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 patient must have tried and failed, contraindication or intolerance to one formulary first line agent such as Topical Corticosteroids (betamethasone, fluocinonide, desoximetasone),Topical Calcipotriene/Calcitriol, Topical Calcipotriene, OR Topical Tazarotene
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a dermatologist
Coverage Duration	12 months
Other Criteria	None

ACTEMRA

Products Affected

- ACTEMRA INTRAVENOUS
- 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 Polyarticular juvenile idiopathic arthritis, Rheumatoid arthritis, OR systemic juvenile idiopathic arthritis AND trial and failure or contraindication or intolerance to either Humira AND Enbrel OR Diagnosis of chimeric antigen receptor (CAR) T cell-induced severe or life-threatening cytokine release syndrome OR Diagnosis of giant cell arteritis
Age Restrictions	2 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

ACTIMMUNE

Products Affected

- ACTIMMUNE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Diagnosis of any medically accepted indications not otherwise excluded from Part D OR atopic dermatitis
Age Restrictions	None
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	None
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 thomboembolic 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	None
Prescriber Restrictions	None
Coverage Duration	6 months - initial. 12 months - renewal
Other Criteria	None

AFINITOR

Products Affected

- AFINITOR
- AFINITOR DISPERZ ORAL TABLET SOLUBLE 2 MG, 3 MG, 5 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 advanced metastatic renal cell carcinoma and patient has failed therapy (disease progressed) with sunitinib or sorafenib OR in combination with lenvatinib, following one prior anti-angiogenic therapy. 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 progressive, well-differentiated, non-functional, neuroendocrine tumors (NET) of gastrointestinal (GI) or lung origin with unresectable, locally advanced or metastatic disease OR renal angiomyolipoma and tuberous sclerosis complex not requiring immediate surgery.
Age Restrictions	18 years of age or older for RCC, pNET, NET of GI or lung origin, advanced HER2-negative breast cancer, and renal angiomyolipoma with TSC. 1 year of age or older for SEGA
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None

ALDURAZYME

Products Affected

- ALDURAZYME

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Diagnosis of Hurler or Hurler-Scheie form of Mucopolysaccharidosis I (MPS I) or Diagnosis of Scheie form of MPS I with moderate to severe symptoms.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

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 AND a history of failure, contraindication, intolerance, or progressed on XALKORI (crizotinib)
Age Restrictions	18 years and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

ALIMTA

Products Affected

- ALIMTA

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

ALPHA1PROTEINASEINH

Products Affected

- PROLASTIN-C
- ZEMAIRA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	not covered for patients with IgA deficiency
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 ?M/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 or 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	None

AMPYRA

Products Affected

- AMPYRA

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 any disease modifying drug (interferon beta 1a, peginterferon beta1a, interferon beta1b, glatiramer, natlizumab, mitoxatrone, dimethyl fumarate, teriflunomide, alemtuzumab) to control disease progression OR has tried and failed, contraindicated, or intolerant to any DMDs
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescibed by or in consulation with a neurologist
Coverage Duration	Initial - 3 months. Renewal - 12 months
Other Criteria	None

APOKYN

Products Affected

- APOKYN

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 ?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 or 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 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 or 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.

BAVENCIO

Products Affected

- BAVENCIO

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 Merkel cell carcinoma or locally advanced or metastatic urothelial carcinoma, in patients with disease progression on or following platinum-containing chemotherapy, or within 12 months of neoadjuvant or adjuvant platinum-containing chemotherapy.
Age Restrictions	12 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	12 months
Other Criteria	None

BELEODAQ

Products Affected

- BELEODAQ

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 peripheral T-cell lymphoma (PTCL) (ANC should be greater than or equal to 1000/mm3 and platelets should be greater than or equal to 50,000/mm3 prior to each cycle)
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

BETASERON

Products Affected

- BETASERON

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	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	For renewal, disease has not progressed and has responded to therapy.

BOSULIF

Products Affected

- BOSULIF ORAL TABLET 100 MG, 500 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 Philadelphia chromosome-positive (Ph+) CML AND one of the following: A) Ph+ CML with resistance, relapse, or inadequate response to prior therapy with one of the following tyrosine kinase inhibitors (TKI): Gleevec [imatinib], Tasigna [nilotinib], Sprycel [dasatinib]
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

BRIVIACT

Products Affected

- BRIVIACT

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	16 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

BUPRENORPHINE

Products Affected

- *buprenorphine hcl injection*
- *buprenorphine hcl sublingual tablet sublingual 2 mg, 8 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 opioid dependence
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	none

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 who have received prior anti-angiogenic therapy.
Age Restrictions	18 years and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

CAPRELSA

Products Affected

- CAPRELSA ORAL TABLET 100 MG, 300 MG

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 or older
Prescriber Restrictions	None
Coverage Duration	3 months
Other Criteria	None

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

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 or 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)

CEREZYME

Products Affected

- CEREZYME

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. Gaucher disease: Long-term enzyme replacement therapy for patients with a confirmed diagnosis of Type 1 Gaucher disease that results in one or more of the following conditions: anemia, thrombocytopenia, bone disease, hepatomegaly, splenomegaly.
Age Restrictions	2 years of age or older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	If this medication is administered by a physician incident to a physicians visit this would be covered by Medicare Part B

CHANTIX

Products Affected

- CHANTIX
- CHANTIX CONTINUING MONTH PAK
- CHANTIX STARTING MONTH PAK

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	List of previous therapies and documentation of response to previous smoking cessation therapies
Age Restrictions	Adults: 18 years and older.
Prescriber Restrictions	None
Coverage Duration	3 months
Other Criteria	Requests for Chantix will be approved for smoking cessation treatment in patients who have documented failure with nicotine replacement therapy, AND who have had failure on a therapeutic course of Bupropion (7-9 weeks), or have a contraindication to its use. Patients should be treated with CHANTIX for 12 weeks. For patients who have successfully stopped smoking at the end of 12 weeks, an additional course of 12 weeks treatment with CHANTIX is recommended to further increase the likelihood of long-term abstinence. Patients who do not succeed in stopping smoking during 12 weeks of initial therapy, or who relapse after treatment, should be encouraged to make another attempt once factors contributing to the failed attempt have been identified and addressed

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 HAE. For prophylaxis against HAE attacks AND History of failure, contraindication, or intolerance of one of the following: 17-alpha alkylated androgen (eg, danazol, oxandrolone) or antifibrinolytic (eg, tranexamic acid).
Age Restrictions	None
Prescriber Restrictions	prescribed by or in consultation with a hematologist or immunologist
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 OR Diagnosis of advanced or metastatic renal cell cancer
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

COPAXONE

Products Affected

- COPAXONE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/ML, 40 MG/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 relapsing-remitting multiple sclerosis OR diagnosis of first clinical episode with MRI features consistent with multiple sclerosis
Age Restrictions	18 years of age or 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

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 unresctable OR metastatic malignant melanoma with BRAF V600E OR V600K mutation. Documentation of combination therapy with vemurafenib
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

CYSTAGON

Products Affected

- CYSTAGON

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	not covered with a penicillamine hypersensitivity
Required Medical Information	Diagnosis of systemic treatment of nephropathic cystinosis
Age Restrictions	none
Prescriber Restrictions	none
Coverage Duration	12 months
Other Criteria	none

DARZALEX

Products Affected

- DARZALEX

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 AND one of the following: A) In combination with lenalidomide and dexamethasone or bortezomib and dexamethasone in patients who have received at least one prior therapy OR B) In combination with pomalidomide and dexamethasone in patients who have received at least two prior therapies including lenalidomide and a proteasome inhibitor OR C) Monotherapy, in patients who have received at least 3 prior therapies including a proteasome inhibitor and an immunomodulatory agent or are double-refractory to a proteasome inhibitor and an immunomodulatory agent
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

ELITEK

Products Affected

- ELITEK

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Diagnosis of malignancy- associated OR chemotherapy-induced hyperuricemia OR previous treatment history
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	6 months
Other Criteria	If this medication is administered by a physician incident to a physicians visit this would be covered by Medicare Part B

EMPLICITI

Products Affected

- EMPLICITI

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 therpay with lenalidomide and dexamethasone. Prescriber must document prior treatment with 1 to 3 previous therapies.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

ENBREL

Products Affected

- ENBREL
- ENBREL SURECLICK

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Active serious infection (including tuberculosis)
Required Medical Information	Diagnosis of one of the following : A) 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 B) 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) C) psoriatic arthritis and patient had an inadequate response, intolerance, or contraindication to methotrexate D) ankylosing spondylitis and patient had an inadequate response, intolerance or contraindication to one or more NSAIDs E) 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 one or more oral systemic treatments (i.e. methotrexate, cyclosporine, acitretin, sulfasalazine).
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Initial 3 months (plaque psoriasis), 12 months (others). Renewal 12 months.
Other Criteria	Patient has been tested for TB and latent TB has been ruled out or is being treated. For renewal, patient has stable disease or has improved while on therapy (e.g., for pJIA, reduction in disease flares, improvement in ACR scoring. For RA, improvement in tender/swollen joint count, improvement in ACR scoring. For PsA, improvement in number of swollen/tender joints, pain, stiffness. For AS, improvement in AS

PA Criteria	Criteria Details
	symptoms, such as stiffness and back pain).

