

# EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

## ACITRETIN

### Products Affected

- *acitretin*

PA Criteria	Criteria Details
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	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.
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a dermatologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

# EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

## 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/mm <sup>3</sup> , a platelet count less than 100,000/mm <sup>3</sup> , 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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# ACTIMMUNE

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### Products Affected

- ACTIMMUNE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of any medically accepted indications not otherwise excluded from Part D OR atopic dermatitis
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### ADEMPAS

#### Products Affected

- ADEMPAS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH AND PAH is symptomatic AND One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH .Chronic thromboembolic pulmonary hypertension (CTEPH) (Initial): One of the following: A) Both of the following: 1) Diagnosis of inoperable or persistent/recurrent CTEPH and 2) CTEPH is symptomatic OR B) Patient is currently on any therapy for the diagnosis of CTEPH. For all indications female patients are enrolled in the ADEMPAS REMS program.
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	6 months - initial. 12 months - renewal
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# AFINITOR

### Products Affected

- AFINITOR

- AFINITOR DISPERZ ORAL TABLET SOLUBLE 2 MG, 3 MG, 5 MG

PA Criteria	Criteria Details
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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 diagnosis of tuberous sclerosis complex (TSC) associated partial seizures.
<b>Age Restrictions</b>	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. 2 years of age or older for TSC associated partial seizures.
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

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## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# ALDURAZYME

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### Products Affected

- ALDURAZYME

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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### ALECENSA

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#### Products Affected

- ALECENSA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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)
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### ALIMTA

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#### Products Affected

- ALIMTA

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



## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### ALIQOPA

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#### Products Affected

- ALIQOPA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Follicular Lymphoma: Diagnosis of relapsed follicular lymphoma in patients who have received at least 2 prior systemic therapies
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Must be prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of therapy

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# ALPHA1PROTEINASEINH

### Products Affected

- PROLASTIN-C

- ZEMAIRA

PA Criteria	Criteria Details
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	not covered for patients with IgA deficiency
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	pulmonologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	none

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### ALUNBRIG

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#### Products Affected

- ALUNBRIG ORAL TABLET 180 MG, 30 MG, 90 MG
- ALUNBRIG 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 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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### AMPYRA

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#### Products Affected

- AMPYRA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	History of seizure. Moderate or severe renal impairment (creatinine clearance less than or equal to 50 mL/minute).
<b>Required Medical Information</b>	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 beta 1a, interferon beta 1b, glatiramer, natalizumab, mitoxatrone, dimethyl fumarate, teriflunomide, alemtuzumab) to control disease progression OR has tried and failed, contraindicated, or intolerant to any DMDs
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	Initial - 3 months. Renewal - 12 months
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### APOKYN

#### Products Affected

- APOKYN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	PD (Initial, reauth): Patient is using Apokyn with any 5-HT3 antagonist (eg, ondansetron, granisetron, dolasetron, palonosetron, alosetron)
<b>Required Medical Information</b>	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, benzotropine, etc.).
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# ARCALYST

### Products Affected

- ARCALYST

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	12 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with or recommendation of, an immunologist, allergist, dermatologist, rheumatologist, neurologist, or other medical specialist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	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.

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### AUSTEDO

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#### Products Affected

- AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Patients with hepatic impairment OR Huntington's disease who also have active suicidal ideation or untreated depression
<b>Required Medical Information</b>	A. CHOREA ASSOCIATED WITH HUNTINGTONS DISEASE: Diagnosis of Chorea associated with Huntington's disease AND prescriber attestation that patient has NOT taken an MAOI in the past 14 days OR B. TARDIVE DYSKINESIA: Diagnosis of medication induced tardive Dyskinesia AND patient has a history of using a dopamine receptor antagonist
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a psychiatrist or neurologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# BAVENCIO

### Products Affected

- BAVENCIO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	12 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None



## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# BELEODAQ

### Products Affected

- BELEODAQ

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of relapsed or refractory peripheral T-cell lymphoma (PTCL) (ANC should be greater than or equal to 1000/mm <sup>3</sup> and platelets should be greater than or equal to 50,000/mm <sup>3</sup> prior to each cycle)
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# BETASERON

### Products Affected

- BETASERON

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of relapsing form of multiple sclerosis OR diagnosis of first clinical episode and MRI features consistent with multiple sclerosis
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For renewal, disease has not progressed and has responded to therapy.

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### BOSULIF

#### Products Affected

- BOSULIF ORAL TABLET 100 MG, 400 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] or Philadelphia chromosome positive chronic myelogenous leukemia, Newly diagnosed, chronic phase
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# BRIVIACT

### Products Affected

- BRIVIACT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of partial-onset seizures, member must have history of inadequate response, contraindication, or intolerance to levetiracetam prior to approval.
<b>Age Restrictions</b>	16 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# BUPRENORPHINE

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### Products Affected

- *buprenorphine hcl injection*
- *buprenorphine hcl sublingual tablet sublingual 2 mg, 8 mg*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of opioid dependence
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	none

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# CABOMETYX

### Products Affected

- CABOMETYX

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Patients who have or are at risk for severe hemorrhage and/or patients with a recent history of bleeding or hemoptysis.
<b>Required Medical Information</b>	Diagnosis of advanced renal cell carcinoma who have received prior anti-angiogenic therapy.
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# CALQUENCE

