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	None

Prior Authorization Criteria

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	None

Prior Authorization Criteria

ALECENSA

Products Affected

- ALECENSA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Diagnosis of metastatic anaplastic lymphoma kinase positive non-small cell lung cancer.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	None

Prior Authorization Criteria

ALPHA1-PROTEINASE INHIBITOR

Products Affected

- PROLASTIN-C INTRAVENOUS SOLUTION RECONSTITUTED 1000 MG

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

Prior Authorization Criteria

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	None

Prior Authorization Criteria

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

Prior Authorization Criteria

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	Prescribed by or in consultation with a neurologist
Coverage Duration	Initial - 3 months. Renewal - 12 months
Other Criteria	None

Prior Authorization Criteria

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.

Prior Authorization Criteria

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

Prior Authorization Criteria

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)

Prior Authorization Criteria

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	Plan Year
Other Criteria	None

Prior Authorization Criteria

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	None

Prior Authorization Criteria

CABOMETYX

Products Affected

- CABOMETYX

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Diagnosis of advanced or metastatic renal cell cancer (RCC).
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	None

Prior Authorization Criteria

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	Plan Year
Other Criteria	None

Prior Authorization Criteria

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)

Prior Authorization Criteria

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 or sinoatrial block or 3rd degree AV block (unless a functioning demand pacemaker is present), or 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

Prior Authorization Criteria

COSENTYX

Products Affected

- COSENTYX 300 DOSE
- COSENTYX SENSOREADY 300 DOSE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Plaque psoriasis (Initial): Diagnosis of moderate to severe plaque psoriasis. One of the following: Failure, contraindication, or intolerance to Enbrel (etanercept) AND Humira (adalimumab), OR for continuation of prior Cosentyx therapy. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: Failure, contraindication, or intolerance to both Enbrel (etanercept) and Humira (adalimumab), OR for continuation of prior Cosentyx therapy. Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. One of the following: Failure, contraindication, or intolerance to both Enbrel (etanercept) and Humira (adalimumab), OR for continuation of prior Cosentyx therapy. All indications (Initial, reauth): Patient is not receiving Cosentyx in combination with a biologic DMARD [eg, Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)]. Patient is not receiving Cosentyx in combination with a Janus kinase inhibitor [eg, Xeljanz (tofacitinib)]. For a diagnosis of PsA or plaque psoriasis, Patient is not receiving Cosentyx in combination with a phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)].
Age Restrictions	None
Prescriber Restrictions	Plaque psoriasis (Initial): Prescribed by or in consultation with a dermatologist. PsA (Initial): Prescribed by or in consultation with a rheumatologist or dermatologist. AS (Initial): Prescribed by or in consultation with a rheumatologist.
Coverage Duration	All indications (Initial, reauth): 12 months
Other Criteria	All indications (Reauth): Documentation of positive clinical response to Cosentyx therapy.

COTELLIC

Products Affected

- COTELLIC

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Diagnosis of unresectable OR metastatic malignant melanoma with BRAF V600E OR V600K mutation AND documentation of combination therapy with vemurafenib.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	None

Prior Authorization Criteria

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

Prior Authorization Criteria

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

Prior Authorization Criteria

DRONABINOL

Products Affected

- *dronabinol*

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

Prior Authorization Criteria

ENBREL

Products Affected

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

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

Prior Authorization Criteria

PA Criteria	Criteria Details
Coverage Duration	Plan Year
Other Criteria	None

Prior Authorization Criteria

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

Prior Authorization Criteria

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	None

Prior Authorization Criteria

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 (idiopathic pulmonary fibrosis [IPF]) and monitoring (hepatic function/LFTs)
Age Restrictions	None
Prescriber Restrictions	Pulmonologist
Coverage Duration	Plan Year
Other Criteria	None

Prior Authorization Criteria

ESRD THERAPY

Products Affected

- PROCRIT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Pretreatment hemoglobin levels of less than 10g/dL. Dose reduction or interruption if hemoglobin exceeds 10 g/dL (CKD not on dialysis-adult, cancer), 11 g/dL (CKD on dialysis), 12 g/dL (pediatric CKD) in addition to supporting statement of diagnosis from physician.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	3 months
Other Criteria	None