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 to IV) and relevant lab work.
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

EPOETIN THERAPY

Products Affected

- PROCRIT INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Hemogloblin less than 10 g/dl for patients receiving Cancer Chemotherapy and Hemoglobin less than 12 and Hematacrit less than 33 for other approved FDA indications in addition to supporting statement of diagnosis from physician
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	3 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 or older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

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	For renewal, patient experienced stabilization from baseline or a less than 10 percent decline in force vital capacity AND the patient has not experienced AST or ALT elevations greater than 5 times the upper limit of normal or greater than 3 times the upper limit of normal with signs or symptoms of severe liver damage.

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

FABRAZYME

Products Affected

- FABRAZYME

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. Fabry disease: For use in patients with Fabry disease. Agalsidase beta reduces globotriaosylceramide (GL-3) deposition in capillary endothelium of the kidney and certain other cell types.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	If this medication is administered by a physician incident to a physicians visit this would be covered by Medicare Part B

FARESTON

Products Affected

- FARESTON

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Diagnosis of acquired or congential long QT syndrome, uncorrected hypokalemia, or uncorrected hypomagnesemia
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	None

FARYDAK

Products Affected

- FARYDAK ORAL CAPSULE 10 MG, 15 MG, 20 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 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 or older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist/hematologist
Coverage Duration	12 months
Other Criteria	None

FENTANYL ORAL

Products Affected

- *fentanyl citrate*

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) Must have tried and failed at least two of the following alts: HYDROMORPHONE, OXYMORPHONE, APAP/CODEINE, OXYCODODONE/APAP, OXYCODONE, HYDROCODONE/APAPC), C) other formulary short-acting strong narcotic analgesic alternatives (other than fentanyl) have been ineffective, not tolerated, or contraindicated, D) prescriber is registered in the Transmucosal Immediate Release Fentanyl (TIRF) Risk Evaluation and Mitigation Strategy Access program
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

FERRIPROX

Products Affected

- FERRIPROX 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 transfusional iron overload due to thalassemia syndromes AND patient has failed prior chelation therapy with Desferal or Exjade (failure is defined as a serum ferritin level greater than 2,500 mcg/L) or patient has a contraindication or intolerance to Desferal or Exjade AND Patient has an absolute neutrophil count greater than 1.5 x 109/L.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	For renewal, patient has experienced at least a 20% reduction in serum ferritin levels and has an absolute neutrophil count greater than 0.5 x 109/L

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 or older
Prescriber Restrictions	prescribed or overseen by a hematologist or immunologist
Coverage Duration	12 months
Other Criteria	None

FORTEO

Products Affected

- FORTEO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Documentation of past therapies and outcomes (failure defined as loss of BMD OR has fragility fracture(s) after a treatment with a first-line pharmacologic treatment bisphosphonate, Evista, or calcitonin). Diagnosis for use. Fracture history. Documentation of high risk for fracture for postmenopausal women, high risk defined with the presence of two of the following: low BMD scores (T-score less than or equal to -2.5 at the spine or hip or both), age greater than 70, or positive family history for osteoporosis in a 1st degree relative.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	2 years
Other Criteria	For postmenopausal women with osteoporosis at high risk for fracture and men with primary or hypogonadal osteoporosis, require documentation of trial and failure on at least one first-line therapy (alendronate, Evista, Atelvia, or Prolia) or documentation of intolerance to at least two first-line therapies. For patients with glucocorticoid induced osteoporosis, require documentation of trial and failure to either alendronate or Atelvia or documented intolerance to both alendronate and Atelvia

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 or 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

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 ms. 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	18 years and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

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	Diagnosis of advanced or metastatic (stage IIIB or IV) NSCLC AND One of the following: 1) Both of the following: a) Patient has known active epidermal growth factor receptor (EGFR) exon 19 deletions, exon 21 (L858R) substitution, exon 18 (G719X, G719) or exon 20 (S7681) mutations as detected by an FDA-approved test or Clinical Laboratory Improvement Amendments-approved facility AND b) GILOTRIF will be used as first-line treatment, OR 2) All of the following: a) disease progressed after platinum-based chemotherapy and b) squamous NSCLC
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None

GLEEVEC

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 in an adult: 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 mutation or with c-KIT mutational status unknown. Diagnosis of one of the following in a pediatric patient: A) Ph+ CML that is newly diagnosed in the chronic phase B) newly diagnosed Ph+ ALL
Age Restrictions	18 years of age or younger - newly diagnosed CML in the chronic phase or newly diagnosed Ph+ ALL. 18 years of age or older for other indications.
Prescriber Restrictions	None
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	Closed epiphyses. 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: sever 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

PA Criteria	Criteria Details
	least 1 month (if previously receiving GH).
Age Restrictions	None
Prescriber Restrictions	PGHD, PWS, GFSGA, TS/NS, SHOX, AGHD, TPAP, IGHDA, ISS: prescribed by endocrinologist. GFCRI: prescribed by endocrinologist or nephrologist
Coverage Duration	12 months
Other Criteria	For renewal of adult indications, patient has experienced an improvement or normalization of IGF-1 levels (not a requirement in patients with panhypopituitarism)

HEPATITIS B

Products Affected

- 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 documenation of immune-active chronic hepatitis B per AASLD guidelines.
Age Restrictions	Adults 18 years of age or older
Prescriber Restrictions	Prescriber must be a gastroenterologist, hepatologist, or infectious disease specialist
Coverage Duration	12 months
Other Criteria	None

HEPATITIS C

Products Affected

- EPCLUSA
- HARVONI
- SOVALDI

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 HCV genotype, subtype and quantitative HCV RNA (viral load) testing any time prior to therapy. Must document the following within 12 weeks of starting therapy, (1) CBC, INR, hepatic function panel, GFR, and TSH if interferon is being used. Must document cirrhosis status, prior treatment history (if any), and planned duration of treatment. FOR GENOTYPE 1,4,5,6 : Must include, trial/failure, contraindication to, or intolerance to Harvoni prior to approval of Epclusa or other non-formulary products. FOR GENOTYPE 2,3 : Must include, trial/failure, contraindication to, or intolerance to Epclusa prior to approval of other non-formulary products.
Age Restrictions	None
Prescriber Restrictions	Prescriber must be a gastroenterologist, hepatologist, or infectious disease specialist
Coverage Duration	Duration of approval per AASLD guidelines based on patient specific criteria
Other Criteria	None

HERCEPTIN

Products Affected

- HERCEPTIN

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) HER2 overexpressing breast cancer AND patient is node positive OR node negative and either ER/PR negative or ER/PR positive with one high risk feature (i.e. pathological tumor size greater than 2 cm, Grade 2-3, or age less than 35 years) AND medication is for adjuvant treatment as part of a regimen consisting of: doxorubicin, cyclophosphamide, and either paclitaxel or docetaxel OR with docetaxel and carboplatin OR as a single agent following multi-modality anthracycline-based therapy, B) HER2-overexpressing metastatic breast cancer AND medication will be used in combination with paclitaxel for first-line treatment OR as a single agent in a patient who received one or more chemotherapy regimens for metastatic disease OR in combination with Perjeta (pertuzumab) in a patient who has not received prior anti-HER2 therapy (e.g., trastuzumab) or chemotherapy for metastatic disease OR in combination with Tykerb (lapatinib) as second-line treatment of HER2+ recurrent or metastatic disease, C) HER2 overexpressing metastatic gastric or gastroesophageal junction adenocarcinoma AND patient has not received prior treatment for metastatic disease AND medicaton will be used in combination with cisplatin and capecitabine or 5-fluorouracil
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Subject to B vs D. Prescriber has assessed the patient's cardiac function/left ventricular ejection fraction prior to initiation of therapy. Female patients of child-bearing potential have been advised of the risk of fetal harm and the need for contraception.

HETLIOZ

Products Affected

- HETLIOZ

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Diagnosis of Non-24-hour-sleep-wake disorder (Non-24) AND patient has documented blindness
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	6 months (initial), 12 months (renewal)
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 or older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

HP ACTHAR

Products Affected

- HP ACTHAR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Documentation of one of the following conditions: 1) Infantile spasms, 2) Acute exacerbation of multiple sclerosis, 3) Exacerbation of rheumatic disorders including psoriatic arthritis, rheumatoid arthritis, juvenile rheumatoid arthritis, ankylosing spondylitis, 4) Exacerbation of or maintenance for collagen diseases including systemic lupus erythematosus, systemic dermatomyositis, 5) Dermatologic diseases including severe erythema multiforme, Stevens Johnson Syndrome, 6) Allergic states such as serum sickness, 7) Ophthalmic diseases including keratitis, iritis, iridocyclitis, diffuse posterior uveitis and choroiditis, optic neuritis, chorioretinitis, anterior segment inflammation, 7) Respiratory diseases such as symptomatic sarcoidosis or 8) Edematous condition from nephrotic syndrome or lupus erythematosus
Age Restrictions	infantile spasms: less than 2 years of age
Prescriber Restrictions	Multiple Sclerosis: neurologist, infantile spasms: prescribed by or in consultation with a neurologist or epileptologist
Coverage Duration	infantile spasms: 4 weeks, Multiple Sclerosis: 3 weeks
Other Criteria	For steroid responsive conditions, conditions number 2 to 7 listed in the Required Medical Information section: medical record documentation of failure of corticosteroid therapy in the last 30 days or reason why corticosteroids cannot be used

HRM - ANTIDEPRESSANTS

Products Affected

- *amitriptyline hcl*
- *doxepin hcl*
- FETZIMA
- FETZIMA TITRATION
- *imipramine hcl*
- *nortriptyline hcl oral capsule*
- *paroxetine hcl*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The drug is being prescribed for an FDA-approved indication AND prescriber attestation that benefit outweighs risk of drugs found to be high risk medications for beneficiaries age 65 and older.
Age Restrictions	Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

HRM - ANTIEMETIC DRUGS

Products Affected

- *hydroxyzine hcl*
- *hydroxyzine pamoate*
- *promethazine hcl*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The drug is being prescribed for an FDA-approved indication AND If formulary non HRM alternatives (Nausea and Vomiting: granisetron, ondansetron or Allergic Reactions: desloratadine, levocetirizine or cetirizine solution) 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 of the alternative(s) AND the prescribing physician attests to the medical necessity for using this high risk medication and intent to monitor for side effects, AND anticipated treatment course/duration.
Age Restrictions	Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.
Prescriber Restrictions	None
Coverage Duration	12/31/2018
Other Criteria	Must try and fail, have contraindication or intolerance to at least 2 non-HRM alternatives: Nausea/Vomiting: granisetron, ondansetron_Allergic Reactions: cetirizine solution, desloratadine, levocetirizine. Part D coverage is not allowed if a hospice program drug benefit is available for the drug in question.

