HEALTHTEAM ADVANTAGE

2018 Prior Authorization Criteria

ACTIMMUNE

Products Affected

- ACTIMMUNE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	This criteria applies to New Starts only.

ADAGEN

Products Affected

- ADAGEN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Severe thrombocytopenia. Use in preparation for or in support of bone marrow transplantation.
Required Medical Information	None
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	Use for direct replacement for deficient enzyme (no benefit achieved in patients with immunodeficiency due to other causes).

ADCIRCA

Products Affected

- ADCIRCA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrent use of organic nitrate or guanylate cyclase stimulators (includes intermittent use)
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization OR B) Doppler echocardiogram if patient is unable to undergo a 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 and older
Prescriber Restrictions	None
Coverage Duration	PAH: Initial: 6 months. Reauth: 12 months.
Other Criteria	PAH (Reauth): Documentation of positive clinical response to therapy. This criteria applies to New Starts only.

ADEMPAS

Products Affected

- ADEMPAS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Diagnosis of pulmonary arterial hypertension (WHO group I) AND diagnosis was confirmed by right heart catheterization OR Patient has a diagnosis of chronic thromboembolic pulmonary hypertension (CTEPH, WHO group 4) AND patient has persistent or recurrent disease after surgical treatment (e.g., pulmonary endarterectomy) or has CTEPH that is inoperable AND female patients are enrolled in the ADEMPAS REMS program.
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	6 months - initial. 12 months - renewal
Other Criteria	This criteria applies to New Starts only.

ALDURAZYME

Products Affected

- ALDURAZYME

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Diagnosis confirmed by measurement of alpha-L-iduronidase activity (enzymatic assay) or DNA testing. For Scheie form of MPS I, must have at least 2 moderate to severe symptoms. Must demonstrate improvement in lung function in patients who have received at least 26 weeks of Aldurazyme on re-authorization.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	None

ALIQOPA

Products Affected

- ALIQOPA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Follicular Lymphoma: Diagnosis of relapsed follicular lymphoma in patients who have received at least 2 prior systemic therapies
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	This criteria applies to New Starts only.

ALPHA1-PROTEINASE INHIBITOR

Products Affected

- PROLASTIN-C INTRAVENOUS SOLUTION RECONSTITUTED 1000 MG
- ZEMAIRA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient has IgA deficiency with antibodies against IgA.
Required Medical Information	Alpha1-proteinase inhibitor concentration is less than 11 micromoles per liter. The FEV1 level is between 35% and 60% predicted OR greater than 60% predicted. If the FEV1 is greater than 60% predicted, then the patient has experienced a rapid decline in lung function (ie, reduction of FEV1 more than 120 mL/year) that warrants treatment.
Age Restrictions	18 years old and older
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	None

ALUNBRIG

Products Affected

- ALUNBRIG

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

AMPHETAMINES

Products Affected

- *amphetamine-dextroamphet er*
- *dextroamphetamine sulfate er*
- *dextroamphetamine sulfate oral tablet*
- VYVANSE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	MAOI concurrent use or within the last 14 days except if prescriber is a psychiatrist with experience prescribing both MAOI and amphetamine/dextroamphetamine drugs.
Required Medical Information	Sleep studies for narcolepsy diagnosis
Age Restrictions	3 years of age and older for amphetamine ER and Dextroamphetamine IR, 6 years of age and older for Vyvanse and Dextroamphetamine ER
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	Consider benefits of use versus the potential risks of serious cardiovascular events

AMPYRA

Products Affected

- AMPYRA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	History of seizure. Moderate or severe renal impairment (creatinine clearance less than or equal to 50 mL/minute).
Required Medical Information	Diagnosis of multiple sclerosis. Patient must demonstrate sustained walking impairment, but with the ability to walk 25 feet (with or without assistance) prior to starting Ampyra.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescibed by or in consulation with a neurologist
Coverage Duration	Initial - 3 months. Renewal - 12 months
Other Criteria	None

ANABOLIC STEROIDS

Products Affected

- *oxandrolone oral*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Known or suspected carcinoma of the prostate or breast (in male patients), carcinoma of the breast in women with hypercalcemia, pregnancy, nephrosis (the nephrotic phase of nephritis), hypercalcemia.
Required Medical Information	None
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	6 months
Other Criteria	None

ARCALYST

Products Affected

- ARCALYST

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Active or chronic infection. Concurrent therapy with other biologics.
Required Medical Information	None
Age Restrictions	12 years of age and older
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	For renewal, patient's condition must have improved or stabilized.

ARMODAFINIL

Products Affected

- *armodafinil*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Diagnosis of Shift Work Sleep Disorder frequently (5 times or more per month) AND experience excessive sleepiness while working or diagnosis of mild obstructive sleep apnea/hypopnea syndrome.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	None

ATOMOXETINE

Products Affected

- *atomoxetine hcl*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	MAOI concurrent use or within the last 14 days
Required Medical Information	None
Age Restrictions	6 years of age and older
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	Monitor for suicidality, clinical worsening, changes in behavior, blood pressure changes, heart rate changes, liver injury.

AUBAGIO

Products Affected

- AUBAGIO

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Severe hepatic impairment. Current treatment with leflunomide. Patients who are pregnant or women of childbearing potential not using reliable contraception.
Required Medical Information	Diagnosis of relapsing forms of multiple sclerosis (e.g., relapsing-remitting MS or progressive-relapsing MS) OR patient has experienced a first clinical episode and has MRI features consistent with multiple sclerosis
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	For renewal, patient has experienced an objective response to therapy (i.e. no or slowed progression of disease)

AURYXIA

Products Affected

- AURYXIA

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

AUSTEDO

Products Affected

- AUSTEDO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Any degree of hepatic impairment or hepatic disease, Patients with active suicidal ideation or who have untreated or inadequately treated depression
Required Medical Information	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
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a psychiatrist or neurologist
Coverage Duration	12 months
Other Criteria	None

BOSULIF

Products Affected

- BOSULIF

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

BOTOX

Products Affected

- BOTOX INJECTION SOLUTION RECONSTITUTED 100 UNIT

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Cosmetic use. Hypersensitivity to any botulinum toxin preparation or any component of the formulation. Infection at the proposed injection site(s).
Required Medical Information	None.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Chronic migraine, initial treatment: 12 weeks. Plan year for all other indications.
Other Criteria	Monitored for life-threatening symptoms of spread of toxin effect from the injection site (e.g., breathing, swallowing difficulties)

BRIVIACT

Products Affected

- BRIVIACT

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

BUPRENORPHINE

Products Affected

- *buprenorphine hcl sublingual*
- *buprenorphine hcl-naloxone hcl sublingual tablet sublingual*
- SUBOXONE SUBLINGUAL FILM

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	None.
Age Restrictions	For patients age 16 years and older, coverage determination is approved for FDA-approved indications not otherwise excluded from Part D. For patients age 0 to 15 years, drug is not covered.
Prescriber Restrictions	None.
Coverage Duration	12 months
Other Criteria	None.

CALQUENCE

Products Affected

- CALQUENCE

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

CAYSTON

Products Affected

- CAYSTON

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

CEREZYME

Products Affected

- CEREZYME INTRAVENOUS SOLUTION RECONSTITUTED 400 UNIT

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Diagnosis confirmed by bone marrow histology, DNA testing, or b-glucocerebrosidase enzyme assay (enzyme activity less than 30 percent). Must have at least one of following conditions: anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly. Must demonstrate a decrease in liver and spleen volume and/or increase in platelet count and/or increase in Hgb concentration in patients who have received at least 24 months of Cerezyme therapy on re-authorization.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	None

CIMZIA

Products Affected

- CIMZIA PREFILLED
- CIMZIA SUBCUTANEOUS KIT 2 X 200 MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Active infection (including TB). Concurrent therapy with other biologics.
Required Medical Information	Screening for latent TB infection and assessment for Hep B risk. For positive latent TB, patient must have completed treatment or is currently receiving treatment for LTBI. HBV infection ruled out or treatment initiated for positive infection. Rheumatoid arthritis (RA) - Must have an inadequate response to either Enbrel or Humira and one of following: 1) inadequate response to methotrexate, 2) inadequate response to another nonbiologic DMARD (e.g., leflunomide, hydroxychloroquine, sulfasalazine) if contraindicated or intolerant to MTX or, 3) intolerance or contraindication to at least 2 nonbiologic DMARDs. Crohn's Disease - Must have an inadequate response or contraindication/intolerance to at least one oral corticosteroid and Humira.
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	Initial: 3 months for Crohn's disease, 1 year for all other indications. Renewal: Plan Year
Other Criteria	For re-authorization, patient's condition must have improved or stabilized. This criteria applies to New Starts only.

COPAXONE

Products Affected

- *glatiramer acetate*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Diagnosis of relapsing-remitting multiple sclerosis OR diagnosis of first clinical episode with MRI features consistent with multiple sclerosis
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	For renewal, patient has no or slowed disease progression

CORLANOR

Products Affected

- CORLANOR

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

CYSTARAN

Products Affected

- CYSTARAN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Patient has a diagnosis of cystinosis AND Patient has corneal cystine crystal accumulation
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	None

DICLOFENAC TOPICAL

Products Affected

- *diclofenac sodium transdermal gel 3 %*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Diclofenac 3% gel: Diagnosis of actinic keratosis
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	None

DRONABINOL

Products Affected

- *dronabinol*
- SYNDROS

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	A. The diagnosis is documented as anorexia associated with weight loss in a patient with AIDS a. AND the patient has had an involuntary weight loss of greater than 10% of pre-illness baseline body weight or a body mass index (BMI) less than 20kg/m2 in the absence of a concurrent illness or medical condition other than HIV that may cause weight loss b. AND the patient has failed to respond to a 30-day drug regimen of megestrol (Megace) c. AND if the patient has received previous dronabinol therapy, he/she must show a positive response to therapy by maintaining or increasing their initial weight and/or muscle mass before initiating dronabinol therapy. B. The diagnosis is documented as nausea and vomiting associated with cancer chemotherapy in a cancer patient a. AND the patient is receiving a chemotherapy or radiation regimen b. AND the patient has had a full trial and failure through at least one cycle of chemotherapy with IV ondansetron AND at least one of the following oral anti-emetic agents: metoclopramide, promethazine, prochlorperazine, meclizine, trimethobenzamide, oral 5-HT3 receptor antagonists e. AND if the patient has received previous dronabinol therapy, he/she must show a positive response by showing a reduced incidence of emesis and/or nausea.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	6 months
Other Criteria	B vs D coverage determination per CMS guidelines

ELAPRASE

Products Affected

- ELAPRASE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Diagnosis confirmed by DNA testing or enzymatic analysis (deficiency of iduronate 2-sulfatase enzyme activity).
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	None

EMPLICITI

Products Affected

- EMPLICITI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Diagnosis of Multiple myeloma and used in combination with lenalidomide and dexamethasone in patients who have received 1 to 3 prior therapies.
Age Restrictions	None
Prescriber Restrictions	Oncologist
Coverage Duration	Plan Year
Other Criteria	This criteria applies to New Starts only.