Prior Authorization Criteria

EXJADE

Products Affected

- EXJADE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Medical documentation of FDA approved diagnosis, serum ferritin levels, and serum creatinine.
Age Restrictions	Covered for those 2 years of age and older with chronic iron overload due to blood transfusions
Prescriber Restrictions	Hematologist
Coverage Duration	3 months
Other Criteria	None

Prior Authorization Criteria

FANAPT

Products Affected

- FANAPT
- FANAPT TITRATION PACK

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Dementia related psychosis (in the absence of an approvable diagnosis), for member 65 years of age or older.
Required Medical Information	Must be utilizing for the treatment of schizophrenia AND Patient must have tried previous treatment or documented intolerance or contraindication to at least 2 of the following: aripiprazole, olanzapine, risperidone, quetiapine or ziprasidone.
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	None

Prior Authorization Criteria

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 [e.g., 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	None

Prior Authorization Criteria

FENTANYL ORAL

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

Prior Authorization Criteria

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.

Prior Authorization Criteria

GILOTRIF

Products Affected

- GILOTRIF

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

Prior Authorization Criteria

GLATIRAMER

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

Prior Authorization Criteria

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	Plan Year
Other Criteria	None

Prior Authorization Criteria

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

Prior Authorization Criteria

PA Criteria	Criteria Details
Other Criteria	None

Prior Authorization Criteria

HEPATITIS C

Products Affected

- MAVYRET
- VOSEVI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Must submit documentation of chronic hepatitis C genotype (confirmed by HCV RNA level within the last 6 months). Must submit laboratory results within 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 ALL GENOTYPES: Trial/failure, contraindication to, or intolerance to Mavyret is required prior to approval of Vosevi.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescriber must be a gastroenterologist, hepatologist, or infectious disease specialist
Coverage Duration	Duration of approval per AASLD Guidelines
Other Criteria	None

Prior Authorization Criteria

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

Prior Authorization Criteria

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*
- *indomethacin er*
- *indomethacin 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

Prior Authorization Criteria

HRM - ANTI-ARRHYTHMICS

Products Affected

- *disopyramide phosphate 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. 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

Prior Authorization Criteria

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	None

Prior Authorization Criteria

HRM - ANTIEMETIC DRUGS

Products Affected

- *hydroxyzine hcl oral syrup*
- *hydroxyzine hcl oral tablet*
- *hydroxyzine pamoate oral*
- *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

Prior Authorization Criteria

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 oral solution*

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

Prior Authorization Criteria

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

Prior Authorization Criteria

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	None

Prior Authorization Criteria

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	None

Prior Authorization Criteria

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, memantine ER,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

Prior Authorization Criteria

HRM - ONCOLOGY

Products Affected

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

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	None

Prior Authorization Criteria

HRM - ORAL AND TRANSDERMAL ESTROGENS AND PROGESTINS

Products Affected

- CLIMARA PRO
- COMBIPATCH
- DIVIGEL TRANSDERMAL GEL 1 MG/GM
- DUAVEE
- *estradiol oral*
- *estradiol transdermal*
- *estradiol-norethindrone acet*
- *estropipate oral tablet 0.75 mg, 1.5 mg*
- EVAMIST
- FYAVOLV
- JINTELI
- MENEST ORAL TABLET 0.3 MG, 0.625 MG, 1.25 MG
- *norethindrone-eth estradiol*
- PREFEST
- 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 Estradiol Cream. Osteoporosis: Alendronate and Risedronate.
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

Prior Authorization Criteria

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

Prior Authorization Criteria

HRM - SEDATIVE HYPNOTIC AGENTS

Products Affected

- *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

Prior Authorization Criteria

HRM - SKELETAL MUSCLE RELAXANTS

Products Affected

- *chlorzoxazone oral tablet 500 mg*
- *cyclobenzaprine hcl oral*
- *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

Prior Authorization Criteria

HUMIRA

Products Affected

- HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT
- HUMIRA PEN SUBCUTANEOUS PEN-INJECTOR KIT
- HUMIRA PEN-CD/UC/HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML
- HUMIRA PEN-PS/UV STARTER SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML
- HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT

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

PA Criteria	Criteria Details
	mesalamine, sulfasalazine, balsalazide) or non-biologic DMARDs (azathioprine, cyclosporine, hydroxychloroquine, leflunomide, sulfasalazine) G) non-infectious uveitis (including intermediate, posterior, and panuveitis) and patient had inadequate response, intolerance or contraindication to conventional therapy with one of the following: systemic or topical corticosteroids or ophthalmic antimuscarinics. OR H) moderate to severe hidradenitis suppurativa
Age Restrictions	2 years of age or older for JIA. 6 years of age or older for pediatric Crohn's disease, 18 years of age or older for all other indications
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	None

Prior Authorization Criteria

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	Diagnosis of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer in combination with an aromatase inhibitor in postmenopausal women as initial endocrine-based therapy OR 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	None

Prior Authorization Criteria

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	None

Prior Authorization Criteria

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	Plan Year
Other Criteria	None

Prior Authorization Criteria

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	None

Prior Authorization Criteria

INCRELEX

Products Affected

- INCRELEX

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Increlex is contraindicated in patients with allergies to mecasermin or any component of the Increlex formulation, for growth promotion in patients with closed epiphyses, for IV administration, in patients with active or suspected neoplasia. Increlex should be discontinued if neoplasia develops while on therapy.
Required Medical Information	Increlex (mecasermin [rDNA origin] injection) is indicated for the long-term treatment of growth failure in children with severe primary IGF-1 deficiency (Primary IGFD) or with growth hormone (GH) gene deletion who have developed neutralizing antibodies to GH. Child has one of the following conditions: Severe primary IGF-1 deficiency, OR Growth hormone gene deletion with developed neutralizing antibodies to growth hormone, OR Genetic mutation of GH receptor (i.e. Laron Syndrome), AND Child has severe growth retardation with height standard deviation score (SDS) more than 3 SDS below the mean for chronological age and sex, AND Child with IGF-1 level greater than or equal to 3 standard deviations below normal based on lab reference range for age and sex, AND Child with normal or elevated growth hormone (GH) levels based on at least one growth hormone stimulation test, AND Evidence of open epiphyses
Age Restrictions	None
Prescriber Restrictions	Pediatric or Endocrinologist
Coverage Duration	6 months
Other Criteria	None

Prior Authorization Criteria

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

Prior Authorization Criteria

IRESSA

Products Affected

- IRESSA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of metastatic NSCLC AND Patient has known active epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations as detected by an FDA-approved test or Clinical Laboratory Improvement Amendments-approved facility
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	Plan Year
Other Criteria	None

Prior Authorization Criteria

ITRACONAZOLE

Products Affected

- *itraconazole oral*

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

Prior Authorization Criteria

IVIG

Products Affected

- BIVIGAM INTRAVENOUS SOLUTION 10 GM/100ML
- CARIMUNE NF INTRAVENOUS SOLUTION RECONSTITUTED 6 GM
- FLEBOGAMMA DIF INTRAVENOUS SOLUTION 5 GM/50ML
- GAMMAGARD INJECTION SOLUTION 2.5 GM/25ML
- GAMMAGARD S/D LESS IGA
- GAMMAKED INJECTION SOLUTION 1 GM/10ML
- 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.

Prior Authorization Criteria

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

Prior Authorization Criteria

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 ivacaftor 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

Prior Authorization Criteria

KISQALI - PENDING CMS APPROVAL

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	
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

Prior Authorization Criteria

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 from the physician
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	None

Prior Authorization Criteria

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.

Prior Authorization Criteria

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.

Prior Authorization Criteria

LENVIMA

Products Affected

- LENVIMA 10 MG DAILY DOSE
- LENVIMA 14 MG DAILY DOSE
- LENVIMA 18 MG DAILY DOSE
- LENVIMA 20 MG DAILY DOSE
- LENVIMA 24 MG DAILY DOSE
- LENVIMA 8 MG DAILY DOSE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Diagnosis of locally recurrent or metastatic, progressive, radioactive iodine-refractory differentiated thyroid cancer OR advanced renal cell carcinoma following one prior anti-angiogenic therapy in combination with everolimus
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	None

Prior Authorization Criteria

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.