### Products Affected

- CALQUENCE

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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# CAPRELSA

### Products Affected

- CAPRELSA ORAL TABLET 100 MG, 300 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Congenital long QT syndrome
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	3 months
<b>Other Criteria</b>	None



## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# CARBAGLU

### Products Affected

- CARBAGLU

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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# 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 <i>P. aeruginosa</i> 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)

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# CEREZYME

### Products Affected

- CEREZYME

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	2 years of age or older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	If this medication is administered by a physician incident to a physicians visit this would be covered by Medicare Part B

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### CHANTIX

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#### 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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### CINRYZE

#### Products Affected

- CINRYZE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	History of life-threatening immediate hypersensitivity reactions, including anaphylaxis to the product.
<b>Required Medical Information</b>	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).
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	prescribed by or in consultation with a hematologist or immunologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# 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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# COPAXONE

### Products Affected

- COPAXONE SUBCUTANEOUS SOLUTION  
PREFILLED SYRINGE 20 MG/ML, 40  
MG/ML

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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# CORLANOR

### Products Affected

- CORLANOR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	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)
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None



## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### COTELLIC

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#### Products Affected

- COTELLIC

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of unresectable OR metastatic malignant melanoma with BRAF V600E OR V600K mutation. Documentation of combination therapy with vemurafenib
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# CYSTAGON

### Products Affected

- CYSTAGON

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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# DACTINOMYCIN

### Products Affected

- *dactinomycin*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Chickenpox or herpes zoster infection
<b>Required Medical Information</b>	For the treatment of regional, locally recurrent or locoregional solid tumor OR Ewing's sarcoma OR Gestational trophoblastic neoplasia OR Nonseminomatous, metastatic malignant tumor of testis OR nephroblastoma OR rhabdomyosarcoma
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Must be prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# DARZALEX

### Products Affected

- DARZALEX

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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### ELITEK

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#### Products Affected

- ELITEK

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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# EMPLICITI

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### Products Affected

- EMLICITI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of multiple myeloma, documentation of combination therapy with lenalidomide and dexamethasone. Prescriber must document prior treatment with 1 to 3 previous therapies.
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### ENBREL

#### Products Affected

- ENBREL

- ENBREL SURECLICK

PA Criteria	Criteria Details
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Active serious infection (including tuberculosis)
<b>Required Medical Information</b>	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).
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Initial 3 months (plaque psoriasis), 12 months (others). Renewal 12 months.
<b>Other Criteria</b>	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 symptoms, such as stiffness and back pain).

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## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### ENDARI

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#### Products Affected

- ENDARI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of sickle cell disease with acute complications AND 1) patient must have intolerance or contraindication to hydroxyurea AND 2) patient must have had 2 or more painful crises within 12 months prior
<b>Age Restrictions</b>	5 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None



## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# ENTRESTO

### Products Affected

- ENTRESTO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	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
<b>Required Medical Information</b>	Statement of diagnosis indicating Heart Failure (NYHA Class II to IV)
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Hemoglobin 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
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	3 months
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# ERIVEDGE

### Products Affected

- ERIVEDGE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### ERLEADA

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#### Products Affected

- ERLEADA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Pregnancy
<b>Required Medical Information</b>	Diagnosis of nonmetastatic, castration-resistant prostate cancer
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or urologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### ESBRIET

#### Products Affected

- ESBRIET

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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### EXJADE

#### Products Affected

- EXJADE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	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.
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	Covered for those 2 years of age and older with chronic iron overload due to blood transfusions
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	3 months
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# 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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# FARESTON

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### Products Affected

- FARESTON

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Diagnosis of acquired or congenital long QT syndrome, uncorrected hypokalemia, or uncorrected hypomagnesemia
<b>Required Medical Information</b>	Diagnosis. Must have previous inadequate response or intolerance to tamoxifen. For reauth: must have chart documentation from prescriber indicating improvement in condition.
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Oncologist or hematologist
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	None



## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# FARYDAK

### Products Affected

- FARYDAK ORAL CAPSULE 10 MG, 15 MG, 20 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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)].
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist/hematologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# FENTANYL ORAL

### Products Affected

- *fentanyl citrate*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Management of acute or post-operative pain, including headache/migraine, dental pain, or use in the emergency room. Opioid non-tolerant patients.
<b>Required Medical Information</b>	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, OXYCODONE/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
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# FERRIPROX

### Products Affected

- FERRIPROX ORAL TABLET

PA Criteria	Criteria Details
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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 $1.5 \times 10^9/L$ .
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For renewal, patient has experienced at least a 20% reduction in serum ferritin levels and has an absolute neutrophil count greater than $0.5 \times 10^9/L$

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### FIRAZYR

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#### Products Affected

- FIRAZYR

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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# 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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# GATTEX

### Products Affected

- GATTEX

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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# GILENYA

### Products Affected

- GILENYA

PA Criteria	Criteria Details
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	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).
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### GILOTRIF

#### Products Affected

- GILOTRIF

PA Criteria	Criteria Details
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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, L861Q) substitution, exon 18 (G719X, G719) or exon 20 (S768I) 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
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None



## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### GLEEVEC

#### Products Affected

- *imatinib mesylate*

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

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## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# GOCOVRI

### Products Affected

- GOCOVRI ORAL CAPSULE EXTENDED RELEASE 24 HOUR 137 MG, 68.5 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Patients with ESRD (CrCl below 15 ml/min/1.73 m <sup>2</sup> )
Required Medical Information	INITIAL: Diagnosis of Parkinsons disease AND (1) Patient is experiencing dyskinesia AND (2) Patient is receiving levodopa based therapy AND (3) Must have documented trial and failure to amantadine immediate release. RENEWAL: (1) must meet the initial criteria above AND (2) Documentation of positive clinical response to Gocovri (e.g., decreased "off" periods, decreased "on" time with troublesome dyskinesia)
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	12 months
Other Criteria	None

## GROWTH HORMONE

**Products Affected**

- NORDITROPIN FLEXPRO

PA Criteria	Criteria Details
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	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.
<b>Required Medical Information</b>	<p>Diagnosis of pediatric indication: A) GHD and bone age at least 1 year or 2 standard deviations (SD) delayed compared with chronological age and 2 stim tests with peak GH secretion below 10 ng/mL or IGF-1/IGFBP3 level more than 2 SDS below mean if CNS pathology, h/o irradiation, or proven genetic cause, B) SGA and birth weight or length 2 or more SDS below mean for gestational age and fails to manifest catch up growth by age 2 (height 2 or more SDS below mean for age and gender), C) CRI and nutritional status has been optimized, metabolic abnormalities have been corrected, and patient has not had renal transplant D) SHOX deficiency or Noonan syndrome E) PWS confirmed by genetic testing, F) Turner Syndrome confirmed by chromosome analysis. For GHD, CRI, SHOX deficiency, Noonan syndrome, and PWS one of the following: height more than 3 SDS below mean for age and gender, or height more than 2 SDS below mean with GV more than 1 SDS below mean, or GV over 1 year 2 SDS below mean. OR Diagnosis of an adult indication: A) childhood- or adult-onset GHD confirmed by 2 standard GH stim tests (provide assay): 1 test must be insulin tolerance test (ITT) with blood glucose nadir less than 40 mg/dL (2.2 mmol/L). If contraindicated, use a standardized stim test (i.e. arginine plus GH releasing hormone [preferred], glucagon, arginine), B) GHD with at least 1 other pituitary hormone deficiency and failed at least 1 GH stim test (ITT preferred), C) GHD with panhypopituitarism (3 or more pituitary hormone deficiencies), D) GHD with irreversible hypothalamic-pituitary structural lesions due to tumors, surgery or radiation of pituitary or hypothalamus region AND a subnormal IGF-1 (after at least 1 month off GH therapy) AND Objective evidence of GHD complications, such as: low bone density, increased visceral fat mass, or cardiovascular complications AND Completed linear growth (GV less than 2 cm/year) AND GH has been discontinued for at least 1 month (if previously receiving GH).</p>

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## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

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

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## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### HEPATITIS B

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#### Products Affected

- VEMLIDY

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Must submit documentation of immune-active chronic hepatitis B per AASLD guidelines.
<b>Age Restrictions</b>	Adults 18 years of age or older
<b>Prescriber Restrictions</b>	Prescriber must be a gastroenterologist, hepatologist, or infectious disease specialist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### HEPATITIS C

#### Products Affected

- EPCLUSA

- HARVONI
- SOVALDI

PA Criteria	Criteria Details
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescriber must be a gastroenterologist, hepatologist, or infectious disease specialist
<b>Coverage Duration</b>	Duration of approval per AASLD guidelines based on patient specific criteria
<b>Other Criteria</b>	None

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## HERCEPTIN

**Products Affected**

- HERCEPTIN

PA Criteria	Criteria Details
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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 medication will be used in combination with cisplatin and capecitabine or 5-fluorouracil
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	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.

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# HETLIOZ

### Products Affected

- HETLIOZ

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



## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### HEXALEN

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#### Products Affected

- HEXALEN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Severe bone marrow depression-indicated by CBC. Severe neurologic toxicity-Seizure.
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### HP ACTHAR

#### Products Affected

- HP ACTHAR

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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, 8) Respiratory diseases such as symptomatic sarcoidosis or 9) Edematous condition from nephrotic syndrome or lupus erythematosus
<b>Age Restrictions</b>	infantile spasms: less than 2 years of age
<b>Prescriber Restrictions</b>	Multiple Sclerosis: neurologist, infantile spasms: prescribed by or in consultation with a neurologist or epileptologist
<b>Coverage Duration</b>	infantile spasms: 4 weeks, Multiple Sclerosis: 3 weeks. All other FDA approved uses: 3 months
<b>Other Criteria</b>	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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### HRM - ANTIDEPRESSANTS

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#### 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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### HRM - ANTIEMETIC DRUGS

#### Products Affected

- *hydroxyzine hcl*

- *hydroxyzine pamoate*
- *promethazine hcl*

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	Automatic approval if member is less than 65 years of age. Prior Auth required for age 65 or older.
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	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.

