution 500 mg/100ml, 750 mg/150ml*
- *levofloxacin intravenous solution 25 mg/ml*
- *magnesium sulfate injection solution 50 %, 50 % (10ml syringe)*
- *meropenem intravenous solution reconstituted 1 gm, 500 mg*
- *methotrexate oral tablet 2.5 mg*
- *methotrexate sodium (pf) injection solution 50 mg/2ml*
- *methotrexate sodium injection solution 250 mg/10ml*
- *metronidazole in nacl intravenous solution 500-0.79 mg/100ml-%*
- *moxifloxacin hcl in nacl intravenous solution 400 mg/250ml*
- MYCAMINE INTRAVENOUS SOLUTION RECONSTITUTED 100 MG, 50 MG
- *mycophenolate mofetil oral capsule 250 mg*
- *mycophenolate mofetil oral suspension reconstituted 200 mg/ml*
- *mycophenolate mofetil oral tablet 500 mg*
- *mycophenolate sodium oral tablet delayed release 180 mg, 360 mg*
- *nafcillin sodium injection solution reconstituted 1 gm*
- *nafcillin sodium intravenous solution reconstituted 10 gm*
- NEBUPENT INHALATION SOLUTION RECONSTITUTED 300 MG
- NEPHRAMINE INTRAVENOUS SOLUTION 5.4 %
- NORMOSOL-M IN D5W INTRAVENOUS SOLUTION
- NORMOSOL-R IN D5W INTRAVENOUS SOLUTION
- NORMOSOL-R PH 7.4 INTRAVENOUS SOLUTION
- *nutrilipid intravenous emulsion 20 %*
- *ondansetron hcl oral solution 4 mg/5ml*
- *ondansetron hcl oral tablet 24 mg, 4 mg, 8 mg*
- *ondansetron oral tablet dispersible 4 mg, 8 mg*
- *paricalcitol oral capsule 1 mcg, 2 mcg, 4 mcg*
- *penicillin g potassium injection solution reconstituted 20000000 unit*
- *penicillin g sodium injection solution reconstituted 5000000 unit*
- PENTAM INJECTION SOLUTION RECONSTITUTED 300 MG
- *piperacillin sod-tazobactam so intravenous solution reconstituted 2.25 (2-0.25) gm, 3.375 (3-0.375) gm, 4.5 (4-0.5) gm, 40.5 (36-4.5) gm*
- PLASMA-LYTE 148 INTRAVENOUS SOLUTION
- PLASMA-LYTE A INTRAVENOUS SOLUTION
- PLENAMINE INTRAVENOUS SOLUTION 15 %
- *potassium chloride in dextrose intravenous solution 20-5 meq/l-%, 40-5 meq/l-%*
- *potassium chloride in nacl intravenous solution 20-0.45 meq/l-%, 20-0.9 meq/l-%, 40-0.9 meq/l-%*
- *potassium chloride intravenous solution 10 meq/100ml, 2 meq/ml, 2 meq/ml (20 ml), 20 meq/100ml, 40 meq/100ml*
- PREMASOL INTRAVENOUS SOLUTION 10 %, 6 %
- PROCALAMINE INTRAVENOUS SOLUTION 3 %
- *prochlorperazine maleate oral tablet 10 mg, 5 mg*
- PROSOL INTRAVENOUS SOLUTION 20 %
- RABAVERT INTRAMUSCULAR SUSPENSION RECONSTITUTED
- RAPAMUNE ORAL SOLUTION 1 MG/ML
- RECOMBIVAX HB INJECTION SUSPENSION 10 MCG/ML, 10 MCG/ML (1ML SYRINGE), 40 MCG/ML, 5 MCG/0.5ML
- *rifampin intravenous solution reconstituted 600 mg*
- SANDIMMUNE ORAL CAPSULE 100 MG, 25 MG
- SANDIMMUNE ORAL SOLUTION 100 MG/ML
- SENSIPAR ORAL TABLET 30 MG, 60 MG, 90 MG
- *sirolimus oral tablet 0.5 mg, 1 mg, 2 mg*
- *sodium chloride injection solution 2.5 meq/ml*
- *sodium chloride intravenous solution 0.45 %, 0.9 %, 3 %, 5 %*

- *sodium lactate intravenous solution 5 meq/ml*
- *tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg*
- TEFLARO INTRAVENOUS SOLUTION RECONSTITUTED 400 MG, 600 MG
- TENIVAC INTRAMUSCULAR INJECTABLE 5-2 LFU
- *tetanus-diphtheria toxoids td intramuscular suspension 2-2 lf/0.5ml*
- *tigecycline intravenous solution reconstituted 50 mg*
- *tobramycin sulfate injection solution 10 mg/ml, 80 mg/2ml*
- TPN ELECTROLYTES INTRAVENOUS SOLUTION
- TRAVASOL INTRAVENOUS SOLUTION 10 %
- TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG
- TROPHAMINE INTRAVENOUS SOLUTION 10 %
- TWINRIX INTRAMUSCULAR SUSPENSION 720-20
- *vancomycin hcl intravenous solution reconstituted 10 gm, 1000 mg, 500 mg*
- VARUBI ORAL TABLET 90 MG
- *voriconazole intravenous solution reconstituted 200 mg*
- XATMEP ORAL SOLUTION 2.5 MG/ML
- ZERBAXA INTRAVENOUS SOLUTION RECONSTITUTED 1.5 (1-0.5) GM

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.

Index of Drugs