HRM - ANTIPSYCHOTICS

Products Affected

- SAPHRIS

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The drug is being prescribed for an FDA-approved indication AND If formulary non HRM alternatives (haloperidol, quetiapine, risperidone, aripiprazole, asenapine, iloperidone, lurasidone, olanzapine, paliperidone, ziprasidone) 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 of the alternative(s) AND the prescribing physician attests to the medical necessity for using this high risk medication and intent to monitor for side effects, AND anticipated treatment course/duration
Age Restrictions	Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.
Prescriber Restrictions	None
Coverage Duration	12/31/2018
Other Criteria	Applies to New Starts only. Must try/fail, have contraindication or intolerance to at least 2 of the following: haloperidol, quetiapine, risperidone, aripiprazole, asenapine, iloperidone, lurasidone, olanzapine, paliperidone, ziprasidone

HRM - ONCOLOGY

Products Affected

- *megestrol acetate*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The drug is being prescribed for an FDA-approved indication AND If formulary non HRM alternatives for diagnosis of cachexia secondary to chronic illness (oxandrolone) 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 of the alternative(s) AND the prescribing physician attests to the medical necessity for using this high risk medication and intent to monitor for side effects, AND anticipated treatment course/duration. For treatment of cancer related diagnosis or endometrial hyperplasia, or endometriosis, requests will be automatically approved.
Age Restrictions	Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Applies to New Starts only

HRM - ORAL AND TRANSDERMAL ESTROGENS AND PROGESTINS

Products Affected

- *estradiol oral*
- *estradiol transdermal*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The drug is being prescribed for an FDA-approved indication AND If formulary non HRM 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 of the alternative(s) AND the prescribing physician attests to the medical necessity for using this high risk medication and intent to monitor for side effects, AND anticipated treatment course/duration. Non-HRM Alternatives: IF BEING USED TO TREAT Bone Density issues must try 2 of the safer alternatives: alendronate, risedronate, ibandronate, raloxifene OR (zoledronic acid for bed-bound patients or for post-hip fracture). IF BEING USED TO TREAT vaginal symptoms member must have had an inadequate response, intolerable side effect, or contraindication to Estrace Vaginal Cream or Vagifem.
Age Restrictions	Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 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: Estrace vaginal cream

HRM - SKELETAL MUSCLE RELAXANTS

Products Affected

- *carisoprodol*
- *cyclobenzaprine hcl*
- *methocarbamol*
- *orphenadrine citrate*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The drug is being prescribed for an FDA-approved indication AND the prescribing physician attests that the benefit outweighs risk of therapy and intent to monitor for side effects, AND anticipated treatment course/duration.
Age Restrictions	Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

HRM-BARBITURATES

Products Affected

- *butalbital-acetaminophen*
- *butalbital-apap-caffeine*
- *butalbital-asa-caff-codeine*
- *butalbital-aspirin-caffeine*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The drug is being prescribed for an FDA-approved indication AND prescriber attestation that benefit outweighs risk of drugs found to be high risk medications for beneficiaries age 65 and older
Age Restrictions	Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

HUMIRA

Products Affected

- HUMIRA PEDIATRIC CROHNS START
- HUMIRA PEN
- HUMIRA PEN-CROHNS STARTER
- HUMIRA PEN-PSORIASIS STARTER
- HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.2ML, 20 MG/0.4ML, 40 MG/0.8ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Active serious infection (including tuberculosis)
Required Medical Information	Diagnosis of one of the following: A) moderate to severe rheumatoid arthritis and inadequate response, intolerance, or contraindication to one or more non-biologic disease modifying anti-rheumatic drugs (DMARDs) (e.g., hydroxychloroquine [HCQ], sulfasalazine, methotrexate [MTX], leflunomide, azathioprine, cyclosporine) B) moderate to severe polyarticular juvenile idiopathic arthritis, juvenile idiopathic arthritis with an inadequate response, intolerance or contraindication to one or more non-biologic DMARDs (e.g., HCQ, sulfasalazine, MTX, leflunomide, azathioprine, cyclosporine) C) psoriatic arthritis and inadequate response, intolerance, or contraindication to MTX D) ankylosing spondylitis and inadequate response, intolerance or contraindication to one or more NSAIDs E) moderate to severe chronic plaque psoriasis (affecting more than 5% of body surface area or crucial body areas such as the hands, feet, face, or genitals) and inadequate response, intolerance or contraindication to one or more oral systemic treatments (e.g., MTX, cyclosporine, acitretin, sulfasalazine) F) moderate to severe Crohn's disease and inadequate response, intolerance, or contraindication to two or more of the following: corticosteroids (e.g., prednisone, methylprednisolone) or non-biologic DMARDs (e.g., azathioprine, MTX, mercaptopurine) G) moderate to severe ulcerative colitis and inadequate response, intolerance or contraindication to two or more of the following: corticosteroids (e.g., prednisone, methylprednisolone), 5-ASA (i.e. mesalamine, sulfasalazine, balsalazide, olsalazine) or non-biologic DMARDs (azathioprine, MTX, mercaptopurine). H) Moderate to severe hidradenitis suppurativa I) Non-infectious intermediate, posterior and panuveitis in adult patients with an inadequate response, intolerance, or contraindication to ONE for the following, 1) systemic OR 2)ophthalmic corticosteroids (e.g., prednisone, methylprednisolone)

EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

PA Criteria	Criteria Details
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Initial - 16 weeks (CD), 12 weeks (UC), 12 months (others). Renewal - 12 months.
Other Criteria	None

HYDROXYPROGESTERONE CAPROATE

Products Affected

- *hydroxyprogesterone caproate*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Breast, cervical, hepatocellular, uterine, or vaginal cancers, hepatic or thromboembolic disease, jaundice, or vaginal bleeding
Required Medical Information	Supporting statement of diagnosis from physician
Age Restrictions	16 years of age and older
Prescriber Restrictions	None
Coverage Duration	21 weeks
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 breast cancer AND disease is a) locally advanced or metastatic, b) hormone receptor (HR) positive, c) human epidermal growth factor receptor 2 (HER2)-negative, and d) patient has failure, contraindication or intolerance to Kisqali. One of the following: a) used in combination with an aromatase inhibitor (eg: anastrozole, exemestane, letrozole) and patient is a postmenopausal woman, OR b) all of the following: used in combination with Faslodex (fulvestrant), disease has progressed following endocrine therapy, 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	None

ICLUSIG

Products Affected

- ICLUSIG ORAL TABLET 15 MG, 45 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 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 (i.e., GLEEVEC [imatinib], 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 (i.e., GLEEVEC [imatinib], SPRYCEL), or B) Patient has the T315I mutation.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist
Coverage Duration	12 months
Other Criteria	None

IDHIFA

Products Affected

- IDHIFA ORAL TABLET 100 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	Diagnosis of relapsed or refractory acute myeloid leukemia with an isocitrate dehydrogenase 2 mutation as detected by an FDA approved test
Age Restrictions	age 18 years and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist
Coverage Duration	12 months
Other Criteria	None

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 MCL AND patient has relapsed or is refractory to at least one prior therapy for the treatment of MCL. OR Diagnosis of CLL. OR Diagnosis of Waldenstroms macroglobulinemia/lymphoplasmacytic lymphoma OR Diagnosis of graft-versus-host disease AND patient has failed 1 or more lines of systemic therapy OR Diagnosis of marginal zone lymphoma AND patient has received 1 prior anti-CD20 based therapy OR Diagnosis of Small lymphocytic lymphoma
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

IMFINZI

Products Affected

- IMFINZI

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 urothelial carcinoma. Patients must have progressed on or following platinum-containing chemotherapy, OR within 12 months of neoadjuvant or adjuvant platinum containing 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	None

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

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 or 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 ORAL TABLET 1 MG, 5 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 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 or older
Prescriber Restrictions	None
Coverage Duration	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
Age Restrictions	1 year of age or older for HBV. 3 years of age or older for HCV. 18 years of age or older for other indications.
Prescriber Restrictions	None
Coverage Duration	Condylomata: 3 mos. HBVe antigen pos: 16 wks, HBVe antigen neg: 48 wks. KS: 16 wks. Others: 12 mos
Other Criteria	None

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	None

ITRACONAZOLE

Products Affected

- *itraconazole*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Diagnosis of onychomycosis requires a positive laboratory test such as (potassium hydroxide-KOH preparation, fungal culture, or nail biopsy) to confirm the diagnosis.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	6 months
Other Criteria	None

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	None

KADCYLA

Products Affected

- KADCYLA

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 HER2-positive metastatic breast cancer and the member has been previously treated with trastuzumab and a taxane
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Prescriber has assessed the patient's hepatic function and left ventricular ejection fraction prior to initiation of therapy. Female patients of child-bearing potential had pregnancy status verified prior to the initiation of Kadcyla and have been advised of the risk of fetal harm and the need for contraception.