ENBREL

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Concomitant use with another biologic, active infection (including TB).
Required Medical Information	Screening for latent TB infection and assessment for Hep B risk. For positive latent TB, patient must have completed treatment or is currently receiving treatment for LTBI. HBV infection ruled out or treatment initiated for positive infection. Rheumatoid arthritis - Must have one of following: 1) inadequate response to methotrexate (MTX), 2) inadequate response to another nonbiologic DMARD (e.g., leflunomide, hydroxychloroquine, sulfasalazine) if contraindicated or intolerant to MTX, 3) intolerance or contraindication to at least 2 nonbiologic DMARDs or, 4) use Humira as first-line therapy with MTX for severely active RA. Polyarticular JIA - Must have an inadequate response to at least one nonbiologic DMARD or intolerance/contraindication to at least 2 nonbiologic DMARDs. Psoriatic arthritis with predominantly peripheral symptoms - Must have an inadequate response to at least an 8-week maximum tolerated dose trial of at least 1 nonbiologic DMARD unless contraindicated or intolerant to such therapy. For plaque psoriasis - Must have more than 5% BSA affected or has crucial body areas (e.g., feet, hands, face, or genitals) affected. Must have an inadequate response to at least a 60-day trial of 2 conventional therapies (e.g., phototherapy, calcipotriene, MTX, acitretin) unless contraindicated or intolerant to such therapies. Crohn's disease - Must have an inadequate response to at least a 60-day trial of 2 conventional therapies (e.g., sulfasalazine, mesalamine, azathioprine, corticosteroids) unless contraindicated or intolerant to such therapies OR an inadequate response or intolerance to either Remicade or Cimzia.
Age Restrictions	For psoriasis, patient must be 18 years of age or older
Prescriber Restrictions	None

PA Criteria	Criteria Details
Coverage Duration	Plan Year
Other Criteria	For continuation of therapy, patient's condition must have improved or stabilized. This criteria applies to New Starts only.

ENDARI

Products Affected

- ENDARI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of acute sickle cell disease AND patient must have trial history of Hydroxyurea. Otherwise Endari requires documentation of (1) history of inadequate treatment with Hydroxyurea OR (2) history of adverse event with Hydroxyurea OR (3) Hydroxyurea is contraindicated.
Age Restrictions	5 years of age and older
Prescriber Restrictions	None
Coverage Duration	Plan year
Other Criteria	None

ENTRESTO

Products Affected

- ENTRESTO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	History of angioedema related to previous ACE inhibitor or ARB therapy, concomitant use or use within 36 hours of ACE inhibitors, concomitant use of aliskiren in patients with diabetes
Required Medical Information	Statement of diagnosis indicating Heart Failure (NYHA Class II through IV).
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	Plan year
Other Criteria	None

EPO

Products Affected

- PROCRIT

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Uncontrolled hypertension
Required Medical Information	For use in an anemic patient prior to surgery. For other indications, all of the following criteria are required: 1) The pretreatment Hgb is less than or equal to 10 g/dL for initial authorization. 2) Dose reduction or interruption if hemoglobin exceeds 10g/dL (CKD not on dialysis-adult, cancer), 11 g/dL (CKD on dialysis), 12 g/dL (pediatic CKD) 3) Once on therapy for 12 weeks, the hemoglobin must increase at least 1 g/dL in response to epoetin alfa.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 weeks
Other Criteria	None

ERLEADA

Products Affected

- ERLEADA

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

ERWINAZE

Products Affected

- ERWINAZE INJECTION

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	Oncologist or hematologist
Coverage Duration	Plan Year
Other Criteria	Patient has developed hypersensitivity to E. coli-derived asparaginase. This criteria applies to New Starts only.

ESBRIET

Products Affected

- ESBRIET

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Appropriate diagnosis (idopathic pulmonary fibrosis [IPF]), monitoring (hepatiac function/LFTs)
Age Restrictions	none
Prescriber Restrictions	pulmonologist
Coverage Duration	Plan Year
Other Criteria	None

EXJADE

Products Affected

- EXJADE

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

FABRAZYME

Products Affected

- FABRAZYME

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Diagnosis confirmed with an enzyme assay measuring a deficiency of alpha-galactosidase enzyme activity or DNA testing.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	None

FARYDAK

Products Affected

- FARYDAK

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Diagnosis of Multiple Myeloma (MM) Used in combination with both of the following: Velcade (bortezomib) and dexamethasone. Patient has received at least two prior treatment regimens which included both of the following: Velcade (bortezomib) and an immunomodulatory agent [eg, Revlimid (lenalidomide), Thalomid (thalidomide)].
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist/hematologist
Coverage Duration	Plan Year
Other Criteria	This criteria applies to New Starts only.

FORTEO

Products Affected

- FORTEO SUBCUTANEOUS SOLUTION 600 MCG/2.4ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Patient meets one of the following criteria: 1) Patient has experienced a prior fragility fracture, or 2) Patient had an inadequate response to an adequate trial of a bisphosphonate (one year) or patient has a contraindication or intolerance to bisphosphonate trial, or 3) Patient has 2 of the following risk factors for fracture: advanced age, parental history of fracture, low body mass index, current smoker, chronic alcohol use, rheumatoid arthritis, chronic steroid use, or other secondary cause of osteoporosis.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	None

GILENYA

Products Affected

- GILENYA ORAL CAPSULE 0.5 MG

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

GILOTRIF

Products Affected

- GILOTRIF

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Supporting statement of diagnosis of metastatic non-small cell lung cancer (NSCLC) from the physician in patients with EGFR exon 19 deletions or exon 21 (L858R) substitution as detected by an FDA-approved test OR Treatment of previously treated metastatic squamous cell NSCLC that has progressed following platinum-based chemotherapy
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	Plan Year
Other Criteria	This criteria applies to New Starts only.

GOCOVRI

Products Affected

- GOCOVRI

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

GONADOTROPIN

Products Affected

- *chorionic gonadotropin intramuscular*
- NOVAREL INTRAMUSCULAR SOLUTION RECONSTITUTED 5000 UNIT

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Fertility indications in females are excluded.
Required Medical Information	Diagnosis of Hypogonadotrophic hypogonadism or Prepubertal cryptorchidism
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	None

GROWTH HORMONE

Products Affected

- NORDITROPIN FLEXPRO

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	For pediatric GHD in neonate with hypoglycemia: patient has a randomly assessed GH level less than 20 ng/mL, other causes of hypoglycemia have been ruled out, and other treatments have been ineffective. For all pediatric patients: patients have short stature or slow growth velocity and have been evaluated for other causes of growth failure. For pediatric GHD, patient has delayed bone age. For pediatric GHD without pituitary disease, patient failed 2 stimulation tests. For pediatric GHD with a pituitary or CNS disorder, patient has clinical evidence of GHD and low IGF-1/IGFBP3. For TS and SHOX patients: diagnosis confirmed by genetic testing. For CRI patients: metabolic, endocrine and nutritional abnormalities have been treated or stabilized and patient has not had a kidney transplant. For SGA: patient has a low birth weight or length for gestational age. For ISS: pediatric GHD has been ruled out with one stimulation test. For adult GHD, patient was assessed for other causes of GHD-like symptoms. For adult GHD without pituitary disease, patient failed 2 stimulation tests. For adult GHD with at least 3 pituitary hormone deficiencies (PHD) or panhypopituitarism: have a low IGF-1. For adult GHD with less than 3 PHD, low IGF-1 and failed one stimulation test. For renewal for adult patients: patient has seen clinical improvement and IGF-1 will be monitored.
Age Restrictions	For Turner syndrome and SGA, 2 years of age and older. For Noonan syndrome and SHOX, 3 years of age and older.
Prescriber Restrictions	Endocrinologist, Pediatric Nephrologist, Gastroenterologist, Nutritional Support Specialist, Infectious Disease Specialist
Coverage Duration	Plan Year
Other Criteria	None

HEPATITIS C

Products Affected

- EPCLUSA
- MAVYRET
- ZEPATIER

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Must submit documentation of chronic hepatitis C genotype (confirmed by HCV RNA level within the last 6 months). Must submit laboratory results within 12 weeks of initiating therapy including: 1) CBC w Platelets, 2) AST/ALT, 3)Total Bilirubin, 4)Serum Albumin, 5)PT/INR, 6)Serum Creatinine, and 7)GFR. FOR GENOTYPES 1 and 4: Must include subtype, trail/failure, contraindication to, or intolerance to Zepatier or Mavyret prior to approval of Epclusa.
Age Restrictions	Patient must be age 18 or over.
Prescriber Restrictions	Prescriber must be a gastroenterologist, hepatologist, or infectious disease specialist
Coverage Duration	Duration of approval per AASLD Guidelines
Other Criteria	None

HEPSERA

Products Affected

- *adefovir dipivoxil*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	A. The patient has been diagnosed with chronic hepatitis B. B. AND the patient has evidence of a positive HBsAg (+ or -) serological marker for greater than 6 months OR evidence by a liver biopsy showing chronic hepatitis. C. AND the patient has a Hepatitis B viral load greater than 20,000 IU/mL (100,000 copies per mL) except if for HBeAg-negative HBV, the viral load is greater than 2,000 IU per mL (10,000 copies per mL). D. AND the patient has elevations in liver aminotransferases (ALT or AST) that are two (2) times greater than normal OR normal liver aminotransferase (ALT or AST) levels with evidence of significant disease found on biopsy. E. AND the patient is not receiving Intron A. F. AND documented evidence of diagnosis, serological markers or liver biopsy, viral load and liver aminotransferases. G. If the patient has received previous Adefovir Dipivoxil treatment, there is documented clinical improvement shown by a drop in viral load or reduction in the patient's liver aminotransferases. H. If patient has renal impairment dose to be reduced to 10mg every 48 hours for CrCl 30 to 49mL/min, 10mg every 72 hours for CrCl 10 to 29mL/min. I. Patient not to be taking tenofovir or PMPA concurrently.
Age Restrictions	12 years and older
Prescriber Restrictions	Gastroenterologist or infectious disease specialist or affiliated with an infectious disease or gastroenterology practice, or a primary care physician with experience in treating HBV.
Coverage Duration	Plan Year
Other Criteria	None