Prior Authorization Criteria

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

Prior Authorization Criteria

LIDOCAINE PATCH

Products Affected

- *lidocaine external patch 5 %*

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

Prior Authorization Criteria

LUPRON

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	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), C) Anemia due to uterine Leiomyomata (Fibroids) (3.75 mg 1-month &11.25 mg 3-month depots only) and Patient is preoperative, D) Central precocious puberty (idiopathic or neurogenic) in children
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.

Prior Authorization Criteria

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	Supporting statement with diagnosis of 1) deleterious or suspected deleterious germline BRCA-mutated (gBRCAm) advanced ovarian cancer and have been treated with 3 or more prior lines of chemotherapy OR 2) recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer and have a complete or partial response to platinum-based chemotherapy OR 3) HER2-negative, deleterious or suspected deleterious germline BRCA mutated (gBRCAm) metastatic breast cancer and have been previously treated with chemotherapy in the neoadjuvant, adjuvant, or metastatic setting.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	None

Prior Authorization Criteria

MEKINIST – PENDING CMS APPROVAL

Products Affected

- MEKINIST

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

Prior Authorization Criteria

METHYLPHENIDATES

Products Affected

- *methylphenidate hcl er (cd)*
- *methylphenidate hcl er (la) oral capsule extended release 24 hour 10 mg*
- *methylphenidate hcl er oral tablet extended release 10 mg, 20 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.

Prior Authorization Criteria

MIGLUSTAT

Products Affected

- *miglustat*

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

Prior Authorization Criteria

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

Prior Authorization Criteria

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)

NATPARA

Products Affected

- NATPARA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Diagnosis of hypocalcemia in patients with hypoparathyroidism
Age Restrictions	None
Prescriber Restrictions	Prescriber is certified in the NATPARA REMS program
Coverage Duration	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	Plan Year
Other Criteria	None

Prior Authorization Criteria

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

Prior Authorization Criteria

NINLARO

Products Affected

- NINLARO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Diagnosis of multiple myeloma, documentation of combination therapy with lenalidomide and dexamethasone. History of 1 prior therapy.
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by or in consultation with a hematologist/oncologist.
Coverage Duration	Plan Year
Other Criteria	None

Prior Authorization Criteria

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

Prior Authorization Criteria

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

Prior Authorization Criteria

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

Prior Authorization Criteria

NUPLAZID

Products Affected

- NUPLAZID ORAL TABLET 17 MG

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

Prior Authorization Criteria

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

Prior Authorization Criteria

OPSUMIT

Products Affected

- OPSUMIT

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 WHO group I AND diagnosis was confirmed by right heart catheterization AND female patients are enrolled in the OPSUMIT REMS program.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	6 months - initial. 12 months - renewal
Other Criteria	IUD or two appropriate contraceptive methods will be used for women of childbearing potential.

Prior Authorization Criteria

ORKAMBI - PENDING CMS APPROVAL

Products Affected

- ORKAMBI ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

Prior Authorization Criteria

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

Prior Authorization Criteria

OXANDROLONE

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

Prior Authorization Criteria

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).

Prior Authorization Criteria

PA Criteria	Criteria Details
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
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

Prior Authorization Criteria

PEGASYS

Products Affected

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

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

Prior Authorization Criteria

POMALYST

Products Affected

- POMALYST

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

Prior Authorization Criteria

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

Prior Authorization Criteria

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

Prior Authorization Criteria

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 one of the following 1) multiple myeloma and medication will be used in combination with dexamethasone 2) autologous hematopoietic stem-cell transplantation (HSCT) in multiple myeloma patients 3) transfusion-dependent anemia due to low- or intermediate-1-risk myelodysplastic syndrome (MDS) associated with a deletion 5q cytogenetic abnormality with or without additional cytogenetic abnormalities 4) 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.