KALYDECO

Products Affected

- KALYDECO

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	For oral granules- 2 years of age or older. For oral tablets- 6 years of age or older.
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	For renewal, patient has experienced benefit from therapy (i.e. improvement in pulmonary lung function [FEV1], decreased number of pulmonary exacerbations)

KEYTRUDA

Products Affected

- KEYTRUDA

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 (NSCLC) whose tumors express PD-L1 OR recurrent or metastatic head and neck squamous cell carcinoma (HNSCC) with disease progression on or after platinum-containing chemotherapy OR unresectable or metastatic melanoma OR classical Hodgkin Lymphoma OR locally advanced or metastatic urothelial carcinoma (in patients who are not eligible for cisplatin- containing chemotherapy, or who have had disease progression during or following platinum-containing chemotherapy or within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy) OR unresectable or metastatic solid tumors that have been identified as having a biomarker referred to as microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) OR metastatic nonsquamous NSCLC in combination with pemetrexed and carboplatin as first-line treatment OR unresectable or metastatic colorectal cancer with disease progression after treatment with fluoropyrimidine, oxaliplatin, and irinotecan - MSI-H, or mismatch repair deficient OR locally advanced or metastatic gastric cancer whose tumors express PD-L1 (as determined by an FDA- approved test) with disease progression on or after 2 or more fluoropyrimidine- and platinum- containing therapies and, if appropriate, human epidermal growth factor 2/neu-targeted therapy
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

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 postmenopausal women.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a oncologist
Coverage Duration	12 months
Other Criteria	None

KORLYM

Products Affected

- KORLYM

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Not covered for pregnant women. Contraindicated in patients taking simvastatin, lovastatin, and CYP3A substrates with narrow therapeutic ranges, such as cyclosporine, dihydroergotamine, ergotamine, fentanyl, pimozide, quinidine, sirolimus, and tacrolimus, and patients who require concomitant treatment with systemic corticosteroids for serious medical conditions or illnesses. Women with a history of unexplained vaginal bleeding. Women with endometrial hyperplasia with atypia or endometrial carcinoma.
Required Medical Information	Diagnosis of endogenous Cushing's syndrome AND diagnosis of type 2 diabetes mellitus or glucose intolerance AND Patient has hyperglycemia secondary to hypercortisolism AND patient has failed or is not a candidate for surgery
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	Based on data regarding the relationship between Phe level and brain function, the National Institutes of Health (NIH) consensus panel recommends that Phe levels be maintained between:2-6 mg/dL (120-360 micromol/L) if less then 12 years of age, 2-10 mg/dL (120-600 micromol/L) if greater than 12 and less then 18 years of age, and 2-15 mg/dL (120-900 micromol/L) if greater than 18 years of age.
Age Restrictions	1 month of age or 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.

LARTRUVO

Products Affected

- LARTRUVO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Diagnosis of soft tissue sarcoma (STS), histologic subtype for which an anthracycline-containing regimen is appropriate, previous treatment failure with radiotherapy or surgery and must document being used in combination with doxorubicin for the first 8 cycles.
Age Restrictions	Adults 18 years of age or older
Prescriber Restrictions	Oncologist
Coverage Duration	12 months
Other Criteria	None

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	None

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 o f 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 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. Renewal - 12 months
Other Criteria	None

LEUPROLIDE

Products Affected

- *leuprolide 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 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
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*

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 asociated with cancer-related neuropathy OR post-herpetic neuralgia.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
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

LUMIZYME

Products Affected

- LUMIZYME

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Diagnosis of late (non-infantile) onset Pompe disease (GAA) deficiency
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

LUPRON

Products Affected

- LUPRON DEPOT (1-MONTH) INTRAMUSCULAR KIT 3.75 MG, 7.5 MG
- LUPRON DEPOT (3-MONTH)
- LUPRON DEPOT (4-MONTH)
- LUPRON DEPOT (6-MONTH)
- LUPRON DEPOT-PED (1-MONTH)

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Pregnancy in patients with child-bearing potential. Breastfeeding. Undiagnosed abnormal vaginal bleeding.
Required Medical Information	Diagnosis of one of the following: A) advanced or metastatic prostate cancer (7.5 mg 1-month, 22.5 mg 3-month, 30 mg 4-month, & 45 mg 6-month depots only), B) Endometriosis (3.75 mg 1-month & 11.25 mg 3-month depots only) and for initial, patient has had an inadequate pain control response or patient has an intolerance or contraindication to one of the following: Danazol OR Combination [estrogen/progesterone] Oral Contraceptives OR Progestins and for retreatment course, Patient is experiencing recurrence of symptoms after an initial course of therapy with leuprolide acetate and Norethindrone acetate 5 mg daily will be co-administered, or C) Anemia due to uterine Leiomyomata (Fibroids) (3.75 mg 1-month &11.25 mg 3-month depots only) and Patient is preoperative
Age Restrictions	Uterine fibroids, endometriosis, Prostate Cancer-18 years of age or older CPP-age 2-11 female OR 2-12 male
Prescriber Restrictions	None
Coverage Duration	Endometriosis- 6 months, Uterine fibroids -3 months, Prostate cancer, Precocious Puberty -12 months
Other Criteria	For endometriosis and uterine fibroids, patient will be using nonhormonal contraception during and for 12 weeks after therapy.

LYNPARZA

Products Affected

- LYNPARZA ORAL CAPSULE
- LYNPARZA ORAL TABLET 100 MG, 150 MG

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	None

MATULANE

Products Affected

- MATULANE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Part B coverage
Required Medical Information	Treatment of Hodgkin's Lymphoma OR medulloblastoma in combination with nitrogen mustard, vincristine and prednisone OR high-grade malignant glioma in combination with lomustine and vincristine
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None

MEKINIST

Products Affected

- MEKINIST ORAL TABLET 0.5 MG, 2 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 unresectable or metastatic melanoma and medication is used as a single agent and patient has a positive BRAF V600E or V600K mutation as detected by an FDA-approved test (THxID-BRAF Kit) or Clinical Laboratory Improvement Amendments (CLIA)-approved facility, and the patient has not received prior BRAF-inhibitor therapy (i.e. Zelboraf, Tafinlar) OR medication will be used in combination with Tafinlar in a patient with BRAF V600E or V600K mutations, as detected by an FDA-approved test (THxID-BRAF kit) or Clinical Laboratory Improvement Amendments (CLIA)-approved facility.
Age Restrictions	None
Prescriber Restrictions	Oncologist
Coverage Duration	12 months
Other Criteria	None

MODAFINIL

Products Affected

- *modafinil oral tablet 100 mg, 200 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

MORPHINE SOL

Products Affected

- *morphine sulfate (concentrate)*
- *morphine sulfate oral solution*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Significant respiratory depression OR severe bronchial asthma
Required Medical Information	None
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

MOZOBIL

Products Affected

- MOZOBIL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Patient is to undergo autologous stem cell transplantation for the treatment of non-Hodgkin's lymphoma or multiple myeloma AND Patient will concomitantly receive a daily dose of a granulocyte colony-stimulating factor (G-CSF) for 4 days prior to the first evening dose of Mozobil and on each day prior to apheresis while using Mozobil.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	4 days
Other Criteria	None

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	Adults 18 years of age or older
Prescriber Restrictions	Infectious Disease Specialist or GI Consult for new starts
Coverage Duration	12 months
Other Criteria	None

NAGLAZYME

Products Affected

- NAGLAZYME

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Mucopolysaccharidosis (MPS VI): Diagnosis of MPS VI (Maroteaux-Lamy Syndrome)
Age Restrictions	3 months of age or older
Prescriber Restrictions	None
Coverage Duration	Initial approval: 6 months Extended approval: Annual review will be based on response to therapy
Other Criteria	If this medication is administered by a physician incident to a physicians visit this would be covered by Medicare Part B

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 in patients with hypoparathyroidism
Age Restrictions	None
Prescriber Restrictions	Prescriber is certified in the NATPARA REMS Program
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	Women who are pregnant or breastfeeding
Required Medical Information	Diagnosis of early stage HER2- overexpressed breast cancer. Must be used after trastuzumab therapy.
Age Restrictions	age 18 years and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None

NEUPOGEN

Products Affected

- NEUPOGEN

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	Nexavar is contraindicated in combination with paclitaxel and carbolatin in patients with squamos cell lung cancer
Required Medical Information	None
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Diagnosis of advanced renal cell carcinoma AND prior therapy with Sutent (sunitinib) or Votrient (Pazopanib) OR For the treatment of patients with locally recurrent or metastatic, progressive, differentiated thyroid carcinoma that is refractory to radioactive iodine treatment OR For the treatment of patients with unresectable hepatocellular carcinoma

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	None

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	For renewal, Patient does not have persistent or sustained supine hypertension (SBP more than 180 mmHg or DBP more than 110 mmHg), Patient does not have persistent or sustained standing or sitting hypertension (SBP more than 180 mmHg or DBP more than 110 mmHg), and Patient had improvement in symptoms of NOH. Sustained mean elevated blood pressure that persists for longer than 5 minutes after change in position. Persistent means elevated BP that occurs on more than one occasion on separate physician office visits