HETLIOZ

Products Affected

- HETLIOZ

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

HRM - ADHD

Products Affected

- *guanfacine hcl oral*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	For patients greater than or equal to 65 years, coverage determination is approved for FDA-approved indications not otherwise excluded from Part D.
Age Restrictions	For patients less than or equal to 64 years, claim will automatically pay.
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	None

HRM - ANALGESICS

Products Affected

- ASCOMP-CODEINE
- *butalbital-apap-caff-cod oral capsule 50-325-40-30 mg*
- *butalbital-apap-caffeine oral tablet 50-325-40 mg*
- *butalbital-asa-caff-codeine*
- *butalbital-aspirin-caffeine oral capsule*
- INDOCIN ORAL
- *indomethacin er*
- *indomethacin oral*
- *ketorolac tromethamine intramuscular solution 60 mg/2ml*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	For patients greater than or equal to 65 years, coverage determination is approved for FDA-approved indications not otherwise excluded from Part D.
Age Restrictions	For patients less than or equal to 64 years, claim will automatically pay.
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	None

HRM - ANTI-ARRHYTHMICS

Products Affected

- *disopyramide phosphate oral*
- NORPACE CR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	For patients greater than or equal to 65 years, coverage determination is approved for FDA-approved indications not otherwise excluded from Part D. Disopyramide: rate control preferred for atrial fibrillation
Age Restrictions	For patients less than or equal to 64 years, claim will automatically pay.
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	None

HRM - ANTIDEPRESSANTS

Products Affected

- *amitriptyline hcl oral*
- *clomipramine hcl oral*
- *doxepin hcl oral*
- *imipramine hcl oral*
- *imipramine pamoate*
- *trimipramine maleate oral*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	For patients greater than or equal to 65 years, coverage determination is approved for FDA-approved indications not otherwise excluded from Part D.
Age Restrictions	For patients less than or equal to 64 years, claim will automatically pay.
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	This criteria applies to New Starts only.

HRM - ANTIEMETIC DRUGS

Products Affected

- *hydroxyzine hcl intramuscular*
- *hydroxyzine hcl oral syrup*
- *hydroxyzine hcl oral tablet*
- *hydroxyzine pamoate oral*
- *promethazine hcl injection*
- *promethazine hcl oral syrup*
- *promethazine hcl oral tablet*
- *promethazine hcl rectal*
- *trimethobenzamide hcl oral*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	For patients greater than or equal to 65 years, coverage determination is approved for FDA-approved indications not otherwise excluded from Part D. Formulary non HRM alternatives are as follows Nausea/Vomiting: granisetron, ondansetron_Allergic Reactions: levocetirizine
Age Restrictions	For patients less than or equal to 64 years, claim will automatically pay.
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	None

HRM - ANTIHISTAMINES

Products Affected

- *carbinoxamine maleate oral solution*
- *carbinoxamine maleate oral tablet 4 mg*
- *clemastine fumarate oral tablet 2.68 mg*
- *cyproheptadine hcl oral*
- *promethazine vc plain*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	For patients greater than or equal to 65 years, coverage determination is approved for FDA-approved indications not otherwise excluded from Part D.
Age Restrictions	For patients less than or equal to 64 years, claim will automatically pay.
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	None

HRM - ANTIHYPERTENSIVE AGENTS

Products Affected

- *methyldopa-hydrochlorothiazide*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	For patients greater than or equal to 65 years, coverage determination is approved for FDA-approved indications not otherwise excluded from Part D. Formulary non HRM alternatives are as follows Low dose thiazide or a second generation calcium channel blocker OR ACE inhibitor, ARB, beta-blocker or combination product based on specific chronic conditions
Age Restrictions	For patients less than or equal to 64 years, claim will automatically pay.
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	None

HRM - ANTIPARKINSON AGENTS

Products Affected

- *benztropine mesylate oral*
- *trihexyphenidyl hcl*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	For patients greater than or equal to 65 years, coverage determination is approved for FDA-approved indications not otherwise excluded from Part D.
Age Restrictions	For patients less than or equal to 64 years, claim will automatically pay.
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	None

HRM - ANTIPSYCHOTICS

Products Affected

- *perphenazine-amitriptyline*
- *thioridazine hcl oral*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	For patients greater than or equal to 65 years, coverage determination is approved for FDA-approved indications not otherwise excluded from Part D.
Age Restrictions	For patients less than or equal to 64 years, claim will automatically pay.
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	This criteria applies to New Starts only.

HRM - BARBITURATES

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	For patients greater than or equal to 65 years, coverage determination is approved for FDA-approved indications not otherwise excluded from Part D. Formulary non HRM alternatives are as follows a) ANXIETY: (citalopram, escitalopram, fluvoxamine, sertraline, duloxetine, venlafaxine, buspirone). b) INSOMNIA: low dose trazodone)
Age Restrictions	For patients less than or equal to 64 years, claim will automatically pay.
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	This criteria applies to New Starts only.

HRM - DEMENTIA AGENTS

Products Affected

- *ergoloid mesylates oral*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	For patients greater than or equal to 65 years, coverage determination is approved for FDA-approved indications not otherwise excluded from Part D. Formulary non HRM alternatives are as follows Antidementia: donepezil,galantamine,Namenda XR,rivastigmine capsule, rivastigmine patch.
Age Restrictions	For patients less than or equal to 64 years, claim will automatically pay.
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	None

HRM - ONCOLOGY

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	For patients greater than or equal to 65 years, coverage determination is approved for FDA-approved indications not otherwise excluded from Part D. Formulary non HRM alternatives for diagnosis of cachexia secondary to chronic illness (dronabinol, oxandrolone)
Age Restrictions	For patients less than or equal to 64 years, claim will automatically pay.
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	This criteria applies to New Starts only.

HRM - ORAL AND TRANSDERMAL ESTROGENS AND PROGESTINS

Products Affected

- CLIMARA PRO
- COMBIPATCH
- DIVIGEL TRANSDERMAL GEL 0.5 MG/0.5GM, 1 MG/GM
- DUAVEE
- *estradiol oral*
- *estradiol transdermal*
- *estradiol-norethindrone acet*
- *estropipate oral tablet 0.75 mg*
- EVAMIST
- FYAVOLV
- JINTELI
- MENEST ORAL TABLET 0.3 MG, 0.625 MG, 1.25 MG
- MENOSTAR
- *norethindrone-eth estradiol oral tablet 1-5 mg-mcg*
- PREFEST
- PREMARIN INJECTION
- PREMARIN ORAL
- PREMPHASE
- PREMPRO

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	For patients greater than or equal to 65 years, coverage determination is approved for FDA-approved indications not otherwise excluded from Part D. Formulary non HRM alternatives are as follows Localized options: Premarin Cream and Estrace Cream. Osteoporosis: Alendronate, Risedronate, Zoledronic Acid.
Age Restrictions	For patients less than or equal to 64 years, claim will automatically pay.
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	None

HRM - PLATELET INHIBITORS

Products Affected

- *dipyridamole oral*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	For patients greater than or equal to 65 years, coverage determination is approved for FDA-approved indications not otherwise excluded from Part D. Formulary non HRM alternatives are as follows Platelet Inhibitors: Cilostazol, Clopidogrel.
Age Restrictions	For patients less than or equal to 64 years, claim will automatically pay.
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	None

HRM - SEDATIVE HYPNOTIC AGENTS

Products Affected

- EDLUAR
- *eszopiclone*
- *zaleplon*
- *zolpidem tartrate er*
- *zolpidem tartrate oral*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	For patients greater than or equal to 65 years, coverage determination is approved for FDA-approved indications not otherwise excluded from Part D.
Age Restrictions	For patients less than or equal to 64 years, claim will automatically pay.
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	None

HRM - SKELETAL MUSCLE RELAXANTS

Products Affected

- *chlorzoxazone oral tablet 500 mg*
- *cyclobenzaprine hcl oral*
- *metaxalone oral tablet 800 mg*
- *methocarbamol oral*
- *orphenadrine citrate er*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	For patients greater than or equal to 65 years, coverage determination is approved for FDA-approved indications not otherwise excluded from Part D.
Age Restrictions	For patients less than or equal to 64 years, claim will automatically pay.
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	None

HUMIRA

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Active infection (including TB), concurrent use with other biologics.
Required Medical Information	Screening for latent TB infection and assessment for Hep B risk. For positive latent TB, patient must have completed treatment or is currently receiving treatment for LTBI. HBV infection ruled out or treatment initiated for positive infection. Rheumatoid arthritis - Must have one of following: 1) inadequate response to methotrexate (MTX), 2) inadequate response to another nonbiologic DMARD (e.g., leflunomide, hydroxychloroquine, sulfasalazine) if contraindicated or intolerant to MTX, 3) intolerance or contraindication to at least 2 nonbiologic DMARDs or, 4) use Humira as first-line therapy with MTX for severely active RA. Polyarticular JIA - Must have an inadequate response to at least one nonbiologic DMARD or intolerance/contraindication to at least 2 nonbiologic DMARDs. Psoriatic arthritis with predominantly peripheral symptoms - Must have an inadequate response to at least an 8-week maximum tolerated dose trial of at least 1 nonbiologic DMARD unless contraindicated or intolerant to such therapy. For plaque psoriasis - Must have more than 5% BSA affected or has crucial body areas (e.g., feet, hands, face, or genitals) affected. Must have an inadequate response to at least a 60-day trial of 2 conventional therapies (e.g., phototherapy, calcipotriene, MTX, acitretin) unless contraindicated or intolerant to such therapies. Crohn's disease - Must have an inadequate response to at least a 60-day trial of 2 conventional therapies (e.g., sulfasalazine, mesalamine, azathioprine, corticosteroids) unless contraindicated or intolerant to such therapies OR an inadequate response or intolerance to either Remicade or Cimzia.
Age Restrictions	For psoriasis, patient must be 18 years of age and older
Prescriber Restrictions	None

PA Criteria	Criteria Details
Coverage Duration	Initial: 3 months for Crohn's disease and plan year for all other indications Renewal: Plan Year
Other Criteria	For re-authorization, patient's condition must have improved or stabilized. This criteria applies to New Starts only.