Prior Authorization Criteria

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	None

Prior Authorization Criteria

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	None

Prior Authorization Criteria

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

Prior Authorization Criteria

SAPHRIS - PENDING CMS APPROVAL

Products Affected

- SAPHRIS

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

Prior Authorization Criteria

SILDENAFIL

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 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
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	None

Prior Authorization Criteria

SOMATULINE DEPOT - PENDING CMS APPROVAL

Products Affected

- SOMATULINE DEPOT

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

Prior Authorization Criteria

SOMAVERT

Products Affected

- SOMAVERT

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

Prior Authorization Criteria

SPRYCEL - PENDING CMS APPROVAL

Products Affected

- SPRYCEL

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

Prior Authorization Criteria

STIVARGA

Products Affected

- STIVARGA

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

Prior Authorization Criteria

SUTENT

Products Affected

- SUTENT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Renal cell carcinoma: Diagnosis of advanced or metastatic renal cell carcinoma OR adjuvant treatment in renal cell carcinoma for patients at high risk of recurrence following nephrectomy. Gastrointestinal stromal tumor (GIST): Diagnosis of GIST after disease progression on or intolerance to Gleevec (imatinib). Pancreatic neuroendocrine tumors: Diagnosis of progressive, well-differentiated pancreatic neuroendocrine tumor that is unresectable locally advanced or metastatic disease.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	Plan Year
Other Criteria	None

Prior Authorization Criteria

SYLATRON

Products Affected

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

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

Prior Authorization Criteria

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

Prior Authorization Criteria

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

Prior Authorization Criteria

TAFINLAR

Products Affected

- TAFINLAR

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

Prior Authorization Criteria

TAGRISSO

Products Affected

- TAGRISSO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Diagnosis of metastatic EGFR mutation-positive, non-small cell lung cancer (NSCLC) OR metastatic, non-small cell lung cancer with confirmed presence of T790M EGFR mutation AND whose disease has progressed on or after EGFR tyrosine kinase inhibitor based therapy. Diagnosis confirmed by an FDA-approved test.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	None

Prior Authorization Criteria

TASIGNA

Products Affected

- TASIGNA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Diagnosis of newly diagnosed Philadelphia chromosome-positive chronic myelogenous leukemia (Ph+ CML) in the chronic phase OR Diagnosis of Ph+ CML with resistance or intolerance to prior therapy.
Age Restrictions	None
Prescriber Restrictions	Oncologist
Coverage Duration	Plan Year
Other Criteria	None

Prior Authorization Criteria

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)

Prior Authorization Criteria

TESTOSTERONES

Products Affected

- ANDROGEL PUMP TRANSDERMAL GEL 20.25 MG/ACT (1.62%)
- ANDROGEL TRANSDERMAL GEL 20.25 MG/1.25GM (1.62%), 40.5 MG/2.5GM (1.62%)
- *testosterone transdermal gel 10 mg/act (2%), 12.5 mg/act (1%), 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

Prior Authorization Criteria

TETRABENAZINE

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

Prior Authorization Criteria

THALOMID – PENDING CMS APPROVAL

Products Affected

- THALOMID

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

Prior Authorization Criteria

TRACLEER

Products Affected

- TRACLEER

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

Prior Authorization Criteria

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

Prior Authorization Criteria

UPTRAVI

Products Affected

- UPTRAVI

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

Prior Authorization Criteria

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	None

Prior Authorization Criteria

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	Plan Year
Other Criteria	None

Prior Authorization Criteria

VRAYLAR

Products Affected

- VRAYLAR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Dementia related psychosis (in the absence of an approvable diagnosis), for member 65 years of age or older.
Required Medical Information	Must be utilizing for the treatment of schizophrenia/Bipolar I Disorder, manic or mixed episodes AND Patient must have tried previous treatment or documented intolerance or contraindication to at least 2 of the following: aripiprazole, olanzapine, risperidone, quetiapine or ziprasidone.
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	None

Prior Authorization Criteria

XALKORI

Products Affected

- XALKORI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Supporting statement of diagnosis from the physician that establishes the cancer as anaplastic lymphoma kinase (ALK)-positive or ROS1-positive non-small cell lung cancer (NSCLC)
Age Restrictions	None
Prescriber Restrictions	Oncologist
Coverage Duration	Plan Year
Other Criteria	None