NOXAFIL

Products Affected

- NOXAFIL ORAL SUSPENSION
- NOXAFIL ORAL TABLET DELAYED RELEASE

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 (pimozide, quinidine), HMG-CoA Reductase inhibitors primarily metabolized through CYP 3A4, or ergot alkaloids
Required Medical Information	Documentation of past therapies and outcomes. Diagnosis of oropharyngeal candidiasis and patient tried and failed 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	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

NUPLAZID

Products Affected

- NUPLAZID

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	None

NUVIGIL

Products Affected

- *armodafinil*

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) and documentation of residual excessive sleepiness B) excessive sleepiness associated with narcolepsy confirmed by sleep lab evaluation (e.g., multiple sleep latency test, polysomnography) 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 Diagnosis of excessive sleepiness associated with shift work disorder by either 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 or older
Prescriber Restrictions	None
Coverage Duration	OSA/hypopnea syndrome - 6 months (initial), 12 months (renewal). Other diagnoses - 12 months.
Other Criteria	None

OCTREOTIDE

Products Affected

- *octreotide acetate*

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	13 months
Other Criteria	None

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	None

OPDIVO

Products Affected

- OPDIVO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Appropriate diagnosis (BRAF V600 wild-type or BRAF V600 mutation-positive unresectable or metastatic melanoma and used as single agent OR unresectable or metastatic melanoma in combination with ipilimumab [Yervoy] OR treatment of patients with metastatic non-small cell lung cancer (NSCLC) with progression on or after platinum-based chemotherapy and patients with EGFR or ALK genomic tumor aberrations should have disease progression (on FDA-approved EGFR- or ALK-directed therapy) prior to receiving nivolumab OR advanced renal cell carcinoma who have received prior anti-angiogenic therapy OR recurrent or metastatic squamous cell carcinoma of the head and neck in patients with disease progression on or after platinum-based chemotherapy OR classical Hodgkin lymphoma in patients who have relapsed or progressed following autologous hematopoietic stem cell transplant (HSCT) and post-transplant brentuximab vedotin OR locally advanced or metastatic urothelial carcinoma in patients with disease progression during or following a platinum-containing therapy or disease progression within 12 months of neoadjuvant or adjuvant treatment with a platinum-containing therapy). OR microsatellite instability-high or mismatch repair deficient metastatic colorectal cancer with progression after treatment of fluoropyrimidine, oxaliplatin, and irinotecan OR treatment of hepatocellular cancer, after disease progression on or intolerance to sorafenib therapy.
Age Restrictions	12 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a hepatologist, gastroenterologist, oncologist or infectious disease specialist
Coverage Duration	12 months
Other Criteria	None

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	6 months - initial. 12 months - renewal
Other Criteria	For renewal, medication was effective (i.e. improved 6 minute walk distance, oxygen saturation, etc.)

ORFADIN

Products Affected

- ORFADIN

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 tyrosinemia type 1
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

ORKAMBI

Products Affected

- ORKAMBI ORAL TABLET 100-125 MG, 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: Must have 1. diagnosis of cystic fibrosis (CF) with documented homozygous F508del mutation confirmed by FDA-approved CF mutation test AND 2. 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 or equal to 6 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

OXANDRIN

Products Affected

- *oxandrolone*

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 and Patient has had an inadequate response, intolerance, or contraindication to nutritional supplements and a nutritional consult was performed 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 lead body mass, or reduction in muscle pain/weakness)

OXYCODONE SOL

Products Affected

- *oxycodone hcl oral concentrate*

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

PCSK9 INHIBITOR

Products Affected

- PRALUENT
- 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	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 2. ONLY for REPATHA: A) Secondary prophylaxis of cardiovascular system in the absence of ASCVD OR B) primary hyperlipidemiahomozygous 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. Documention of HeFH in both parents 3. Diagnosis of clinical atherosclerotic cardiovascular disease (CVD) 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 (TIA), 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 70 mg/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 70 mg/dL CONTINUING THERAPY:Will continue to be used in combination with maximally tolerated statin (unless statin intolerant)
Age Restrictions	Repatha: 13 years of age or older for diagnosis HoFM, Diagnosis CVD or HeFH : 18 years of age or older
Prescriber	Must be prescribed by, or in consultation with, a cardiologist,

PA Criteria	Criteria Details
Restrictions	endocrinologist, or lipid specialist
Coverage Duration	Initial - 8 weeks. Renewal - 12 months.
Other Criteria	None

PEGYLATED INTERFERON

Products Affected

- PEGASYS
- PEGASYS PROCLICK SUBCUTANEOUS SOLUTION 135 MCG/0.5ML, 180 MCG/0.5ML

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 Diagnosis of HBeAg-positive and chronic hepatitis B infection.
Age Restrictions	5 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

PHENYLBUTYRATE

Products Affected

- *sodium phenylbutyrate*

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

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)

PROLEUKIN

Products Affected

- PROLEUKIN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Diagnosis of coma OR toxic psychosis lasting greater than 48 hours during an earlier course of therapy
Required Medical Information	Metastatic Renal Cell Carcinoma or Metastatic Melanoma: Good neurologic or ambulatory performance status (ie, 0 or 1 by Eastern Cooperative Oncology Group, 70-100% by Karnofsky scoring system). Adequate organ function (ie, heart, lungs, kidneys) as determined by all of the following: normal cardiac stress test results, Forced expiratory volume in 1 second (FEV1) greater than 2 L on pulmonary function tests, creatinine concentration 1.5 mg/dL or less.
Age Restrictions	Metastatic Renal Cell Carcinoma or Metastatic Melanoma: 18 years and older
Prescriber Restrictions	Oncologist
Coverage Duration	Metastatic Renal Cell Carcinoma or Metastatic Melanoma: 3 months
Other Criteria	All uses: for continuation of 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.

QUININE SULFATE

Products Affected

- *quinine sulfate*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Prolongation of QT interval. Glucose-6-phosphate dehydrogenase deficiency. Myasthenia gravis. Known hypersensitivity to mefloquine or quinidine. Optic neuritis. Diagnosis of Blackwater fever
Required Medical Information	Patient has a diagnosis of one of the following: A) uncomplicated Plasmodium falciparum malaria B) uncomplicated Plasmodium vivax malaria C) babesiosis
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	One month
Other Criteria	None

RADICAVA

Products Affected

- RADICAVA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Sulfite hypersensitivity
Required Medical Information	Diagnosis of amyotrophic lateral sclerosis and must meet all of the following: living independently, functionality retained most activities of daily living (defined as scores of 2 points or better on each individual item of the ALS Functional Rating Scale, normal respiratory function defined as percent-predicted forced vital capacity values of percent FVC greater or equal to 80 percent, disease duration of 2 years or less.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in collaboration with a neurologist
Coverage Duration	Initial: 6 months. Reauth: 12 months
Other Criteria	For renewal, patient must meet initial criteria and not have more than a 6 point decline in the ALS Functional Rating Scale from baseline. BvD determination per CMS guidelines

RAVICTI

Products Affected

- RAVICTI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	acute hyperammonemia. N-acetylglutamate synthase (NAGS) deficiency
Required Medical Information	Diagnosis of urea cycle disorder involving deficiencies of carbamoyl phosphate synthetase (CPS), ornithine transcarbamoylase (OTC), or argininosuccinic acid synthetase (AAS) confirmed via enzymatic, biochemical, or genetic testing AND patient has tried and had an inadequate response, is intolerant, or has a contraindication to Buphenyl
Age Restrictions	2 months of age or older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

RECLAST

Products Affected

- *zoledronic acid intravenous solution*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Diagnosis. For postmenupausal osteoporosis must have previous inadequate response or intolerance to alendronate, ibandronate, Prolia, or Forteo.a previous osteoporotic vertebral or hip fracture, a a T-score equal to or worse than 2.5 at the lumbar spine, femoral neck, or total hip region, or a T-score of 1 to 2.5 plus a FRAX calculator based 10-year risk of greater than or equal to 20% for a major osteoporotic fracture of the spine, hip, shoulder, or wrist, or a 10-year risk of greater than or equal to 3% for a hip fracture
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

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 (eg, debridement, infection control, and/or pressure relief).
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Diabetic Neuropathic Ulcers: Maximum 5 months.
Other Criteria	None

REMODULIN

Products Affected

- REMODULIN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	Initial: 6 months. Reauth: 12 months.
Other Criteria	Subject to Part B vs. D Review

RESTASIS

Products Affected

- RESTASIS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Active ocular infection
Required Medical Information	A documented diagnosis of xerophthalmia
Age Restrictions	16 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

REVATIO

Products Affected

- *sildenafil citrate*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Receiving nitrate therapy (includes intermittent use)
Required Medical Information	Diagnosis of pulmonary arterial hypertension that was confirmed by right heart catheterization
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 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	None
Required Medical Information	For active myeloma, patient meets one of the following: 1) Revlimid is used after at least one prior therapy or as salvage therapy. 2) Revlimid is used with dexamethasone as primary induction therapy or in combination with melphalan and prednisone in nontransplant candidates. 3) Revlimid is used as maintenance monotherapy following response to either stem cell transplant or primary induction therapy. For Low or Intermediate-1 Risk myelodysplastic syndrome (MDS): for those with 5q deletion, patients should have transfusion-dependent anemia or symptomatic anemia with clinically significant cytopenias. For those with non-5q deletion MDS and symptomatic anemia, patients should have failed to respond to epoetin alfa or darbepoetin or have a pretreatment serum erythropoietin levels greater than 500 mU/mL and a low probability of response to immunosuppressive therapy. For female patients of childbearing potential, pregnancy is excluded by 2 negative serum or urine pregnancy tests. For all patients, complete blood counts are monitored for hematologic toxicity while receiving Revlimid.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