HUMIRA PEDIATRIC

Products Affected

- HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Active infection (including TB), concurrent use with other biologics.
Required Medical Information	Screening for latent TB infection and assessment for Hep B risk. For positive latent TB, patient must have completed treatment or is currently receiving treatment for LTBI. HBV infection ruled out or treatment initiated for positive infection. Polyarticular JIA - Must have an inadequate response to at least one nonbiologic DMARD or intolerance/contraindication to at least 2 nonbiologic DMARDs. Crohn's disease - Must have an inadequate response to at least a 60-day trial of 2 conventional therapies (e.g., sulfasalazine, mesalamine, azathioprine, corticosteroids) unless contraindicated or intolerant to such therapies OR an inadequate response or intolerance to either Remicade or Cimzia.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Initial: 3 months for Crohn's disease and plan year for all other indications Renewal: Plan Year
Other Criteria	For re-authorization, patient's condition must have improved or stabilized. This criteria applies to New Starts only.

HYDROXYPROGESTERONE CAPROATE

Products Affected

- *hydroxyprogesterone caproate intramuscular solution*

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

IBRANCE

Products Affected

- IBRANCE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Appropriate diagnosis (used in combination with an aromatase inhibitor for the treatment of postmenopausal women with hormone receptor HR-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced breast cancer OR diagnosis of the treatment of HR-positive, HER2-negative advanced or metastatic breast cancer in combination with fulvestrant in women with disease progression following endocrine therapy.)
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Plan Year
Other Criteria	This criteria applies to New Starts only.

ICLUSIG

Products Affected

- ICLUSIG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Diagnosis of chronic phase, accelerated phase, or blast phase chronic myeloid leukemia (CML) in adult patients who are T315I-positive or for whom no other tyrosine kinase inhibitor therapy is indicated OR Diagnosis of Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ ALL) in adult patients who are T315I-positive or for whom no other tyrosine kinase inhibitor therapy is indicated
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist
Coverage Duration	Plan Year
Other Criteria	This criteria applies to New Starts only.

IDHIFA

Products Affected

- IDHIFA

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

IMBRUVICA

Products Affected

- IMBRUVICA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Supporting statement of diagnosis from the physician
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	This criteria applies to New Starts only.

IMFINZI

Products Affected

- IMFINZI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of locally advanced or metastatic urothelial carcinoma. Patients must have progressed on or following platinum-containing chemotherapy, OR within 12 months of neoadjuvant or adjuvant platinum containing chemotherapy
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a oncologist
Coverage Duration	Plan year
Other Criteria	This criteria applies to New Starts only.

INCRELEX

Products Affected

- INCRELEX

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Closed epiphyses. Active or suspected malignancy. IV administration of Increlex.
Required Medical Information	Prior to starting therapy, a height greater than 3 SD below the mean for chronological age and sex, and an IGF-1 level greater than or equal to 3 SD below the mean for chronological age and gender. One stimulation test showing patient has a normal or elevated GH level.
Age Restrictions	Between 2 and 20 years of age
Prescriber Restrictions	Endocrinologist
Coverage Duration	Plan Year
Other Criteria	None

INTRAROSA

Products Affected

- INTRAROSA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Vaginal bleeding or dysfunctional uterine bleeding of an undetermined origin, known or suspected estrogen-dependent neoplasia.
Required Medical Information	Diagnosis of moderate to severe dyspareunia or atrophic vaginitis due to menopause.
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	Plan year
Other Criteria	None

ITRACONAZOLE

Products Affected

- *itraconazole oral capsule*
- SPORANOX ORAL SOLUTION

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	A. ventricular dysfunction (e.g., congestive heart failure (CHF) or history of CHF) do not use for onychomycosis. B. If the patient is taking/receiving any of the following: concomitant use with drugs metabolized by CYP3A4 (e.g., cisapride, dofetilide, pimozide, quinidine)
Required Medical Information	Patients with a diagnosis of blastomycosis, pulmonary or extrapulmonary OR patients with a diagnosis of histoplasmosis, including chronic cavitary pulmonary disease or disseminated, non-meningeal histoplasmosis OR patients with a diagnosis of aspergillosis, pulmonary or extrapulmonary OR patients with a diagnosis of onychomycosis of the toenail, with or without fingernail involvement, due to dermatophytes (tinea unguium) OR patients with a diagnosis of onychomycosis of the fingernail due to dermatophytes (tinea unguium). For onychomycosis, diagnosis has been confirmed with a fungal diagnostic test (e.g., KOH preparation, fungal culture, or nail biopsy).
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 weeks
Other Criteria	None

IVIG

Products Affected

- CARIMUNE NF INTRAVENOUS SOLUTION RECONSTITUTED 6 GM
- GAMMAGARD INJECTION SOLUTION 2.5 GM/25ML
- GAMMAGARD S/D LESS IGA
- GAMMAPLEX INTRAVENOUS SOLUTION 10 GM/100ML, 10 GM/200ML, 20 GM/200ML, 5 GM/50ML
- GAMUNEX-C INJECTION SOLUTION 1 GM/10ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	IgA deficiency with antibody formation and a history of hypersensitivity. History of anaphylaxis or severe systemic reaction to human immune globulin. Presence of risk factor(s) for acute renal failure, unless the patient will receive IGIV products at the minimum concentration available and at the minimum rate of infusion practicable.
Required Medical Information	None
Age Restrictions	None
Prescriber Restrictions	CIDP diagnosis by a neurologist
Coverage Duration	Plan Year
Other Criteria	Gamunex/Gamunex-C: if administered SC outside of a controlled healthcare setting, appropriate treatment (eg, anaphylaxis kit) should be available for managing an acute hypersensitivity reaction.

JUXTAPID

Products Affected

- JUXTAPID

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Moderate to severe liver impairment or active liver disease including unexplained persistent abnormal liver function tests. Pregnancy. Concomitant use with strong or moderate CYP3A4 inhibitors.
Required Medical Information	Diagnosis of homozygous familial hypercholesterolemia AND Patient has tried and had an inadequate response or intolerance to statins
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	None

KALYDECO

Products Affected

- KALYDECO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Cystic Fibrosis (Initial): Diagnosis of cystic fibrosis AND the patient has 1 mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to Kalydeco potentiation based on clinical and/or in vitro assay data. (Reauthorization): Documentation of one of the following while on Kalydeco therapy: Improved lung function or stable lung function.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	None

KANUMA

Products Affected

- KANUMA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Diagnosis of Lysosomal acid lipase deficiency
Age Restrictions	None
Prescriber Restrictions	prescribed by hepatologist
Coverage Duration	Plan Year
Other Criteria	None

KEYTRUDA

Products Affected

- KEYTRUDA INTRAVENOUS SOLUTION

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Diagnosis of unresectable or metastatic melanoma OR first-line treatment of metastatic non-small cell lung cancer (NSCLC) in patients with high PD-L1 expressing tumors and with no EGFR or ALK genomic tumor aberrations OR treatment of metastatic NSCLC in patients with PD-L1 expression who have disease progression on or after platinum-containing chemotherapy (patients with EGFR or ALK genomic tumor aberrations should have disease progression on approved therapy for these aberrations prior to receiving Keytruda) OR recurrent or metastatic squamous cell carcinoma of the head and neck in patients with disease progression on or after platinum-containing chemotherapy OR treatment of adult or pediatric patients with classical Hodgkin lymphoma (in patients who are refractory or who have relapsed after 3 or more prior lines of therapy) OR first-line treatment (in combination with pemetrexed plus carboplatin) of metastatic nonsquamous NSCLC 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 treatment of patients with recurrent locally advanced or metastatic gastric or gastroesophageal junction adenocarcinoma whose tumors express PD-L1 as determined by an FDA-approved test with disease progression on or after two or more prior lines of therapy including fluoropyrimidine-and platinum-containing chemotherapy and if appropriate HER2 neu-targeted therapy.
Age Restrictions	None
Prescriber Restrictions	None

PA Criteria	Criteria Details
Coverage Duration	Plan Year
Other Criteria	This criteria applies to New Starts only.

KINERET

Products Affected

- KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Active infection, concurrent therapy with other biologics.
Required Medical Information	Must have one of following: 1) inadequate response to methotrexate (MTX), 2) inadequate response to another nonbiologic DMARD (e.g., leflunomide, hydroxychloroquine, sulfasalazine) if contraindicated or intolerant to MTX, 3) intolerance or contraindication to at least 2 nonbiologic DMARDs or, 4) use Kineret as first-line therapy with MTX for severely active RA. For Diagnosis of CAPs, Kineret will be approved.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	For re-authorization, patient's condition must have improved or stabilized. This criteria applies to New Starts only.

KISQALI

Products Affected

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

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

KORLYM

Products Affected

- KORLYM

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

KUVAN

Products Affected

- KUVAN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Blood phenylalanine (Phe) levels. Pretreatment blood phenylalanine (Phe) levels greater than 10mg/dL if the patient is older than 12 years of age or greater than 6mg/dL if less than or equal to 12 years of age. Response to a therapeutic trial (greater than or equal to a 30% reduction in blood Phe levels) is required for long-term authorization.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Initial: 2 months. Renewal: 12 months.
Other Criteria	Blood Phe levels should be checked after 1 week of therapy and periodically up to one month during a therapeutic trial.

KYNAMRO

Products Affected

- KYNAMRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Moderate to severe liver impairment or active liver disease including unexplained persistent abnormal liver function tests.
Required Medical Information	Diagnosis of homozygous familial hypercholesterolemia AND Patient has tried and had an inadequate response or intolerance to statins
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Initial - 6 months. Renewal - 12 months
Other Criteria	For renewal, patient has responded to therapy with a decrease in LDL levels.

LARTRUVO

Products Affected

- LARTRUVO

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

LETAIRIS

Products Affected

- LETAIRIS

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Pregnancy
Required Medical Information	Diagnosis of pulmonary arterial hypertension that was confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.) AND Patient has WHO Group I PAH AND pregnancy must be excluded prior to the start of therapy. Female patients of childbearing age will be educated about the potential hazards associated with Letairis use in pregnancy.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	IUD (intrauterine device) or two appropriate contraceptive methods will be used for women of childbearing potential. This criteria applies to New Starts only.