Prior Authorization Criteria

XELJANZ – PENDING CMS APPROVAL

Products Affected

- XELJANZ ORAL TABLET 5 MG
- XELJANZ XR

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

Prior Authorization Criteria

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 patient with multiple myeloma.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Plan Year
Other Criteria	None

Prior Authorization Criteria

XOLAIR – PENDING CMS APPROVAL

Products Affected

- XOLAIR

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

Prior Authorization Criteria

XTANDI

Products Affected

- XTANDI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Diagnosis of metastatic castration-resistant prostate cancer AND the patient has tried and had an inadequate response, contraindication or intolerance to Zytiga.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed or in consultation with an oncologist or urologist
Coverage Duration	Plan Year
Other Criteria	None

Prior Authorization Criteria

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	Plan Year
Other Criteria	None

Prior Authorization Criteria

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

Prior Authorization Criteria

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	Plan Year
Other Criteria	None

Prior Authorization Criteria

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	None

Prior Authorization Criteria

ZYKADIA

Products Affected

- ZYKADIA

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

Prior Authorization Criteria

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.

PART B VERSUS PART D

Products Affected

- ABELCET
- *acetylcysteine inhalation*
- *acyclovir sodium intravenous solution*
- *albuterol sulfate inhalation*
- AMBISOME
- AMINOSYN II INTRAVENOUS SOLUTION 10 %, 8.5 %
- AMINOSYN II/ELECTROLYTES
- AMINOSYN/ELECTROLYTES
- AMINOSYN-HBC
- AMINOSYN-PF
- AMINOSYN-RF
- *amphotericin b injection*
- *aprepitant*
- ASTAGRAF XL
- AZASAN
- *azathioprine oral*
- *budesonide inhalation*
- *calcitonin (salmon)*
- *caspofungin acetate*
- *chlorpromazine hcl oral tablet 10 mg, 25 mg*
- 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
- *colistimethate sodium (cba)*
- *cromolyn sodium inhalation*
- *cyclophosphamide oral capsule*
- *cyclosporine modified*
- *cyclosporine oral capsule*
- DEPO-PROVERA INTRAMUSCULAR SUSPENSION 400 MG/ML
- *dextrose intravenous solution 10 %, 5 %*
- *diphtheria-tetanus toxoids dt*
- *duramorph*
- ELIGARD
- ENGERIX-B INJECTION SUSPENSION 10 MCG/0.5ML, 20 MCG/ML
- ENVARSUS XR
- FIRMAGON
- FREAMINE HBC
- GENGRAF ORAL CAPSULE 100 MG, 25 MG
- GENGRAF ORAL SOLUTION
- *granisetron hcl oral*
- HEPATAMINE
- IMOVAX RABIES
- INTRALIPID
- INTRON A
- *ipratropium bromide inhalation*
- *ipratropium-albuterol*
- *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*
- *methotrexate oral*
- *methotrexate sodium (pf) injection solution 50 mg/2ml*
- *methotrexate sodium injection solution 250 mg/10ml*
- *mycophenolate mofetil*
- *mycophenolate sodium*
- NEBUPENT
- NEPHRAMINE

- *nutrilipid intravenous emulsion 20 %*
- *ondansetron*
- *ondansetron hcl oral*
- PLENAMINE
- PREMASOL
- PROCALAMINE
- PROSOL
- PULMOZYME
- RABAVERT
- RAPAMUNE ORAL SOLUTION
- RECOMBIVAX HB
- SANDIMMUNE ORAL SOLUTION
- SENSIPAR
- *sirolimus oral*
- *tacrolimus oral*
- TENIVAC
- *tetanus-diphtheria toxoids td*
- *tigecycline*
- *tobramycin inhalation*
- TPN ELECTROLYTES INTRAVENOUS SOLUTION
- TRAVASOL
- TRELSTAR MIXJECT
- TREXALL
- TROPHAMINE INTRAVENOUS SOLUTION 10 %
- TWINRIX
- VARUBI ORAL
- XATMEP
- 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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