RITUXAN

Products Affected

- RITUXAN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Rheumatoid Arthritis (RA) (init): Patient is not receiving Rituxan in combination with a biologic DMARD [eg, Enbrel (etanercept), Orencia (abatacept), Kineret (anakinra)]. Patient is not receiving Rituxan in combination with a Janus kinase inhibitor [eg, Xeljanz (tofacitinib)].
Required Medical Information	Non-Hodgkin's Lymphoma (NHL): As first-line treatment of diffuse large B-cell, CD20-positive, NHL in combination with CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone) or other anthracycline-based chemotherapy regimens, or as first-line treatment of follicular, CD20-positive, B-cell NHL in combination with chemotherapy, or as a single-agent maintenance therapy for the treatment of follicular, CD20-positive, B-cell NHL in patients achieving a complete or partial response to Rituxan in combination with chemotherapy, or for the treatment of low-grade, CD20-positive, B-cell NHL in patients with stable disease following first-line treatment with CVP (cyclophosphamide, vincristine, prednisolone/prednisone) chemotherapy or who achieve a partial or complete response following first-line treatment with CVP (cyclophosphamide, vincristine, prednisolone/prednisone) chemotherapy, or diagnosis of relapsed or refractory, low grade or follicular CD20-positive, B-cell non-Hodgkin?s lymphoma. Rheumatoid Arthritis (RA) (init): Concurrently on or contraindication, or intolerance to methotrexate. Failure, contraindication, or intolerance (F/C/I) to a TNF antagonist (eg, adalimumab, etanercept, infliximab). Wegener?s Granulomatosis (WG) and Microscopic Polyangiitis (MPA): Patient is concurrently on glucocorticoids (eg, prednisone) OR contraindication or intolerance to glucocorticoids (eg, prednisone). Immune or idiopathic thrombocytopenic purpura (ITP): F/C/I to one of the following: corticosteroids, immunoglobulins, or splenectomy. Documented platelet count of less than 50x10^9 /L.
Age Restrictions	None
Prescriber Restrictions	ITP: Prescribed by or in consultation with a hematologist or oncologist. RA: Prescribed by or in consultation with a rheumatologist. WG, MPA:

PA Criteria	Criteria Details
	Prescribed by or in consultation with a nephrologist, pulmonologist, or rheumatologist.
Coverage Duration	12 months
Other Criteria	Monitored for pulmonary toxicity

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 Advanced Ovarian Cancer and all of the following criteria: 1. BRCA mutation positive as 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. Renewal will be based on lack of disease progression or unacceptable toxicity.
Age Restrictions	Adults 18 years of age or older
Prescriber Restrictions	Hematologist or Oncologist
Coverage Duration	12 months
Other Criteria	None

RYDAPT

Products Affected

- RYDAPT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
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 sytemic mastocytosis
Age Restrictions	age 18 years and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None

SABRIL

Products Affected

- SABRIL
- *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 or older. Infantile spasms - at least one month to 2 years of age
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

SANDOSTATIN

Products Affected

- SANDOSTATIN LAR 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 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 trial. Reauthorization: 12 months if demonstrated benefit
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

SIRTURO

Products Affected

- SIRTURO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	none
Required Medical Information	Used as a part of a combination regimen to treat pulmonary multi-drug resistant tuberculosis infection (MDR-TB)
Age Restrictions	none
Prescriber Restrictions	Infectious Disease Specialist
Coverage Duration	24 weeks
Other Criteria	Administer in combination with at least 3 other drugs proven to be or at least 4 other drugs suspected of being effective against the patient's Mycobacterium tuberculosis isolate.[

SOLTAMOX

Products Affected

- SOLTAMOX

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Concomitant coumarin-type anticoagulant therapy OR history of thromboembolic disease such as DVT or PE
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	None

SOMATULINE

Products Affected

- *octreotide acetate*
- SOMATULINE DEPOT SUBCUTANEOUS SOLUTION 120 MG/0.5ML, 60 MG/0.2ML, 90 MG/0.3ML

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: Acromegaly in patients who have had an inadequate response to surgery and/or radiotherapy, or for whom surgery and/or radiotherapy is not an option OR unresectable, well- or moderately-differentiated, locally advanced or metastatic carcinoid gastroenteropancreatic neuroendocrine tumor, OR treatment of hyperthyroidism secondary to thyrotropinoma, OR carcinoid syndrome
Age Restrictions	Adults: 18 years and older.
Prescriber Restrictions	None
Coverage Duration	Initial approval: 3 months. Extended approval: 3 months with dose adjusted according to response
Other Criteria	If this medication is administered by a physician incident to a physicians visit this would be covered by Medicare Part B

SOMAVERT

Products Affected

- SOMAVERT SUBCUTANEOUS SOLUTION RECONSTITUTED 10 MG, 15 MG, 20 MG, 25 MG, 30 MG

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

SPRYCEL

Products Affected

- SPRYCEL ORAL TABLET 100 MG, 140 MG, 20 MG, 50 MG, 70 MG, 80 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	One of the following: A) Diagnosis of newly diagnosed Ph+ CML in the chronic phase AND Patient is positive for Ph+ or BCR-ABL positive as detected by bone marrow cytogenetics, FISH or PCR OR B) Diagnosis of Ph+ CML AND History of failure, resistance, or relapse to prior tyrosine kinase inhibitor therapy with GLEEVEC [imatinib]AND Patient has received mutation testing AND Patient does not have the T315I mutation OR C) Diagnosis of Ph+ CML with intolerance to prior tyrosine kinase inhibitor therapy with GLEEVEC [imatinib] . Ph+ acute lymphoblastic leukemia (ALL): Diagnosis of Ph+ ALL.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Oncologist
Coverage Duration	12 months
Other Criteria	Coverage is provided for the following indications. 1. For newly diagnosed adults with Philadelphia chromosome-positive (Ph+) chronic myeloid leukemia (CML) in chronic phase. 2. For adults with chronic, accelerated, or myeloid or lymphoid blast phase Ph+ CML with resistance or intolerance to prior therapy including imatinib. 3. For adults with Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ ALL) with resistance or intolerance to prior therapy.

STELARA

Products Affected

- STELARA INTRAVENOUS
- STELARA SUBCUTANEOUS

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 (toficitinib)].Patient is not receiving Stelara

PA Criteria	Criteria Details
	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	None
Age Restrictions	None
Prescriber Restrictions	Oncologist
Coverage Duration	12 months
Other Criteria	A documented 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)

SUBOXONE

Products Affected

- SUBOXONE SUBLINGUAL FILM 12-3 MG, 2-0.5 MG, 4-1 MG, 8-2 MG

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 opioid dependence
Age Restrictions	16 years of age or older
Prescriber Restrictions	None
Coverage Duration	Initial - 6 months. Renewal - 6 months
Other Criteria	None

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.
Age Restrictions	None
Prescriber Restrictions	Oncologist
Coverage Duration	12 months
Other Criteria	None

SYLATRON

Products Affected

- SYLATRON

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Autoimmune hepatitis. Hepatic decompensation (Child-Pugh score greater than 6 [Class B 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	None

SYNAGIS

Products Affected

- SYNAGIS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Patient will use palivizumab for immunoprophylaxis of respiratory syncytial virus (RSV) during the peak months of infection in the patients geographic region AND Patient meets one of the following criteria: A) Infants born at 28 weeks, six days gestation or earlier and who are younger than 12 months of age at the start of the RSV season OR B) Infants born at 29 to 31 weeks, six days gestation and who are younger than six months of age at the start of the RSV season OR C) Infants born at 32 to 34 weeks, six days gestation and who are younger than three months of age at the start of RSV season with at least one of the following risk factors may be dosed until 90 days of age: Child care attendance or Sibling younger than five years of age living in the same household (who is not a multiple birth younger than one year of age) OR D) Infants and children younger than one year of age at the start of RSV season with either congenital abnormalities of the airway or neuromuscular disease that compromises handling of respiratory secretions OR E) Infants and children younger than two years of age with hemodynamically significant congenital heart disease and who have at least one of the following criteria: Receiving medication to control congestive heart failure, Has moderate to severe pulmonary hypertension, or Has cyanotic heart disease OR F) Infants and children younger than two years of age who have received medical therapy (oxygen, bronchodilator, diuretic, or corticosteroid therapy) for chronic lung disease within six months of the start of the RSV season
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months

PA Criteria	Criteria Details
Other Criteria	Approve 5 doses based on patient body weight

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
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 or older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

SYPRINE

Products Affected

- SYPRINE

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

TABLOID

Products Affected

- TABLOID

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	None
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy

TAFINLAR

Products Affected

- TAFINLAR ORAL CAPSULE 50 MG, 75 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	A documented positive BRAF V600E or V600K 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 confirmed presence of T790M EGFR tumor mutation by cobas EGFR Mutation Test v2
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

TARCEVA

Products Affected

- TARCEVA ORAL TABLET 100 MG, 150 MG, 25 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	None
Prescriber Restrictions	Oncologist
Coverage Duration	12 months
Other Criteria	For the diagnosis of locally advanced, unresectable, or metastatic carcinoma of pancreas, Tarceva is used in combination with gemcitabine. For the diagnosis of locally advanced or metastatic non-small cell lung cancer, the patient has met one of the following: 1. The patient has failed one or more prior chemotherapy regimens, such as platinum based chemotherapy OR 2. The patient has an epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 (L858R) substitution mutation which requires no prerequisite therapy.