LEUKINE

Products Affected

- LEUKINE INTRAVENOUS

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Administration within 24 hours preceding or following chemotherapy or radiotherapy, hypersensitivity to yeast-derived products. For prophylaxis of febrile neutropenia: use to increase the chemotherapy dose intensity or dose schedule above established regimens. For treatment of febrile neutropenia, when patient receives Neulasta during the current chemotherapy cycle. For AML only, excessive (greater than or equal to 10%) leukemic myeloid blasts in the bone marrow or peripheral blood.
Required Medical Information	For patients with nonmyeloid malignancies receiving myelosuppressive chemotherapy: Leukine may be used for the prevention of chemotherapy-induced febrile neutropenia if the patient experienced febrile neutropenia with a prior chemotherapy cycle OR the patient is at high risk (greater than 20%) or intermediate risk (10-20%) for developing febrile neutropenia. Patients at low risk (less than 10%) for developing febrile neutropenia may also receive Leukine for prophylaxis if there is a significant risk for serious medical consequences due to febrile neutropenia and the intent of chemotherapy is to prolong survival or cure the disease. Leukine is allowable for the treatment of febrile neutropenia in patients who have received prophylaxis with Leukine (or Neupogen) OR in patients at risk for infection-related complications. All patients must receive baseline and regular monitoring of complete blood counts and platelet counts.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	6 months
Other Criteria	None

LIDOCAINE TD

Products Affected

- *lidocaine external patch 5 %*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Supporting statement of diagnosis from the physician
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	For the FDA-labeled indication of post-herpetic neuralgia, no additional criteria are required to be met. For diabetic neuropathy: the patient must have previous use and inadequate response or intolerance to any ONE neuropathic pain medication, including (but not limited to) Cymbalta and Lyrica that are labeled for neuropathic pain.

LUPRON

Products Affected

- *leuprolide acetate injection*
- LUPRON DEPOT (1-MONTH)
- LUPRON DEPOT (3-MONTH) INTRAMUSCULAR KIT 11.25 MG, 22.5 MG
- LUPRON DEPOT (4-MONTH)
- LUPRON DEPOT (6-MONTH)
- LUPRON DEPOT-PED (1-MONTH) INTRAMUSCULAR KIT 11.25 MG, 15 MG
- LUPRON DEPOT-PED (3-MONTH) INTRAMUSCULAR KIT 30 MG (PED)

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

LYNPARZA

Products Affected

- LYNPARZA

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

MAKENA

Products Affected

- MAKENA

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

METHYLPHENIDATES

Products Affected

- DAYTRANA TRANSDERMAL PATCH 15 MG/9HR
- *methylphenidate hcl er (cd)*
- *methylphenidate hcl er (la)*
- *methylphenidate hcl er oral tablet extended release 18 mg, 20 mg, 27 mg, 36 mg, 54 mg, 72 mg*
- *methylphenidate hcl er oral tablet extended release 24 hour*
- *methylphenidate hcl oral solution*
- *methylphenidate hcl oral tablet*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	MAOI concurrent use or within the last 14 days
Required Medical Information	Sleep studies for narcolepsy diagnosis
Age Restrictions	6 years of age and older
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	Consider benefits of use versus the potential risks of serious cardiovascular events.

MODAFINIL

Products Affected

- *modafinil*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Diagnosis of excessive sleepiness associated with obstructive sleep apnea (OSA)/hypopnea syndrome OR Diagnosis of excessive sleepiness associated with narcolepsy and patient has tried, 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
Age Restrictions	17 years of age or older
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	None

MOZOBIL

Products Affected

- MOZOBIL

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

MS INTERFERONS

Products Affected

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

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

MYLOTARG

Products Affected

- MYLOTARG INTRAVENOUS SOLUTION RECONSTITUTED 4.5 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	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
Age Restrictions	Relapsed of refractory AML: 2 years and older, Newly diagnosed AML: 18 years and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	This criteria applies to New Starts only.

NAGLAZYME

Products Affected

- NAGLAZYME

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Diagnosis confirmed by DNA testing or an enzymatic assay showing a deficiency in N-acetylgalactosamine activity. Patient must have at least one MPS VI symptom. For re-authorization of Naglazyme, patient must demonstrate improvement in walking and/or stair-climbing capacity.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	None

NERLYNX

Products Affected

- NERLYNX

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

NEULASTA

Products Affected

- NEULASTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Treatment for febrile neutropenia, known hypersensitivity to filgrastim, use in the period 14 days before and 24 hours after administration of chemotherapy, use in patients with myeloid malignancy, use to increase the chemotherapy dose intensity or dose schedule beyond established regimens.
Required Medical Information	For patients with non-myeloid malignancies receiving myelosuppressive chemotherapy: Neulasta may be used for the prevention of chemotherapy-induced febrile neutropenia if the patient experienced febrile neutropenia with a prior chemotherapy cycle OR the patient is at high risk (greater than 20%) or intermediate risk (10-20%) for developing febrile neutropenia. Patients at low risk (less than 10%) for developing febrile neutropenia may also receive Neulasta prophylaxis if there is a significant risk for serious medical consequences due to febrile neutropenia and the intent of chemotherapy is to prolong survival or cure the disease. All patients must receive baseline and regular monitoring of complete blood counts and platelet counts.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	6 months
Other Criteria	None

NEUPOGEN

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Administration within 24 hours preceding or following chemotherapy or radiotherapy, E coli hypersensitivity. For prophylaxis of febrile neutropenia: use to increase the chemotherapy dose intensity or dose schedule beyond established regimen. For treatment of febrile neutropenia, when patient receives Neulasta during the current chemotherapy cycle.
Required Medical Information	For patients with nonmyeloid malignancies receiving myelosuppressive chemotherapy: Neupogen or Zarxio may be used for the prevention of chemotherapy-induced febrile neutropenia if the patient experienced febrile neutropenia with a prior chemotherapy cycle OR the patient is at high risk (greater than 20%) or intermediate risk (10-20%) for developing febrile neutropenia. Patients at low risk (less than 10%) for developing febrile neutropenia may receive Neupogen or Zarxio for prophylaxis if there is a significant risk for serious medical consequences due to febrile neutropenia and the intent of chemotherapy is to prolong survival or cure the disease. Neupogen or Zarxio is allowable for the treatment of febrile neutropenia in patients who have received prophylaxis with Neupogen or Zarxio (or Leukine) OR in patients at risk for infection-related complications. All patients must receive baseline and regular monitoring of complete blood counts and platelet counts.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	6 months
Other Criteria	None

NORTHERA

Products Affected

- NORTHERA

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

NUCALA

Products Affected

- NUCALA

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

NUEDEXTA

Products Affected

- NUEDEXTA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Patient diagnosis of pseudobulbar affect.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	None

NUPLAZID

Products Affected

- NUPLAZID

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

OCTREOTIDE

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	None

OPDIVO

Products Affected

- OPDIVO INTRAVENOUS SOLUTION
  100 MG/10ML, 40 MG/4ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Diagnosis of 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 OR adjuvant treatment of melanoma in patients with lymph node involvement or metastatic disease who have undergone complete resection 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 in combination with ipilimumab OR as monotherapy in patients 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 after autologous hematopoietic stem cell transplant (HSCT) and brentuximab vedotin OR classical Hodgkin lymphoma that has relapsed or progressed after 3 or more lines of systemic therapy that includes an autologous hematopoietic stem cell transplantation (HSCT) OR locally advanced or metastatic urothelial carcinoma in patients with disease progression on or following platinum-containing therapy or within 12 months of neoadjuvant or adjuvant treatment with a platinum-containing therapy OR microsatellite instability-high or mismatch repair deficient metastatic colorectal cancer with progression after treatment of fluoropyrimidine, oxaliplatin, and irinotecan OR treatment of hepatocellular cancer, after disease progression on or intolerance to sorafenib therapy.
Age Restrictions	12 years of age or older
Prescriber Restrictions	None

PA Criteria	Criteria Details
Coverage Duration	Plan Year
Other Criteria	This criteria applies to New Starts only.

OPSUMIT

Products Affected

- OPSUMIT

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Supporting statement of diagnosis and relevant medical information from physician
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	This criteria applies to New Starts only.

ORAL FENTANYL

Products Affected

- *fentanyl citrate buccal*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patients taking strong or moderate cytochrome P450 3A4 inhibitor(s) (e.g., aprepitant, clarithromycin, diltiazem, erythromycin, fosamprenavir, fluconazole, itraconazole, ketoconazole, nefazodone, nelfinavir, ritonavir, verapamil) who will not be monitored or have dosing adjustments made if necessary.
Required Medical Information	None
Age Restrictions	16 years of age and older (fentanyl oral lozenge)
Prescriber Restrictions	None
Coverage Duration	6 months
Other Criteria	None

ORENCIA

Products Affected

- ORENCIA CLICKJECT
- ORENCIA INTRAVENOUS
- ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

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

ORKAMBI

Products Affected

- ORKAMBI ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Initial Therapy: Must have diagnosis of cystic fibrosis (CF) with documented homozygous F508del mutation confirmed by FDA-approved CF mutation test. Continuation of therapy: 1. Documentation patient is tolerating and responding to medication (i.e. improved FEV1, weight gain, decreased exacerbations, etc.)
Age Restrictions	6 years of age or older
Prescriber Restrictions	Must be prescribed by, or in conjunction with, a pulmonologist or is from a CF center accredited by the Cystic Fibrosis Foundation
Coverage Duration	Plan Year
Other Criteria	None

OSPHENA

Products Affected

- OSPHENA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Vaginal bleeding or dysfunctional uterine bleeding of an undetermined origin, known or suspected estrogen-dependent neoplasia, acute thromboembolism or a past history of thromboembolic disease (including patients with a history of DVT, pulmonary embolism, retinal vein thrombosis, stroke, or myocardial infarction, known or suspected pregnancy.
Required Medical Information	Diagnosis of moderate to severe dyspareunia or atrophic vaginitis due to menopause.
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	Plan year
Other Criteria	None

OXSORALEN

Products Affected

- *methoxsalen rapid*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Aphakia, melanoma, or invasive squamous cell carcinoma
Required Medical Information	The patient must be diagnosed with cutaneous T-cell lymphoma OR psoriasis AND if the diagnosis is psoriasis, the patient must have previous must have previous inadequate treatment response or intolerance or contraindication to at least one topical steroid.
Age Restrictions	None
Prescriber Restrictions	Dermatologist or Oncologist or affiliated with a dermatologist/oncologist practice
Coverage Duration	Plan Year
Other Criteria	None

PCSK9 INHIBITOR

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	FOR PRALUENT: MUST MEET CRITERIA #1 OR #3. FOR REPATHA: MUST MEET CRITERIA #1, #2 OR #3. 1. Diagnosis of heterozygous familial hypercholesterolemia (HeFH) confirmed by genotyping OR Simon Broome criteria: Total cholesterol greater than 290mg/dL or LDL cholesterol greater than 190mg/dL, PLUS ONE OF THE FOLLOWING: Tendon xanthomas in patient, or 1st degree relative (parent, sibling, child), or 2nd degree relative (grandparent, uncle, aunt) OR DNA-based evidence of LDL receptor mutation, familial defective apo B-100, or PCSK9 mutation 2a. Myocardial infarction prophylaxis, stroke prophylaxis, and to reduce risk of coronary revascularization in patients with established CVD OR 2b. Diagnosis of homozygous familial hypercholesterolemia (HoFH) confirmed by genotyping OR diagnosis based on the following: a. History of untreated LDL-C greater than 500 mg/dL AND xanthoma before 10 years of age OR b. Documentation of HeFH in both parents 3. Diagnosis of clinical atherosclerotic cardiovascular disease (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: 1. Documented response to Praluent or Repatha, defined as ONE of the following: a. The patient is tolerating medication b. Will continue to be used in combination with maximally tolerated statin (unless statin intolerant).
Age Restrictions	Repatha: 13 years of age or older for diagnosis HoFM, Diagnosis CVD or HeFH AND Praluent or Repatha : 18 years of age or older