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### HRM - ONCOLOGY

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#### 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
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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 formulary 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 Estrogen Vaginal Cream or Estrogen Vaginal Tablets
<b>Age Restrictions</b>	Automatic approval if member is less than 65 years of age. Prior Auth required for age 65 or older.
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Bone Density: alendronate, risedronate, ibandronate, raloxifene (zoledronic acid for bed-bound patients or for post-hip fracture). Vaginal Symptoms: Estrace vaginal cream

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### HRM - SKELETAL MUSCLE RELAXANTS

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#### 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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### HRM-BARBITURATES

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#### Products Affected

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



## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### 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)

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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# HYDROXYPROGESTERONE CAPROATE

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### Products Affected

- *hydroxyprogesterone caproate*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Breast, cervical, hepatocellular, uterine, or vaginal cancers, hepatic or thromboembolic disease, jaundice, or vaginal bleeding
<b>Required Medical Information</b>	Supporting statement of diagnosis from physician
<b>Age Restrictions</b>	16 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	21 weeks
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### IBRANCE

#### Products Affected

- IBRANCE

PA Criteria	Criteria Details
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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)].
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### 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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### IDHIFA

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#### Products Affected

- IDHIFA ORAL TABLET 100 MG, 50 MG

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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# IMBRUVICA

### Products Affected

- IMBRUVICA ORAL CAPSULE 140 MG, 70 MG
- IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG, 560 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 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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### IMFINZI

#### Products Affected

- IMFINZI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of 1) 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 OR 2) Diagnosis of unresectable stage III non-small cell lung cancer AND disease has not progressed following concurrent platinum-based chemotherapy and radiation therapy
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None



## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# INCRELEX

### Products Affected

- INCRELEX

PA Criteria	Criteria Details
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	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.
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	2 years of age and older
<b>Prescriber Restrictions</b>	Pediatric or Endocrinologist
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	For renewal, patient has experienced improvement

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# INHALED TOBRAMYCIN

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### Products Affected

- TOBI PODHALER

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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### INLYTA

#### Products Affected

- INLYTA ORAL TABLET 1 MG, 5 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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)
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### INTRON-A

#### Products Affected

- INTRON A

PA Criteria	Criteria Details
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Uncontrolled depression. Solid organ transplant other than liver. Autoimmune hepatitis or other autoimmune condition known to be exacerbated by interferon and ribavirin.
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	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.
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Condylomata: 3 mos. HBVe antigen pos: 16 wks, HBVe antigen neg: 48 wks. KS: 16 wks. Others: 12 mos
<b>Other Criteria</b>	None

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## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### IRESSA

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#### Products Affected

- IRESSA

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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# ITRACONAZOLE

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### Products Affected

- *itraconazole*

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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### JAKAFI

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#### Products Affected

- JAKAFI

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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### KADCYLA

#### Products Affected

- KADCYLA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Patient has a diagnosis of HER2-positive metastatic breast cancer and the member has been previously treated with trastuzumab and a taxane
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	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.



## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# KALYDECO

### Products Affected

- KALYDECO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	For oral granules- 2 years of age or older. For oral tablets- 6 years of age or older.
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For renewal, patient has experienced benefit from therapy (i.e. improvement in pulmonary lung function [FEV1], decreased number of pulmonary exacerbations)

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# KEYTRUDA

### Products Affected

- KEYTRUDA

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

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## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# KISQALI

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### Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### KORLYM

#### Products Affected

- KORLYM

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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### KUVAN

#### Products Affected

- KUVAN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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 than 12 years of age, 2-10 mg/dL (120-600 micromol/L) if greater than 12 and less than 18 years of age, and 2-15 mg/dL (120-900 micromol/L) if greater than 18 years of age.
<b>Age Restrictions</b>	1 month of age or older
<b>Prescriber Restrictions</b>	specialist knowledgeable in the management of PKU
<b>Coverage Duration</b>	Initial Approval: 2 months. Extended Approval: 6 month intervals
<b>Other Criteria</b>	Blood Phe levels should be checked after 1 week of therapy and periodically up to one month during a therapeutic trial.

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# LARTRUVO

### Products Affected

- LARTRUVO INTRAVENOUS SOLUTION  
190 MG/19ML, 500 MG/50ML

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	Adults 18 years of age or older
<b>Prescriber Restrictions</b>	Oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### LENVIMA

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#### 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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# LETAIRIS

### Products Affected

- LETAIRIS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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 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.
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Initial - 6 months. Renewal - 12 months
<b>Other Criteria</b>	None



## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# LEUPROLIDE

### Products Affected

- *leuprolide acetate*

PA Criteria	Criteria Details
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	CPP - Prescribed by or in consultation with a pediatric endocrinologist
<b>Coverage Duration</b>	12 months. CPP testing: one time dose.
<b>Other Criteria</b>	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.