TARGRETIN

Products Affected

- *bexarotene*
- TARGRETIN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Definite diagnosis of cutaneous T-cell lymphoma (CTCL) AND refractory to any prior systemic therapy (such as methotrexate)
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.

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	One of the following: A) Diagnosis of newly diagnosed Philadelphia chromosome positive (Ph+) CML in the chronic phase AND Patient is positive for Ph+ or BCR-ABL positive as detected by bone marrow cytogenetics, FISH or PCR OR B) Diagnosis of Ph+ CML AND History of failure, resistance, or relapse to prior tyrosine kinase inhibitor therapy with GLEEVEC [imatinib] AND Patient has received mutation testing AND Patient does not have the T315I mutation OR C) Diagnosis of Ph+ CML with intolerance to prior tyrosine kinase inhibitor therapy with GLEEVEC [imatinib]
Age Restrictions	None
Prescriber Restrictions	Oncologist
Coverage Duration	12 months
Other Criteria	Coverage is provided for the treatment of newly diagnosed adult patients with Philadelphia chromosome positive chronic myeloid leukemia (Ph+ CML) in chronic phase OR the treatment of chronic phase (CP) and accelerated phase (AP) Ph+ CML in adult patients resistant to or intolerant to prior therapy that included imatinib.

TAZORAC

Products Affected

- *tazarotene*
- TAZORAC

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 or older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

THALOMID

Products Affected

- THALOMID ORAL CAPSULE 100 MG, 150 MG, 200 MG, 50 MG

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 that is newly diagnosed and is receiving concurrent dexamethasone OR Diagnosis of severe erythema nodosum leprosum with cutaneous manifestations and the medication will not be used as monotherapy if the member has moderate to severe neuritis OR for acute treatment of the cutaneous manifestations of moderate to severe erythema nodosum leprosum.
Age Restrictions	None
Prescriber Restrictions	Oncologist
Coverage Duration	AS, ulcers-1 month. ENL, MM-End of year. WM, GVHD, primary brain tumor-6 months. Other uses-3 months
Other Criteria	Patient will be monitored for signs of venous thromboembolism

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	6 months - initial. 12 months - renewal
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	None

TRETINOIN

Products Affected

- *tretinoin external*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Approval will be given to all members using this agent for a medically necessary FDA approved non-cosmetic indication.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

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	None
Age Restrictions	None
Prescriber Restrictions	Oncologist
Coverage Duration	12 months
Other Criteria	Coverage is provided in combination with capecitabine, for the treatment of patients with advanced or metastatic breast cancer whose tumors overexpress HER2 and who have received prior therapy including an anthracycline, a taxane, and trastuzumab OR in combination with letrozole for the treatment of postmenopausal women with hormone receptor positive metastatic breast cancer that overexpresses the HER2 receptor for whom hormonal therapy is indicated.

TYMLOS

Products Affected

- TYMLOS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Documentation of high risk for fracture for postmenopausal women AND trial and failure, contraindication, or intolerance to one osteoporosis treatment (e.g., alendronate, risedronate, zoledronic acid, Prolia (denosumab)). High risk defined with the presence of two of the following: low BMD scores (T-score less than or equal to -2.5 at the spine or hip or both), age greater than 70, or history of osteoporotic fracture.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Initial: 1 year Reauth: Treatment duration has not exceeded 24 months during pt lifetime
Other Criteria	None

TYSABRI

Products Affected

- TYSABRI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	History of progressive multifocal leukoencephalopathy.
Required Medical Information	MULTIPLE SCLEROSIS: TRIAL OF AN INTERFERON OR COPAXONE. CROHN'S DISEASE: TRIAL OF A TNF-ALPHA INHIBITOR. RENEWAL: CROHN'S: PATIENT IS NOT ON CONCOMITANT CORTICOSTEROID TREATMENT AFTER 6 MONTHS ON NATALIZUMAB, OR HAS NOT RECEIVED MORE THAN 3 MONTHS OF A CORTICOSTEROID WITHIN THE PAST 12 MONTHS.
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	MULTIPLE SCLEROSIS:12 MONTHS. CROHN'S DISEASE: 6 MONTHS. RENEWAL: CROHN'S: 12 MONTHS.
Other Criteria	Patient and physician are registered in the TOUCH prescribing program. For renewal, patient had an objective response to therapy (e.g., decreased flare).

UPTRAVI

Products Affected

- UPTRAVI ORAL TABLET 1000 MCG, 1200 MCG, 1400 MCG, 1600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG
- UPTRAVI ORAL TABLET THERAPY 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 pulmonary arterial hypertension (WHO Group 1) was 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.
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 A) 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)) OR B) Palliative treatment of lymphoid or myeloid leukemia OR C) Palliative treatment of Hodgkin's Disease stages III and IV OR palliative treatment of lymphosarcoma OR palliative treatment of polycythemia vera OR palliative treatment of squamos cell carcinoma of bronchus
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

VECTIBIX

Products Affected

- VECTIBIX

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Diagnosis of epidermal growth factor receptor (EGFR)-expressing, metastatic colorectal carcinoma with disease progression following fluoropyrimidine-, oxaliplatin-, and irinotecan-containing chemotherapy regimens OR Diagnosis of wild-type KRAS metastatic colorectal cancer and used in combination with FOLFOX therapy.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	Subject to B vs D

VELCADE

Products Affected

- VELCADE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Hypersensitivity to bortezomib, boron, or mannitol. Intrathecal administration.
Required Medical Information	Diagnosis of mantle cell lymphoma OR multiple myeloma and at least 1 prior therapy
Age Restrictions	None
Prescriber Restrictions	Oncologist or hematologist
Coverage Duration	12 months
Other Criteria	All uses: for continuation of therapy

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	Concomitant use of strong CYP3A inhibitor during the initial and titration phase
Required Medical Information	Treatment of chronic lymphocytic leukemia (CLL) for patients with 17p deletion (as detected by an approved test) and have had at least 1 prior therapy
Age Restrictions	18 years and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

VENTAVIS

Products Affected

- VENTAVIS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Congestive heart failure due to severe left ventricular systolic dysfunction.
Required Medical Information	Diagnosis o f 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 III or IV.
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	Initial - 6 months. Renewal - 12 months
Other Criteria	Part D if patient in long term care (defined by customer location code on claim) otherwise Part B.

VORICONAZOLE

Products Affected

- *voriconazole intravenous*
- *voriconazole oral suspension reconstituted*
- *voriconazole oral tablet*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	None
Prescriber Restrictions	Infectious Disease Specialist
Coverage Duration	6 months
Other Criteria	None

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 (e.g., doxorubicin, dacarbazine, ifosfamide, epirubicin, docetaxel, or vinorelbine).
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

VYXEOS

Products Affected

- VYXEOS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of therapy related acute myeloid leukemia or acute myeloid leukemia with myelodysplasia related changes. If the patient has the diagnosis of therapy related acute myeloid leukemia, it must be newly diagnosed.
Age Restrictions	age 18 years and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	BvD determination per CMS guidelines

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	Documented diagnosis of locally advanced or metastatic non small cell lung cancer. Member has the anaplastic lymphoma receptor tyrosine kinase (ALK) genetic mutation as detected by an FDA-approved test.
Age Restrictions	None
Prescriber Restrictions	Oncologist
Coverage Duration	12 months
Other Criteria	None

XENAZINE

Products Affected

- *tetrabenazine oral tablet 12.5 mg, 25 mg*

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.

XGEVA

Products Affected

- XGEVA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Hypocalcemia (calcium less than 8.0 mg/dL).
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 bone metastases from solid tumors
Age Restrictions	13 years and older for treatment of giant cell tumor of the bone, 18 years and older for all other indications
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 or 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	Diagnosis of metastatic castration-resistant prostate cancer \AND the patient has tried and had an inadequate response, contraindication or intolerance to Zytiga.
Age Restrictions	None
Prescriber Restrictions	None
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, cataplexy or both and for patients with excessive daytime sleepiness, patient has had a previous trial with or has a contraindication, intolerance, or allergy to Provigil or Nuvigil.
Age Restrictions	18 years of age or 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)

YERVOY

Products Affected

- YERVOY

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 AND If the request is for re-induction, the patient had no significant toxicity with the prior course of Yervoy AND the patient experienced progression after having stable disease for longer than three months or relapse after having a clinical response to therapy AND the prescriber is aware of the Yervoy REMS program OR used as adjuvant therapy for the diagnosis of cutaneous melanoma in patients with pathologic involvement of regional lymph nodes of more than 1mm who have undergone complete resection, including total lymphadenectomy.
Age Restrictions	12 years of age and older
Prescriber Restrictions	None
Coverage Duration	16 weeks, 12 months when used as adjuvant therapy
Other Criteria	Authorization will be for 4 doses for unresectable or metastatic melanoma

YONDELIS

Products Affected

- YONDELIS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Diagnosis and lab values: ANC, serum creatine phosphokinase, serum creatinine, liver function tests, and left ventricular ejection fraction
Age Restrictions	Adults 18 years of age or older
Prescriber Restrictions	Must be prescribed by an oncologist
Coverage Duration	12 months
Other Criteria	None

ZAVESCA

Products Affected

- ZAVESCA

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 or 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 a oncologist or gyno oncologist
Coverage Duration	12 months
Other Criteria	None

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 and 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	None

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 (e.g., bexarotene, romidepsin, etc.)
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