PA Criteria	Criteria Details
Prescriber Restrictions	Must be prescribed by, or in consultation with, a cardiologist, endocrinologist, or lipid specialist
Coverage Duration	Initial approval: 8 weeks, Renewal approval: Plan Year
Other Criteria	None

PEGASYS

Products Affected

- PEGASYS PROCLICK
- PEGASYS SUBCUTANEOUS SOLUTION

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Decompensated liver disease. Autoimmune hepatitis. Concomitant administration of didanosine with ribavirin in patients coinfected with HIV.
Required Medical Information	Chronic hepatitis B: Diagnosis of chronic hepatitis B infection, and patient is without decompensated liver disease. Chronic Hepatitis C: Criteria will be applied consistent with current AASLD-IDSA guidance
Age Restrictions	HCV: 18 years of age or older if used as triple therapy, otherwise 5 years of age or older. Hepatitis B: 3 years of age or older.
Prescriber Restrictions	ID specialist, Gastroenterologist, Oncologist
Coverage Duration	HCV:12 weeks to 72 weeks total depending on genotype and initial vs. renewal therapy. HBV:48 weeks.
Other Criteria	Monitor for evidence of depression.

PROMACTA

Products Affected

- PROMACTA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	For new starts, at the time of diagnosis of ITP or hepatitis C infection associated thrombocytopenia, one of the following are required: 1) a pretreatment platelet count less than 30,000/microL or 2) a platelet count less than or equal to 50,000/microL with significant mucous membrane bleeding or risk factors for bleeding. Patients must be evaluated for other causes of thrombocytopenia and have had an insufficient response or intolerance to corticosteroids, or immunoglobulins, or splenectomy. For continuation of therapy, one of the following are required: 1) an increase in platelet count to greater than or equal to 50,000/microL or 2) an increase in platelet level that is sufficient to avoid clinically important bleeding after at least 4 weeks of Promacta at the maximum dose. For all patients receiving Promacta therapy, if platelets increase above 200,000/microL, therapy will be adjusted to maintain the minimal platelet count needed to reduce the risk for bleeding. Liver function must be assessed pretreatment and regularly throughout therapy. To continue Promacta therapy, alanine aminotransferase levels must not be greater than or equal to 3 times the upper limit of normal with any of the following characteristics: progressive, persistent, accompanied by increased bilirubin or symptoms of liver injury or evidence of hepatic decompensation.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	6 month initial, 12 month renewal if adequate platelet response, 3 month w/o platelet response
Other Criteria	None

RADICAVA

Products Affected

- RADICAVA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Sulfite hypersensitivity
Required Medical Information	Diagnosis of amyotrophic lateral sclerosis and must meet all of the following: functionality retained most activities of daily living (defined as scores of 2 points or better on each individual item of the ALS Functional Rating Scale, normal respiratory function defined as percent-predicted forced vital capacity values of percent FVC greater or equal to 80 percent, disease duration of 2 years or less).
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	12 months
Other Criteria	None

REGRANEX

Products Affected

- REGRANEX

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

RELISTOR

Products Affected

- RELISTOR SUBCUTANEOUS SOLUTION

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Mechanical gastrointestinal obstruction, known or suspected.
Required Medical Information	A. Relistor is being prescribed for treatment of 1) opioid-induced constipation in adult patients with chronic non-cancer pain OR 2) opioid-induced constipation in adult patients with advanced illness who are receiving palliative care, when response to laxative therapy has not been sufficient. AND B. patient must have previous trial/failure of polyethylene glycol.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	4 Months
Other Criteria	None

REVATIO

Products Affected

- *sildenafil citrate oral tablet 20 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Nitrate therapy
Required Medical Information	Diagnosis o f pulmonary arterial hypertension that was confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.) AND Patient has WHO Group I PAH
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	This criteria applies to New Starts only.

REVLIMID

Products Affected

- REVLIMID

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Pregnancy
Required Medical Information	Diagnosis of multiple myeloma and patient has received at least one prior therapy and medication will be used in combination with dexamethasone OR diagnosis of transfusion-dependent anemia due to low- or intermediate-1-risk myelodysplastic syndromes associated with a deletion 5q cytogenetic abnormality with or without additional cytogenetic abnormalities OR diagnosis of mantle cell lymphoma whose disease has relapsed or progressed after two prior therapies, one of which included bortezomib AND patient is enrolled in the Revlimid REMS Program
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	Male and female patients of child-bearing potential should be instructed on the importance of proper utilization of appropriate contraceptive methods for Revlimid use. Patients should be monitored for signs and symptoms of thromboembolism. This criteria applies to New Starts only.

REXULTI

Products Affected

- REXULTI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Statement of Diagnosis from the prescriber and documented trial and failure, contraindication, or intolerance to aripiprazole
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	This criteria applies to New Starts only.

RIBAVIRIN

Products Affected

- REBETOL ORAL SOLUTION
- RIBASPHERE ORAL TABLET 400 MG, 600 MG
- RIBASPHERE RIBAPAK
- *ribavirin oral capsule*
- *ribavirin oral tablet 200 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Hemoglobin less than 8.5 g/dL. Hemoglobinopathy. History of unstable heart disease. Creatinine clearance less than 50 mL/minute and unwilling to use modified dose of ribavirin. Pregnancy (self or partner).Unwilling to use effective contraception. Coadministration with didanosine in HIV coinfected patients.
Required Medical Information	Chart notes / written medical summary documenting diagnosis of Chronic HCV are required. Recent lab reports documenting elevated HCV RNA are required, along with genotype.
Age Restrictions	None
Prescriber Restrictions	ID specialist, gastroenterologist, or oncologist
Coverage Duration	12 weeks to a total 72 weeks depending on genotype and initial vs. renewal therapy.
Other Criteria	Patient has been instructed to practice effective contraception during therapy and for six months after stopping ribavirin therapy.

RITUXAN

Products Affected

- RITUXAN INTRAVENOUS SOLUTION

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	History of severe skin or infusion reaction with Rituxan than cannot be appropriately managed, use in combination with another biologic agent
Required Medical Information	For rheumatoid arthritis (RA): an inadequate response to MTX or another nonbiologic DMARD if MTX is contraindicated or not tolerated except when RA is severely active and frontline Rituxan therapy is warranted AND an inadequate response to a TNF antagonist (unless contraindicated). For continuation of RA therapy, improvement in clinical symptoms (may include improvement in tender and swollen joint count, mobility, or stiffness, or delay in progression of disease) is required from the last treatment course, which was at least 16 weeks earlier. Hematologic malignancies must be positive for CD20. Rituxan must be used in combination with chemotherapy for mantle cell lymphoma (or other agents), Burkitt's lymphoma, lymphoblastic lymphoma, and AIDS-related B-cell lymphoma. Induction therapy for Burkitt's lymphoma. Prior to initiating therapy, prescriber must have assessed the patient's risk for hepatitis B and, if appropriate, ruled out or initiated treatment for hepatitis B.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	Monitored for pulmonary toxicity. This criteria applies to New Starts only.

RUBRACA

Products Affected

- RUBRACA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	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. OR 2. 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.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Hematologist or Oncologist
Coverage Duration	Plan Year
Other Criteria	This criteria applies to New Starts only.

RYDAPT

Products Affected

- RYDAPT

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

SAMSCA

Products Affected

- SAMSCA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patients with anuria, patients requiring an urgent increase in serum sodium, patients unable to sense and respond to thirst, concomitant use of a strong CYP 3A inhibitor (e.g., clarithromycin, ketoconazole).
Required Medical Information	Treatment with Samsca is being initiated or re-initiated in a hospital where serum sodium can be monitored closely
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	30 days
Other Criteria	None

SANDOSTATIN LAR

Products Affected

- SANDOSTATIN LAR DEPOT

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Patient received initial treatment with Sandostatin Injection (not the Depot form) for at least 2 weeks and treatment with Sandostatin Injection was effective and tolerable.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	None

SEROSTIM

Products Affected

- SEROSTIM SUBCUTANEOUS SOLUTION RECONSTITUTED 4 MG, 5 MG, 6 MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Acute critical illness, active malignancy.
Required Medical Information	Patient is on concurrent antiretroviral therapy and alternative causes of wasting have been ruled out or treated appropriately. For continuation of therapy, patients treated for 12 or more weeks with Serostim must show a response to therapy (body mass index has improved or stabilized).
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 weeks
Other Criteria	None

SOMATULINE DEPOT

Products Affected

- SOMATULINE DEPOT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Diagnosis 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
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	This criteria applies to New Starts only.

SOMAVERT

Products Affected

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

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

SORIATANE

Products Affected

- *acitretin*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Severely impaired liver function, severely impaired kidney function, chronic abnormally elevated blood lipid values, currently taking methotrexate or tetracycline.
Required Medical Information	1. If the patient is female and able to bear children (e.g., no hysterectomy, not reached menopause, has achieved menses). AND 2. pregnancy has been excluded as confirmed by 2 negative urine or serum pregnancy tests with a sensitivity of at least 25 mIU/mL. AND 3. the patient has chosen to use any of the following methods of contraception: one primary form (e.g., tubal ligation, partner's vasectomy, intrauterine devices, birth control pills, injectable/implantable/insertable/topical hormonal birth control products) plus one secondary form (e.g., diaphragms, latex condoms, cervical caps) used in combination with a spermicide OR absolute abstinence AND 4. the patient has agreed to use her chosen form of contraception for at least 1 month before initiation of acitretin therapy, during acitretin therapy, and for at least 3 years after discontinuation of therapy AND 5. the patient has been advised that ethanol must not be ingested by female patients during acetretin treatment and for 2 months following therapy AND 6. the patient will have a negative pregnancy test on a monthly basis.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	Female patient or guardian signed a Patient Agreement/Informed Consent.