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# LIDOCAINE PATCH

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### Products Affected

- *lidocaine external patch*

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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# LONSURF

### Products Affected

- LONSURF

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For initial treatment: Absolute neutrophil count 1,500/mm <sup>3</sup> or greater or febrile neutropenia resolved, platelet count 75,000/mm <sup>3</sup> or greater, and grade 3 or 4 nonhematological reactions resolved to grade 0 or 1

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# LUMIZYME

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### Products Affected

- LUMIZYME

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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### 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)
- LUPRON DEPOT-PED (3-MONTH)

PA Criteria	Criteria Details
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Pregnancy in patients with child-bearing potential. Breastfeeding. Undiagnosed abnormal vaginal bleeding.
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	Uterine fibroids, endometriosis, Prostate Cancer-18 years of age or older CPP-age 2-11 female OR 2-12 male
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Endometriosis- 6 months, Uterine fibroids -3 months, Prostate cancer, Precocious Puberty -12 months
<b>Other Criteria</b>	For endometriosis and uterine fibroids, patient will be using nonhormonal contraception during and for 12 weeks after therapy.

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## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# 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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# MATULANE

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### Products Affected

- MATULANE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Part B coverage
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### 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 Tafenlar 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



## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### MODAFINIL

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#### Products Affected

- *modafinil oral tablet 100 mg, 200 mg*

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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### MORPHINE SOL

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#### Products Affected

- *morphine sulfate (concentrate)*

- *morphine sulfate oral solution*

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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# MOZOBIL

### Products Affected

- MOZOBIL

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	4 days
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# MYLOTARG

### Products Affected

- MYLOTARG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	INITIAL: A. Newly- diagnosed, CD33 positive acute myeloid leukemia (AML) or B. Relapsed or refractory CD33 positive AML. CONTINUATION OF THERAPY: 1) patient continues to meet initial criteria and 2) patients with newly diagnosed AML have not exceeded a maximum of 8 cycles
<b>Age Restrictions</b>	Relapsed or refractory AML: 2 years and older, Newly diagnosed AML: 18 years and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### MYTESI

#### Products Affected

- MYTESI

PA Criteria	Criteria Details
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	Adults 18 years of age or older
<b>Prescriber Restrictions</b>	Infectious Disease Specialist or GI Consult for new starts
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# NAGLAZYME

### Products Affected

- NAGLAZYME

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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### NATPARA

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#### Products Affected

- NATPARA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of hypocalcemia in patients with hypoparathyroidism
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescriber is certified in the NATPARA REMS Program
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

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## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### NERLYNX

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#### Products Affected

- NERLYNX

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Women who are pregnant or breastfeeding
<b>Required Medical Information</b>	Diagnosis of early stage HER2- overexpressed breast cancer. Must be used after trastuzumab therapy.
<b>Age Restrictions</b>	age 18 years and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None



## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# NEUPOGEN

### Products Affected

- NEUPOGEN

PA Criteria	Criteria Details
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	<p>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.</p>
<b>Age Restrictions</b>	None

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<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### NEXAVAR

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#### Products Affected

- NEXAVAR

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Nexavar is contraindicated in combination with paclitaxel and carboplatin in patients with squamous cell lung cancer
<b>Required Medical Information</b>	None
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### NINLARO

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#### Products Affected

- NINLARO

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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# NORTHERA

### Products Affected

- NORTHERA

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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### NOXAFIL

#### Products Affected

- NOXAFIL ORAL SUSPENSION
- NOXAFIL ORAL TABLET DELAYED RELEASE

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Concomitant treatment with sirolimus, CYP 3A4 substrates (pimozide, quinidine), HMG-CoA Reductase inhibitors primarily metabolized through CYP 3A4, or ergot alkaloids
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### NUPLAZID

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#### Products Affected

- NUPLAZID

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of Parkinson disease psychosis including hallucinations and/or delusions
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# NUVIGIL

### Products Affected

- *armodafinil*

PA Criteria	Criteria Details
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	17 years of age or older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	OSA/hypopnea syndrome - 6 months (initial), 12 months (renewal). Other diagnoses - 12 months.
<b>Other Criteria</b>	None



## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# OCTREOTIDE

### Products Affected

- *octreotide acetate*

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Supporting statement of diagnosis from the physician
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	13 months
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### ODOMZO

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#### Products Affected

- ODOMZO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of locally advanced basal cell carcinoma of the skin and specific documentation of negative pregnancy status
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### OPDIVO

#### Products Affected

- OPDIVO

PA Criteria	Criteria Details
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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 OR adjuvant treatment of metastatic melanoma that involve lymph nodes and patient has undergone complete resection.
<b>Age Restrictions</b>	12 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a hepatologist, gastroenterologist, oncologist or infectious disease specialist
<b>Coverage Duration</b>	12 months

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<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Other Criteria</b>	None

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# OPSUMIT

### Products Affected

- OPSUMIT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Pregnancy.
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	6 months - initial. 12 months - renewal
<b>Other Criteria</b>	For renewal, medication was effective (i.e. improved 6 minute walk distance, oxygen saturation, etc.)