ZOMETA

Products Affected

- *zoledronic acid intravenous concentrate*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Current treatment with Reclast.
Required Medical Information	Diagnosis of hypercalcemia of malignancy and has a corrected calcium greater than or equal to 12 mg/dL OR Diagnosis of multiple myeloma and associated bone disease (e.g., osteolytic bone lesions, bone metastases, osteopenia, etc.) OR Diagnosis of a solid tumor (e.g., breast cancer, prostate cancer that has progressed after at least one hormonal therapy (i.e. antiandrogen [bicalutamide, flutamide, nilutamide], LHRH agonist [leuprolide, goserelin], LHRH antagonists [degarelix]), kidney cancer, non-small cell lung cancer, or thyroid cancer) and patient has bone metastases and medication will be used in conjunction with standard antineoplastic therapy and medication is used for the prevention of skeletal-related events (e.g. spinal cord compression, hypercalcemia, bone pain or lesions requiring radiation or surgery) AND Patient has tried and had an inadequate response or has a contraindication/intolerance to pamidronate
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

ZORTRESS

Products Affected

- ZORTRESS ORAL TABLET 0.5 MG

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 or 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 (e.g., 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 (i.e. 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 (e.g., 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(e.g., rituximab, alkylating agents [cyclophosphamide, chlorambucil], anthracyclines [doxorubicin, daunorubicin], purine analogs [fludarabine]).
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

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 metastatic non-small cell lung cancer AND patient has anaplastic lymphoma kinase (ALK)-positive disease as detected by an FDA-approved or Clinical Laboratory Improvement Amendments (CLIA)-approved facility
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

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) AND Zytiga will be used in combination with prednisone.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

ZYVOX

Products Affected

- *linezolid*

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

PART B VERSUS PART D

Products Affected

- ABELCET INTRAVENOUS SUSPENSION 5 MG/ML
- ABRAXANE INTRAVENOUS SUSPENSION RECONSTITUTED 100 MG
- *acetylcysteine inhalation solution 10 %, 20 %*
- *acyclovir sodium intravenous solution 50 mg/ml*
- ADRIAMYCIN INTRAVENOUS SOLUTION 2 MG/ML
- ADRUCIL INTRAVENOUS SOLUTION 500 MG/10ML
- *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
- AMINOSYN II INTRAVENOUS SOLUTION 10 %, 7 %, 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*
- *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
- AVASTIN INTRAVENOUS SOLUTION 400 MG/16ML
- *azacitidine injection suspension reconstituted 100 mg*
- *azathioprine oral tablet 50 mg*
- BENLYSTA INTRAVENOUS SOLUTION RECONSTITUTED 120 MG, 400 MG
- BICNU INTRAVENOUS SOLUTION RECONSTITUTED 100 MG
- *bleomycin sulfate injection solution reconstituted 30 unit*
- *budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml*
- *busulfan intravenous solution 6 mg/ml*
- CANCIDAS INTRAVENOUS SOLUTION RECONSTITUTED 50 MG, 70 MG
- *carboplatin intravenous solution 150 mg/15ml*
- *caspofungin acetate intravenous solution reconstituted 50 mg, 70 mg*
- *chlorpromazine hcl injection solution 50 mg/2ml*
- *chlorpromazine hcl oral tablet 10 mg, 25 mg*
- *cisplatin intravenous solution 100 mg/100ml*
- *cladribine intravenous solution 10 mg/10ml*
- 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 %
- *clofarabine intravenous solution 1 mg/ml*
- *cromolyn sodium inhalation nebulization solution 20 mg/2ml*
- *cyclophosphamide oral capsule 25 mg, 50 mg*

- *cyclosporine intravenous solution 50 mg/ml*
- *cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg*
- *cyclosporine modified oral solution 100 mg/ml*
- *cyclosporine oral capsule 100 mg, 25 mg*
- *cytarabine injection solution 20 mg/ml*
- *daunorubicin hcl intravenous injectable 5 mg/ml*
- DEPO-PROVERA INTRAMUSCULAR SUSPENSION 400 MG/ML
- *dexrazoxane intravenous solution reconstituted 250 mg*
- *diphtheria-tetanus toxoids dt intramuscular suspension 25-5 lfu/0.5ml*
- *docetaxel intravenous concentrate 80 mg/4ml*
- *doxorubicin hcl intravenous solution 2 mg/ml*
- *doxorubicin hcl liposomal intravenous injectable 2 mg/ml*
- *dronabinol oral capsule 10 mg, 2.5 mg, 5 mg*
- EMEND INTRAVENOUS SOLUTION RECONSTITUTED 150 MG
- EMEND ORAL SUSPENSION RECONSTITUTED 125 MG
- ENGERIX-B INJECTION SUSPENSION 10 MCG/0.5ML, 10 MCG/0.5ML (0.5ML SYRINGE), 20 MCG/ML
- *epirubicin hcl intravenous solution 200 mg/100ml*
- *etoposide intravenous solution 500 mg/25ml*
- FASLODEX INTRAMUSCULAR SOLUTION 250 MG/5ML
- *fluorouracil intravenous solution 2.5 gm/50ml*
- FREAMINE HBC INTRAVENOUS SOLUTION 6.9 %
- FUSILEV INTRAVENOUS SOLUTION RECONSTITUTED 50 MG
- *ganciclovir sodium intravenous solution reconstituted 500 mg*
- *gemcitabine hcl intravenous solution reconstituted 1 gm*
- GENGRAF ORAL CAPSULE 100 MG, 25 MG, 50 MG
- GENGRAF ORAL SOLUTION 100 MG/ML
- *granisetron hcl oral tablet 1 mg*
- HEPATAMINE INTRAVENOUS SOLUTION 8 %
- *idarubicin hcl intravenous solution 10 mg/10ml*
- *ifosfamide intravenous solution reconstituted 1 gm*
- INTRALIPID INTRAVENOUS EMULSION 20 %, 30 %
- *ipratropium bromide inhalation solution 0.02 %*
- *ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml*
- *irinotecan hcl intravenous solution 100 mg/5ml*
- ISTODAX (OVERFILL) INTRAVENOUS SOLUTION RECONSTITUTED 10 MG
- KYPROLIS INTRAVENOUS SOLUTION RECONSTITUTED 30 MG, 60 MG
- *leucovorin calcium injection solution reconstituted 100 mg, 350 mg*
- LEUKINE INTRAVENOUS SOLUTION RECONSTITUTED 250 MCG
- *levetiracetam intravenous solution 500 mg/5ml*
- *levoleucovorin calcium intravenous solution 175 mg/17.5ml*
- *melphalan hcl intravenous solution reconstituted 50 mg*
- *mesna intravenous solution 100 mg/ml*
- *methotrexate oral tablet 2.5 mg*
- *methotrexate sodium (pf) injection solution 1 gm/40ml, 50 mg/2ml*
- *methotrexate sodium injection solution reconstituted 1 gm*
- *methylprednisolone sodium succ injection solution reconstituted 1000 mg*
- MIACALCIN INJECTION SOLUTION 200 UNIT/ML
- *mitomycin intravenous solution reconstituted 20 mg, 40 mg, 5 mg*
- MUSTARGEN INJECTION SOLUTION RECONSTITUTED 10 MG
- *mycophenolate mofetil hcl intravenous solution reconstituted 500 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*
- NEBUPENT INHALATION SOLUTION RECONSTITUTED 300 MG
- NEPHRAMINE INTRAVENOUS SOLUTION 5.4 %
- NIPENT INTRAVENOUS SOLUTION RECONSTITUTED 10 MG
- NULOJIX INTRAVENOUS SOLUTION RECONSTITUTED 250 MG
- *nutrilipid intravenous emulsion 20 %*
- OCTAGAM INTRAVENOUS SOLUTION 1 GM/20ML, 2 GM/20ML
- *ondansetron hcl injection solution 4 mg/2ml, 4 mg/2ml (2ml syringe)*
- *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*
- *oxaliplatin intravenous solution 100 mg/20ml*
- *paclitaxel intravenous concentrate 300 mg/50ml*
- *paricalcitol intravenous solution 5 mcg/ml*
- *perphenazine oral tablet 4 mg, 8 mg*
- PREMASOL INTRAVENOUS SOLUTION 10 %, 6 %
- PRIVIGEN INTRAVENOUS SOLUTION 20 GM/200ML
- PROCALAMINE INTRAVENOUS SOLUTION 3 %
- *prochlorperazine edisylate injection solution 5 mg/ml*
- PROGRAF INTRAVENOUS SOLUTION 5 MG/ML
- PROSOL INTRAVENOUS SOLUTION 20 %
- 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
- 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*
- SYNDROS ORAL SOLUTION 5 MG/ML
- *tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg*
- TECENTRIQ INTRAVENOUS SOLUTION 1200 MG/20ML
- TENIVAC INTRAMUSCULAR INJECTABLE 5-2 LFU
- *tetanus-diphtheria toxoids td intramuscular suspension 2-2 lf/0.5ml*
- *tobramycin inhalation nebulization solution 300 mg/5ml*
- *topotecan hcl intravenous solution reconstituted 4 mg*
- TRAVASOL INTRAVENOUS SOLUTION 10 %
- TREANDA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG
- TRISENOX INTRAVENOUS SOLUTION 10 MG/10ML
- TROPHAMINE INTRAVENOUS SOLUTION 10 %
- *vinblastine sulfate intravenous solution 1 mg/ml*
- VINCASAR PFS INTRAVENOUS SOLUTION 1 MG/ML
- *vincristine sulfate intravenous solution 1 mg/ml*
- *vinorelbine tartrate intravenous solution 50 mg/5ml*
- XATMEP ORAL SOLUTION 2.5 MG/ML
- ZORTRESS ORAL TABLET 0.25 MG

Details

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

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