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	A documented diagnosis of metastatic colorectal cancer AND documentation of prior therapy with ALL of the following per the indication: 1. (fluoropyrimidine-, oxaliplatin-, and irinotecan)-based chemotherapy 2. bevacizumab (Avastin) 3. panitumumab (Vectibix) OR cetuximab (Erbitux) (for KRAS mutation-negative patients only) OR a documented diagnosis of locally advanced, unresectable or metastatic gastrointestinal stromal tumor (GIST) who have been previously treated with imatinib mesylate (Gleevec) and sunitinib malate (Sutent) OR a documented diagnosis of hepatocellular carcinoma in patients previously treated with sorafenib (Nexavar).
Age Restrictions	18 years of age or older
Prescriber Restrictions	Oncologist
Coverage Duration	Plan Year
Other Criteria	This criteria applies to New Starts only.

SYMDEKO

Products Affected

- SYMDEKO

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

SYMLIN

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Severe hypoglycemia that required assistance during the past 6 months, gastroparesis, patient requires drug therapy to stimulate gastrointestinal motility, the presence of hypoglycemia unawareness (i.e., inability to detect and act upon the signs or symptoms of hypoglycemia).
Required Medical Information	None
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	The patient must have inadequate glycemic control (HbA1c greater than 7% but less than 9%) at initiation of therapy, patient currently receiving optimal mealtime insulin therapy. If taking Symlin in previous 6 months, patient demonstrated a reduction in HbA1c since initiating Symlin therapy

TECFIDERA

Products Affected

- TECFIDERA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Diagnosis of relapsing forms of multiple sclerosis (relapsing-remitting MS or progressive-relapsing MS, or secondary-progressive MS) OR patient has experienced a first clinical episode and has MRI features consistent with multiple sclerosis
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	For renewal, Patient had an objective response to therapy (ie no or slowed progression of disease)

TESTOSTERONES

Products Affected

- ANDRODERM TRANSDERMAL PATCH 24 HOUR
- ANDROGEL PUMP TRANSDERMAL GEL 20.25 MG/ACT (1.62%)
- ANDROGEL TRANSDERMAL GEL 20.25 MG/1.25GM (1.62%), 40.5 MG/2.5GM (1.62%)
- *testosterone transdermal gel 10 mg/act (2%), 25 mg/2.5gm (1%), 50 mg/5gm (1%)*
- *testosterone transdermal solution*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Female, prostate cancer, breast cancer.
Required Medical Information	Before the start of testosterone therapy patient has (or patient currently has) a confirmed low testosterone level (i.e. total testosterone less than 300 ng/dL, free or bioavailable, testosterone less than 5 ng/dL) or absence of endogenous testosterone.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	None

THALOMID

Products Affected

- THALOMID

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Pregnancy
Required Medical Information	Diagnosis of multiple myeloma that is newly diagnosed and is receiving concurrent dexamethasone OR of Acute treatment of cutaneous manifestations of moderate/severe erythema nodosum leprosum AND medication will not be used as monotherapy in the presence of moderate to severe neuritis OR Maintenance treatment for prevention/suppression of cutaneous manifestations of erythema nodosum leprosum recurrence
Age Restrictions	12 years of age or older
Prescriber Restrictions	Oncologist
Coverage Duration	Plan Year
Other Criteria	Patients are monitored for signs and symptoms of thromboembolism. Male and female patients of child-bearing potential are instructed on the importance of proper utilization of appropriate contraceptive methods. This criteria applies to New Starts only.

TOPICAL IMMUNOSUPPRESSANT

Products Affected

- ELIDEL
- *tacrolimus external*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	A. The diagnosis is documented as atopic dermatitis or eczema. B. AND patients must be at least 2 years of age C. AND patients who have completed a documented trial and failure of at least two medium or higher potency topical steroids or have documented intolerance or unresponsiveness to medium or higher potency topical steroids D. AND patients have been advised that Elidel and tacrolimus should only be used to treat the immediate problem and then should be stopped when the condition improves.
Age Restrictions	Elidel and tacrolimus 0.03%: 2 years of age and older, tacolimus 0.1%: 16 years of age and older
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	None

TRACLEER

Products Affected

- TRACLEER

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	AST/ALT level greater than 3 times upper limit of normal (ULN). Pregnancy. Concomitant use of cyclosporine A or glyburide.
Required Medical Information	PAH confirmed by right heart catheterization. NYHA Class II-IV symptoms.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	Female patients of childbearing potential must use more than one method of contraception concurrently. This criteria applies to New Starts only.

TYMLOS

Products Affected

- TYMLOS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of postmenopausal osteoporosis AND one of the following: 1) Patient has experienced a prior fragility fracture, OR 2) Patient has 2 of the following risk factors for fracture: advanced age, parental history of fracture, low body mass index, current smoker, chronic alcohol use, rheumatoid arthritis, chronic steroid use, or other secondary cause of osteoporosis OR 3) Patient had an inadequate response to an adequate trial of a bisphosphonate (one year) or patient has a contraindication or intolerance to bisphosphonate trial.
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	Plan year
Other Criteria	None

TYSABRI

Products Affected

- TYSABRI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	History of progressive multifocal leukoencephalopathy.
Required Medical Information	Diagnosis of relapsing form of multiple sclerosis and medication will be used as monotherapy and patient had an inadequate response, intolerance, or contraindication to conventional therapy with one of the following: An interferon beta product, Copaxone, Gilenya OR Diagnosis of moderate to severe active Crohn's disease and medication will not be used in combination with immunosuppressants or inhibitors of tumor necrosis factor-alfa and patient had an inadequate response, intolerance, or contraindication to any of the following: Humira, Remicade, or Cimzia.
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	MS - 12 months. CD, initial - 3 months, renewal - 12 months.
Other Criteria	Patient and physician are registered in the TOUCH prescribing program. For renewal, patient had an objective response to therapy (e.g., decreased flare). This criteria applies to New Starts only.

UPTRAVI

Products Affected

- UPTRAVI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Diagnosis of pulmonary arterial hypertension (WHO Group 1) 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	Plan Year
Other Criteria	None

VARIZIG

Products Affected

- VARIZIG INTRAMUSCULAR SOLUTION

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Medication will be given through the intramuscular route AND the medication will be used for passive immunization of varicella.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	1 month
Other Criteria	None

VEMLIDY

Products Affected

- VEMLIDY

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Must submit documenation of immune-active chronic hepatitis B per AASLD guidelines.
Age Restrictions	Patient must be age 18 or over.
Prescriber Restrictions	Prescriber must be a gastroenterologist, hepatologist, or infectious disease specialist
Coverage Duration	Plan Year
Other Criteria	None

VENCLEXTA

Products Affected

- VENCLEXTA
- VENCLEXTA STARTING PACK

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	CLL for patients with 17p deletion and have had at least 1 prior therapy
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	This criteria applies to New Starts only.

VERZENIO

Products Affected

- VERZENIO

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

VIMPAT

Products Affected

- VIMPAT

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	Plan Year
Other Criteria	This criteria applies to New Starts only.

VPRIV

Products Affected

- VPRIV

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concomitant use of miglustat (Zavesca)
Required Medical Information	Diagnosis confirmed by bone marrow histology, DNA testing, or measurement of beta-glucocerebrosidase enzyme activity of less than 30 percent. Patient must have at least one of the following conditions as a result of Type 1 Gaucher disease: anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly. Patients who have previously received 24 months of VPRIV therapy must have one of the following responses to continue therapy: 1) A decrease in liver and spleen volume 2) An increase in platelet count, or 3) An increase in hemoglobin concentration.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	None

VYXEOS

Products Affected

- VYXEOS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of therapy related acute myeloid leukemia (t-AML) or acute myeloid leukemia with myelodysplasia related changes (AML-MRC). If the patient has the diagnosis of therapy related acute myeloid leukemia (t-AML), it must be newly diagnosed.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	B vs D coverage determination per CMS guidelines, This criteria applies to New Starts only.

XENAZINE

Products Affected

- *tetrabenazine*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patients with untreated or inadequately treated depression or who are actively suicidal, history of hepatic disease, use in combination with MAO inhibitors or reserpine (or it has been less than 20 days since reserpine was discontinued).
Required Medical Information	None
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	None

XGEVA

Products Affected

- XGEVA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Uncorrected hypocalcemia
Required Medical Information	1.) Patient has bone metastases from a solid tumor. OR 2.) Patient has or giant cell tumor of the bone that is unresectable or where surgical resection is likely to result in severe morbidity. OR 3.) Patient has hypercalcemia of malignancy refractory to bisphosphonate therapy OR 4) Prevention of skeletal related events in patients with multiple myeloma
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	None

XIFAXAN

Products Affected

- XIFAXAN

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	18 years of age and older (Xifaxan 550mg)
Prescriber Restrictions	None
Coverage Duration	Hepatic encephalopathy-6 months,travelers diarrhea (200mg tab)-3 days,IBS-D (550mg tab) for 14 days
Other Criteria	None

XOLAIR

Products Affected

- XOLAIR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Diagnosis of moderate to severe persistent allergic asthma AND Evidence of specific allergic sensitivity confirmed by positive skin test (i.e. prick/puncture test) or blood test (i.e. radioallergosorbent test) for a specific IgE or in vitro reactivity to a perennial aeroallergen AND Pretreatment serum IgE levels greater than 30 and less than 700 IU/mL AND Symptoms are not adequately controlled with maximally tolerated dose of inhaled corticosteroid (ICS) plus long-acting beta2-agonist (LABA) for at least 3 months OR documented intolerance to inhaled corticosteriod (ICS) plus long-acting beta2 agonist(LABA), OR contraindication to inhaled corticosteriod (ICS) plus long-acting beta2 agonist(LABA) OR diagnosis of chronic idiopathic urticaria who remain symptomatic despite H1 antihistamine treatment.
Age Restrictions	6 years of age and older
Prescriber Restrictions	Asthma specialist (i.e., allergist, immunologist, or pulmonologist) or dermatologist
Coverage Duration	Plan Year
Other Criteria	To continue therapy, patients must demonstrate an improvement in asthma control with use of Xolair.

XURIDEN

Products Affected

- XURIDEN

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

XYREM

Products Affected

- XYREM

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	If the patient is taking/receiving any of the following: anxiolytics, sedatives, hypnotics, barbiturates, benzodiazepines or ethanol.
Required Medical Information	A. The diagnosis is documented as excessive daytime sleepiness OR the diagnosis is documented as cataplexy (a condition characterized by weak or paralyzed muscles) in patients with narcolepsy. C. AND if the patient has received prior treatment with Xyrem, the patient must experience a decrease in daytime sleepiness and/or cataplexy in a narcoleptic patient.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	3 months
Other Criteria	None

YONDELIS

Products Affected

- YONDELIS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Diagnosis and lab values: ANC, platelet count, creatine phosphokinase, and left ventricular ejection fraction.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Must be prescribed by an oncologist
Coverage Duration	Plan Year
Other Criteria	This criteria applies to New Starts only.