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### ORFADIN

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#### Products Affected

- ORFADIN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of hereditary tyrosinemia type 1
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### ORKAMBI

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#### Products Affected

- ORKAMBI ORAL TABLET 100-125 MG, 200-125 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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.)
<b>Age Restrictions</b>	Must be greater than or equal to 6 years of age
<b>Prescriber Restrictions</b>	Must be prescribed by, or in conjunction with, a pulmonologist or is from a CF center accredited by the Cystic Fibrosis Foundation
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# OXANDRIN

### Products Affected

- *oxandrolone*

PA Criteria	Criteria Details
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Breast or prostate cancer in men. Breast cancer in women with hypercalcemia. Pregnancy. Nephrosis or nephrotic phase of nephritis. Hypercalcemia.
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Osteoporosis bone pain: 1 month. Other diagnoses: 3 months
<b>Other Criteria</b>	For renewal, patient has experienced an objective improvement (i.e. weight gain, increase in lead body mass, or reduction in muscle pain/weakness)



## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# OXYCODONE SOL

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### Products Affected

- *oxycodone hcl oral concentrate*

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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### PCSK9 INHIBITOR

#### Products Affected

- PRALUENT
- REPATHA

- REPATHA PUSHTRONEX SYSTEM
- REPATHA SURECLICK

PA Criteria	Criteria Details
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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) Myocardial infarction prophylaxis, stroke prophylaxis, and to reduce risk of coronary revascularization in pts with established CVD OR B) primary hyperlipidemia homozygous familial hypercholesterolemia (HoFH) confirmed by genotyping OR diagnosis based on the following: a. History of untreated LDL-C greater than 500 mg/dL AND xanthoma before 10 years of age OR b. Documentation of HeFH in both parents 3. Diagnosis of clinical atherosclerotic cardiovascular disease (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)
<b>Age Restrictions</b>	Repatha: 13 years of age or older for diagnosis HoFM, Diagnosis CVD or HeFH : 18 years of age or older
<b>Prescriber</b>	Must be prescribed by, or in consultation with, a cardiologist,

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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### PEGYLATED INTERFERON

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**Products Affected**

- PEGASYS

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

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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# PHENYL BUTYRATE

### 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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# POMALYST

### Products Affected

- POMALYST

PA Criteria	Criteria Details
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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 Evaluation and Mitigation Strategy) program
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Oncologist or hematologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	A documented diagnosis of multiple myeloma and received at least two prior therapies including lenalidomide (Revlimid) and bortezomib (Velcade)

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## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# PROLEUKIN

### Products Affected

- PROLEUKIN

PA Criteria	Criteria Details
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Diagnosis of coma OR toxic psychosis lasting greater than 48 hours during an earlier course of therapy
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	Metastatic Renal Cell Carcinoma or Metastatic Melanoma: 18 years and older
<b>Prescriber Restrictions</b>	Oncologist
<b>Coverage Duration</b>	Metastatic Renal Cell Carcinoma or Metastatic Melanoma: 3 months
<b>Other Criteria</b>	All uses: for continuation of therapy

## PULMONARY FIBROSIS

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**Products Affected**

- OFEV

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



## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# PULMOZYME

### Products Affected

- PULMOZYME

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of cystic fibrosis
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	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.

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# QUININE SULFATE

### Products Affected

- *quinine sulfate*

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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# RADICAVA

### Products Affected

- RADICAVA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Sulfite hypersensitivity
<b>Required Medical Information</b>	Diagnosis of amyotrophic lateral sclerosis and must meet all of the following: 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.
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in collaboration with a neurologist
<b>Coverage Duration</b>	Initial: 6 months. Reauth: 12 months
<b>Other Criteria</b>	BvD determination per CMS guidelines

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# RAVICTI

### Products Affected

- RAVICTI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	acute hyperammonemia. N-acetylglutamate synthase (NAGS) deficiency
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	2 months of age or older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### 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 postmenopausal osteoporosis must have previous inadequate response or intolerance to alendronate, ibandronate, Prolia, or Forteo. a previous osteoporotic vertebral or hip fracture, 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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# REGRANEX

### Products Affected

- REGRANEX

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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).
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Diabetic Neuropathic Ulcers: Maximum 5 months.
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# REMODULIN

### Products Affected

- REMODULIN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist or cardiologist.
<b>Coverage Duration</b>	Initial: 6 months. Reauth: 12 months.
<b>Other Criteria</b>	Subject to Part B vs. D Review

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### RESTASIS

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#### Products Affected

- RESTASIS

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



## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### REVATIO

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#### 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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### REVLIMID

#### Products Affected

- REVLIMID

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

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# RITUXAN

### Products Affected

- RITUXAN

PA Criteria	Criteria Details
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	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)].
<b>Required Medical Information</b>	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 $50 \times 10^9 /L$ .
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	ITP: Prescribed by or in consultation with a hematologist or oncologist. RA: Prescribed by or in consultation with a rheumatologist. WG, MPA: Prescribed by or in consultation with a nephrologist, pulmonologist, or

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<b>PA Criteria</b>	<b>Criteria Details</b>
	rheumatologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Monitored for pulmonary toxicity

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# RUBRACA

### Products Affected

- RUBRACA

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

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### RYDAPT

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#### Products Affected

- RYDAPT

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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### 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, levetiracetam, 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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# SANDOSTATIN

### Products Affected

- SANDOSTATIN LAR DEPOT

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



## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### SIGNIFOR

#### Products Affected

- SIGNIFOR

PA Criteria	Criteria Details
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Initial: 6 months trial. Reauthorization: 12 months if demonstrated benefit
<b>Other Criteria</b>	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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# 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.[

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# SOLTAMOX

### Products Affected

- SOLTAMOX

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Concomitant coumarin-type anticoagulant therapy OR history of thromboembolic disease such as DVT or PE
<b>Required Medical Information</b>	Diagnosis for use. Documentation of inability to swallow tablet formulation.
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# 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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# SOMAVERT

### Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	IV administration of Somavert, concomitant use of Sandostatin or Somatuline.
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Endocrinologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### SPRYCEL

#### Products Affected

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

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

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## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### STELARA

#### Products Affected

- STELARA INTRAVENOUS

- STELARA SUBCUTANEOUS

PA Criteria	Criteria Details
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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).
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Plaque psoriasis (initial): Prescribed by or in consultation with a dermatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist.
<b>Coverage Duration</b>	All uses (Initial, reauth): 12 months
<b>Other Criteria</b>	Reauthorization (all indications): Documentation of positive clinical response to Stelara therapy. All indications (initial, reauth): Patient is not receiving Stelara in combination with either of the following: Biologic DMARD [eg, Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab), Otezla (apremilast)] or a Janus Kinase Inhibitor [eg, Xeljanz (tofacitinib)]. Patient is not receiving Stelara in combination with a phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla

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<b>PA Criteria</b>	<b>Criteria Details</b>
	(apremilast)].



## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# 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 (Erbix) (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)

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### SUBOXONE

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#### Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Patient has a diagnosis of opioid dependence
<b>Age Restrictions</b>	16 years of age or older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Initial - 6 months. Renewal - 6 months
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# SUTENT

### Products Affected

- SUTENT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of gastrointestinal stromal tumors after disease progression on or intolerance to Gleevec OR Diagnosis of progressive, well-differentiated pancreatic neuroendocrine tumors in a patient with unresectable locally advanced or metastatic disease OR Diagnosis of advanced/metastatic renal cell carcinoma OR Renal cell carcinoma, Adjuvant therapy following nephrectomy in patients at high risk for recurrence
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# SYLATRON

### Products Affected

- SYLATRON

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Autoimmune hepatitis. Hepatic decompensation (Child-Pugh score greater than 6 [Class B or C])
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### SYMDEKO

#### Products Affected

- SYMDEKO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Concomitant use with strong CYP3A inducers
<b>Required Medical Information</b>	Diagnosis of cystic fibrosis and patient is homozygous for the F508del mutation OR has mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to tezacaftor/ivacaftor verified by a FDA-approved mutation test
<b>Age Restrictions</b>	12 years of age and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Initial-6 months. renewal-12 months.
<b>Other Criteria</b>	Documentation of baseline transaminases (ALT and AST). Documentation of AST and ALT every 3 months during the first year of treatment, and annually thereafter.

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# SYNAGIS

### Products Affected

- SYNAGIS

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

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<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Other Criteria</b>	Approve 5 doses based on patient body weight

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### SYNAREL

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#### Products Affected

- SYNAREL

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	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.
<b>Required Medical Information</b>	Diagnosis of central precocious puberty
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None



## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### SYNRIBO

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#### Products Affected

- SYNRIBO

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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### SYPRINE

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#### Products Affected

- SYPRINE

- *trientine hcl*

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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### TABLOID

#### Products Affected

- TABLOID

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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# TAFINLAR

### Products Affected

- TAFINLAR ORAL CAPSULE 50 MG, 75 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	A documented positive BRAF V600E or V600K mutation as detected by an FDA-approved test
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Tafinlar should not be used in patients with wild-type BRAF melanoma due to the potential risk of tumor promotion in these patients

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# TAGRISO

### Products Affected

- TAGRISO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of metastatic, non-small cell lung cancer with confirmed presence of T790M EGFR tumor mutation by cobas EGFR Mutation Test v2
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# 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.

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# 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.

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### TASIGNA

#### Products Affected

- TASIGNA

PA Criteria	Criteria Details
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Long QT syndrome. Uncorrected hypokalemia. Uncorrected hypomagnesemia. Concomitant use with a drug known to prolong the QT interval or strong cytochrome P450 3A4 inhibitors
<b>Required Medical Information</b>	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]
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Coverage is provided for the treatment of newly diagnosed 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 patients resistant to or intolerant to prior therapy that included imatinib.



## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# 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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# THALOMID

### Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Pregnancy
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Oncologist
<b>Coverage Duration</b>	AS, ulcers-1 month. ENL, MM-End of year. WM, GVHD, primary brain tumor-6 months. Other uses-3 months
<b>Other Criteria</b>	Patient will be monitored for signs of venous thromboembolism

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### TRACLEER

#### Products Affected

- TRACLEER ORAL TABLET

- TRACLEER ORAL TABLET SOLUBLE

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.

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# TRELSTAR

### Products Affected

- TRELSTAR MIXJECT

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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# TRETINOIN

### Products Affected

- *tretinoin external*

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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# 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.

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# TYMLOS

### Products Affected

- TYMLOS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	Initial: 1 year Reauth: Treatment duration has not exceeded 24 months during pt lifetime
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# TYSABRI

### Products Affected

- TYSABRI

PA Criteria	Criteria Details
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	History of progressive multifocal leukoencephalopathy.
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	MULTIPLE SCLEROSIS: 12 MONTHS. CROHN'S DISEASE: 6 MONTHS. RENEWAL: CROHN'S: 12 MONTHS.
<b>Other Criteria</b>	Patient and physician are registered in the TOUCH prescribing program. For renewal, patient had an objective response to therapy (e.g., decreased flare).



## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### UPTRAVI

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#### 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

**EnvisionRxPlus 2018 Formulary Prior Authorization Criteria**

**VALCHLOR**

**Products Affected**

- VALCHLOR

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

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## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# VECTIBIX

### Products Affected

- VECTIBIX

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Subject to B vs D

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### VELCADE

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#### Products Affected

- *bortezomib*

- 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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# VENCLEXTA

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### Products Affected

- VENCLEXTA

- VENCLEXTA STARTING PACK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Concomitant use of strong CYP3A inhibitor during the initial and titration phase
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### VENTAVIS

#### Products Affected

- VENTAVIS

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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# VERZENIO

### Products Affected

- VERZENIO

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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# VORICONAZOLE

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### Products Affected

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

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



## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### VOTRIENT

#### Products Affected

- VOTRIENT

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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).
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# VYXEOS

### Products Affected

- VYXEOS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	age 18 years and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	BvD determination per CMS guidelines

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### XALKORI

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#### Products Affected

- XALKORI

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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### 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 genotyped 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.

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### XGEVA

#### Products Affected

- XGEVA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Hypocalcemia (calcium less than 8.0 mg/dL).
<b>Required Medical Information</b>	Diagnosis of hypercalcemia of malignancy, refractory to bisphosphonate therapy OR diagnosis of giant cell tumor of bone that is unresectable or where surgical resection is likely to result in severe morbidity OR treatment used for prevention of skeletal-related events in patients with multiple myeloma or bone metastases from solid tumors.
<b>Age Restrictions</b>	13 years and older for treatment of giant cell tumor of the bone, 18 years and older for all other indications
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### XOLAIR

#### Products Affected

- XOLAIR

PA Criteria	Criteria Details
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	6 years of age or older
<b>Prescriber Restrictions</b>	Allergist, immunologist, pulmonologist or dermatologist
<b>Coverage Duration</b>	Initial: 6 months trial. Extended approval: 6 months if demonstrated benefit
<b>Other Criteria</b>	If this medication is administered by a physician incident to a physicians visit this would be covered by Medicare Part B

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## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### XTANDI

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#### Products Affected

- XTANDI

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of metastatic castration-resistant prostate cancer \AND the patient has tried and had an inadequate response, contraindication or intolerance to Zytiga.
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### XURIDEN

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#### Products Affected

- XURIDEN

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



## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### XYREM

#### Products Affected

- XYREM

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Concomitant treatment with sedative hypnotic agents. Succinic semialdehyde dehydrogenase deficiency.
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For renewal, the patient had a positive response to the medication (increased sleep quality for patients with narcolepsy)

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# 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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# YONDELIS

### Products Affected

- YONDELIS

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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### ZAVESCA

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#### Products Affected

- ZAVESCA

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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### ZEJULA

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#### Products Affected

- ZEJULA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a oncologist or gyno oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# ZELBORAF

### Products Affected

- ZELBORAF

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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 OR diagnosis of Erdheim-Chester disease with BRAF V600 mutation.
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	Oncologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### ZOLINZA

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#### Products Affected

- ZOLINZA

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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### ZOMETA

#### Products Affected

- *zoledronic acid intravenous concentrate*

PA Criteria	Criteria Details
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Current treatment with Reclast.
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None



## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# ZORTRESS

### Products Affected

- ZORTRESS ORAL TABLET 0.5 MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	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
<b>Age Restrictions</b>	18 years of age or older
<b>Prescriber Restrictions</b>	Prescriber is experienced in immunosuppressive therapy and management of transplant patients.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Part B if transplant covered by Medicare. otherwise Part D

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

# ZYDELIG

### Products Affected

- ZYDELIG

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

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## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### ZYKADIA

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#### Products Affected

- ZYKADIA

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

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### ZYTIGA

#### Products Affected

- ZYTIGA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	None
<b>Required Medical Information</b>	Diagnosis of metastatic prostate cancer AND Zytiga will be used in combination with prednisone AND one of the following 1) Patient has castration-resistant disease (defined by tumor growth/disease progression, risk in PSA levels, new metastases) OR 2) Patient has high-risk castration-sensitive disease
<b>Age Restrictions</b>	None
<b>Prescriber Restrictions</b>	None
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	None

## EnvisionRxPlus 2018 Formulary Prior Authorization Criteria

### 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

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### 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 %, 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*
- *carboplatin intravenous solution 150 mg/15ml*
- *casprofungin 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, 50 mg/50ml*
- *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*

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- *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 100 mg/5ml, 500 mg/25ml*
- FASLODEX INTRAMUSCULAR SOLUTION 250 MG/5ML
- *fluorouracil intravenous solution 2.5 gm/50ml, 5 gm/100ml*
- 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
- 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, 250 mg/10ml, 50 mg/2ml*
- *methotrexate sodium injection solution 250 mg/10ml*
- *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*

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- *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*
- *oxaliplatin intravenous solution reconstituted 100 mg*
- *paclitaxel intravenous concentrate 100 mg/16.7ml, 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, 25 MG
- TRISENOX INTRAVENOUS SOLUTION 12 MG/6ML
- 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

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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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