YONSA

Products Affected

- YONSA

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

ZAVESCA

Products Affected

- *miglustat*
- ZAVESCA

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

ZEJULA

Products Affected

- ZEJULA

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

ZORBTIVE

Products Affected

- ZORBTIVE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Active malignancy (newly diagnosed or recurrent), acute critical illness due to complications following open heart or abdominal surgery, accidental trauma or acute respiratory failure
Required Medical Information	For continuation of therapy, patient show a response to Zorbtive therapy (e.g., requirements for nutritional support have decreased or the patient's weight has stabilized or increased).
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	4 weeks initial, 4 weeks renewal
Other Criteria	None

ZYTIGA

Products Affected

- ZYTIGA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	None
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	Used in combination with prednisone. This criteria applies to New Starts only.

PART B VERSUS PART D

Products Affected

- ABELCET
- ABRAXANE
- *acetylcysteine inhalation*
- *acyclovir sodium intravenous solution*
- ADRIAMYCIN INTRAVENOUS SOLUTION
- ADRUCIL INTRAVENOUS SOLUTION 500 MG/10ML
- *albuterol sulfate inhalation*
- ALIMTA
- AMBISOME
- AMINOSYN II INTRAVENOUS SOLUTION 10 %, 8.5 %
- AMINOSYN II/ELECTROLYTES
- AMINOSYN/ELECTROLYTES
- AMINOSYN-HBC
- AMINOSYN-PF
- AMINOSYN-RF
- *amiodarone hcl intravenous solution 150 mg/3ml*
- *amphotericin b injection*
- *aprepitant oral capsule 80 & 125 mg*
- *argatroban intravenous solution 250 mg/2.5ml*
- ARRANON
- ASTAGRAF XL
- ATGAM
- AVASTIN
- *azacitidine*
- AZASAN
- *azathioprine oral*
- *azathioprine sodium*
- BAVENCIO
- BELEODAQ
- BENLYSTA INTRAVENOUS
- BICNU
- BIVIGAM INTRAVENOUS SOLUTION 10 GM/100ML
- *bleomycin sulfate injection solution reconstituted 30 unit*
- *bortezomib*
- *budesonide inhalation*
- *busulfan*
- *calcitonin (salmon)*
- *carboplatin intravenous solution 150 mg/15ml*
- *caspofungin acetate*
- CESAMET
- *chlorpromazine hcl injection solution 50 mg/2ml*
- *chlorpromazine hcl oral tablet 10 mg, 25 mg*
- *cidofovir intravenous*
- *cisplatin intravenous solution 100 mg/100ml, 50 mg/50ml*
- *cladribine intravenous solution 10 mg/10ml*
- CLINIMIX E/DEXTROSE (2.75/10)
- CLINIMIX E/DEXTROSE (2.75/5)
- CLINIMIX E/DEXTROSE (4.25/10)
- CLINIMIX E/DEXTROSE (4.25/25)
- CLINIMIX E/DEXTROSE (4.25/5)
- CLINIMIX E/DEXTROSE (5/15)
- CLINIMIX E/DEXTROSE (5/20)
- CLINIMIX E/DEXTROSE (5/25)
- CLINIMIX/DEXTROSE (2.75/5)
- CLINIMIX/DEXTROSE (4.25/10)
- CLINIMIX/DEXTROSE (4.25/20)
- CLINIMIX/DEXTROSE (4.25/25)
- CLINIMIX/DEXTROSE (4.25/5)
- CLINIMIX/DEXTROSE (5/15)
- CLINIMIX/DEXTROSE (5/20)
- CLINIMIX/DEXTROSE (5/25)
- CLINISOL SF
- *clofarabine*
- *colistimethate sodium (cba)*
- *colistimethate sodium injection*
- *cromolyn sodium inhalation*
- *cyclophosphamide oral capsule*
- *cyclosporine intravenous*
- *cyclosporine modified*
- *cyclosporine oral capsule*
- CYRAMZA
- *cytarabine (pf) injection solution 100 mg/ml*
- *cytarabine injection solution*

- *dacarbazine intravenous solution reconstituted 200 mg*
- *dactinomycin*
- *daunorubicin hcl intravenous injectable*
- *decitabine*
- DEPO-PROVERA INTRAMUSCULAR SUSPENSION 400 MG/ML
- *dexrazoxane intravenous solution reconstituted 250 mg*
- *dextrose intravenous solution 10 %, 5 %*
- *diphtheria-tetanus toxoids dt*
- *docetaxel intravenous concentrate 80 mg/4ml*
- *docetaxel intravenous solution 160 mg/16ml, 80 mg/8ml*
- *doxorubicin hcl intravenous solution*
- *doxorubicin hcl liposomal*
- *duramorph*
- ELIGARD
- ELITEK
- EMEND INTRAVENOUS SOLUTION RECONSTITUTED 150 MG
- EMEND ORAL SUSPENSION RECONSTITUTED
- ENGERIX-B INJECTION
- ENVARSUS XR
- *epirubicin hcl intravenous solution 200 mg/100ml*
- ERBITUX INTRAVENOUS SOLUTION 100 MG/50ML
- ETOPOPHOS
- *etoposide intravenous solution 100 mg/5ml, 500 mg/25ml*
- FASLODEX INTRAMUSCULAR SOLUTION 250 MG/5ML
- FIRMAGON
- FLEBOGAMMA DIF INTRAVENOUS SOLUTION 5 GM/50ML
- *fludarabine phosphate intravenous solution reconstituted*
- *fluorouracil intravenous solution 2.5 gm/50ml, 5 gm/100ml*
- FREAMINE HBC
- GAMMAKED INJECTION SOLUTION 1 GM/10ML
- *ganciclovir sodium intravenous solution reconstituted*
- *gemcitabine hcl intravenous solution reconstituted 1 gm*
- GENGRAF ORAL CAPSULE 100 MG, 25 MG
- GENGRAF ORAL SOLUTION
- *granisetron hcl intravenous solution 0.1 mg/ml, 1 mg/ml*
- *granisetron hcl oral*
- HALAVEN
- *heparin (porcine) in d5w*
- *heparin sod (porcine) in d5w intravenous solution 100 unit/ml*
- HEPATAMINE
- HERCEPTIN
- *ibandronate sodium intravenous solution 3 mg/3ml*
- *idarubicin hcl intravenous solution 10 mg/10ml*
- *ifosfamide intravenous solution reconstituted 1 gm*
- IMOVAX RABIES
- INTRALIPID INTRAVENOUS EMULSION 30 %
- INTRON A
- *ipratropium bromide inhalation*
- *ipratropium-albuterol*
- *irinotecan hcl intravenous solution 100 mg/5ml*
- ISTODAX (OVERFILL)
- KEPIVANCE
- KYPROLIS INTRAVENOUS SOLUTION RECONSTITUTED 30 MG, 60 MG
- *leucovorin calcium injection solution reconstituted 100 mg, 350 mg*
- *levalbuterol hcl inhalation nebulization solution 0.31 mg/3ml, 0.63 mg/3ml, 1.25 mg/0.5ml, 1.25 mg/3ml*
- *levocarnitine oral solution*
- *levocarnitine oral tablet*
- *levoleucovorin calcium intravenous solution*
- *levoleucovorin calcium intravenous solution reconstituted 50 mg*

- *lincomycin hcl injection*
- *melphalan hcl*
- *mesna*
- *methotrexate oral*
- *methotrexate sodium (pf) injection solution 100 mg/4ml, 200 mg/8ml, 250 mg/10ml, 50 mg/2ml*
- *methotrexate sodium injection solution 250 mg/10ml*
- *methotrexate sodium injection solution reconstituted*
- MIACALCIN INJECTION
- *mitomycin intravenous*
- *mitoxantrone hcl intravenous concentrate 25 mg/12.5ml*
- MUSTARGEN
- *mycophenolate mofetil*
- *mycophenolate mofetil hcl*
- *mycophenolate sodium*
- NEBUPENT
- NEPHRAMINE
- NULOJIX
- *nutrilipid intravenous emulsion 20 %*
- *ondansetron*
- *ondansetron hcl injection solution 4 mg/2ml, 4 mg/2ml (2ml syringe)*
- *ondansetron hcl oral*
- *oxaliplatin intravenous solution 100 mg/20ml*
- *oxaliplatin intravenous solution reconstituted 100 mg*
- *paclitaxel intravenous concentrate 100 mg/16.7ml, 300 mg/50ml*
- *palonosetron hcl intravenous solution*
- *pamidronate disodium intravenous solution*
- PERJETA
- PLENAMINE
- PREMASOL
- PROCALAMINE
- PROGRAF INTRAVENOUS
- PROLEUKIN
- PROSOL
- PULMOZYME
- RABAVERT
- RAPAMUNE ORAL SOLUTION
- RECOMBIVAX HB
- REMODULIN
- SANDIMMUNE ORAL
- SENSIPAR
- SIMULECT INTRAVENOUS SOLUTION RECONSTITUTED 20 MG
- *sirolimus oral*
- SYNERCID
- *tacrolimus oral*
- TECENTRIQ
- TENIVAC
- *tetanus-diphtheria toxoids td*
- *thiotepa injection*
- THYMOGLOBULIN
- *tigecycline*
- *tobramycin inhalation*
- TOPOSAR INTRAVENOUS SOLUTION 1 GM/50ML
- *topotecan hcl intravenous solution reconstituted*
- TORISEL
- TPN ELECTROLYTES INTRAVENOUS SOLUTION
- *tranexamic acid intravenous solution 1000 mg/10ml*
- TRAVASOL
- TREANDA INTRAVENOUS SOLUTION RECONSTITUTED
- TRELSTAR MIXJECT
- TREXALL
- TRISENOX INTRAVENOUS SOLUTION 12 MG/6ML
- TROPHAMINE INTRAVENOUS SOLUTION 10 %
- TWINRIX
- VARUBI ORAL
- VECTIBIX INTRAVENOUS SOLUTION 100 MG/5ML
- VELCADE INJECTION
- VENTAVIS INHALATION SOLUTION 20 MCG/ML
- *vinblastine sulfate intravenous solution*
- VINCASAR PFS
- *vincristine sulfate intravenous*
- *vinorelbine tartrate intravenous solution 50 mg/5ml*

- XATMEP
- YERVOY INTRAVENOUS SOLUTION 50 MG/10ML
- ZALTRAP INTRAVENOUS SOLUTION 100 MG/4ML
- ZANOSAR
- *zoledronic acid intravenous concentrate*
- *zoledronic acid intravenous solution 5 mg/100ml*
- ZORTRESS

Details

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

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