ABRAXANE

Products Affected

- ABRAXANE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For relapsed or refractory melanoma, individual is using as a single agent and Eastern Cooperative Oncology Group (ECOG) performance status of 0-2 following at least one prior therapy. For ovarian cancer (epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer) individual is using as a single agent and Disease is persistent or recurrent.

ACTIMMUNE

Products Affected

- ACTIMMUNE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

ADEMPAS

Products Affected

- ADEMPAS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Use in combination with nitrates (such as but not limited to, nitroglycerin) or nitric oxide donors (such as but not limited to, amyl nitrite) in any form OR Use in combination with phosphodiesterase (PDE) inhibitors [such as, PDE-5 inhibitors (sildenafil, tadalafil, vardenafil) or nonspecific PDE inhibitors (dipyridamole, theophylline)].
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Individual has catheterization-proven diagnosis of pulmonary arterial hypertension (PAH), WHO Group 1 AND has WHO functional class II-IV symptoms. Or individual has catheterization-proven diagnosis of chronic thromboembolic pulmonary hypertension (CTEPH), WHO Group 4 AND Individual has WHO functional class II-IV symptoms AND using for one of the following: Persistent or recurrent pulmonary hypertension after at least 180 days following surgical treatment with pulmonary endarterectomey OR Inoperable (via pulmonary endarterectomey) CTEPH OR diagnosis of severe hepatic impairment (Child-Pugh class C) OR diagnosis of pulmonary veno-occlusive disease (PVOD) OR individual is on dialysis or has creatinine clearance less than 15mL/min.

AFINITOR

Products Affected

- AFINITOR
- AFINITOR DISPERZ

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

ALDURAZYME

Products Affected

- ALDURAZYME

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis is confirmed by: (a) Documented deficiency in alpha-L-iduronidase enzyme activity of less than 10% of the lower limit of normal range as measured in fibroblasts or leukocytes or (b)Documented alpha-L-iduronidase gene sequencing.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For dx of mucopolysaccharidosis I (MPS I) AND Individual has one of the following forms of MPS I: (1) Hurler OR (2) Hurler-Scheie OR (3) Scheie with moderate to severe symptoms manifestations including any of the following: (a) Cardiac valve abnormalities (such as aortic or mitral valve regurgitation, with or without insufficiency or stenosis) or (b) Corneal clouding, open-angle glaucoma, and retinal degeneration, progressive or (c) Craniofacial or growth retardation or (d) Frequent, moderate to severe upper respiratory infections or (e) Hepatosplenomegaly or (f) Hernias (such as hiatal, inguinal, or umbilical) or (g) Neurological symptoms resulting from cervical instability or cervical spinal cord compression or (h) Skeletal and joint involvement, progressive (such as, arthropathy, back pain, joint stiffness, lumbar spondylolisthesis, lumbar spinal compression, osteopenia, or osteoporosis).

ALECENSA

Products Affected

- ALECENSA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

ALIMTA

Products Affected

- ALIMTA INTRAVENOUS RECON SOLN 500 MG

PA Criteria	Criteria Details
Covered Uses	**Under CMS Review**
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

ALPHA1-PROTEINASE INHIBITOR

Products Affected

- PROLASTIN-C

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Alpha 1 proteinase inhibitors may not be approved for individuals with IgA antibodies.
Required Medical Information	Documented alpha-1 antitrypsin level is less than or equal to 11micro-mol/L. Individual has clinically evident emphysema and one of the following: Moderate airflow obstruction is evidenced by forced expiratory volume (FEV1) of 30-65 percent of predicted value, prior to initiation of therapy OR a rapid decline in lung function as measured by a change in FEV1 greater than 120 ml/year.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

ALUNBRIG

Products Affected

- ALUNBRIG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

AMPHETAMINE SALTS

Products Affected

- *dextroamphetamine-amphetamine oral capsule,extended release 24hr*
- *dextroamphetamine-amphetamine oral tablet 10 mg, 12.5 mg, 15 mg, 20 mg, 30 mg, 5 mg, 7.5 mg*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	For dx ADHD, 3 years of age or older for immediate release. For Narcolepsy, 6 years of age or older for immediate release
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

AMPYRA

Products Affected

- AMPYRA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Member has a history of seizures, OR moderate or severe renal impairment (defined as creatinine clearance less than or equal to 50 mL/min)
Required Medical Information	For initial approval, member has been objectively assessed for functional impairment related to ambulation AND documentation has been provided. For renewal, member achieved and sustained clinically significant improvement in ambulation related functional status AND documentation has been provided. Documentation may include chart notes, consultation notes.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Intial approval 12 weeks, renewal 1 year
Other Criteria	N/A

ANADROL 50

Products Affected

- ANADROL-50

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Anadrol 50 may not be used to not replace other supportive measures for anemia such as transfusion, correction of iron, folic acid, B12 or pyridoxine deficiency, antibacterial therapy, or the appropriate use of corticosteroids. Using to enhance athletic ability. Individual has a diagnosis of Carcinoma of the prostate or breast in male individuals or Carcinoma of the breast in females with Hypercalcemia. Individual has a diagnosis of nephrosis (nephrotic phase of nephritis). Individual has a diagnosis of severe hepatic dysfunction.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	Individual has a diagnosis of a deficient red cell production-associated anemia, such as but not limited to: acquired aplastic anemia, congenital aplastic anemia, myelofibrosis, or myelotoxic drug-associated hypoplastic anemia.

APOKYN

Products Affected

- APOKYN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Erectile Dysfunction (ED) use
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

ARCALYST

Products Affected

- ARCALYST

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Use in combination with other IL-1 inhibitors or tumor necrosis factor (TNF) inhibitors. Individual is receiving live vaccines. Exhibiting evidence of active or chronic infection(s), including tuberculosis, or a history of recurrent infections. Individual has not had a tuberculin skin test (TST) or Centers for Disease Control (CDC)-recommended equivalent to evaluate for latent tuberculosis prior to initiating treatment with rilonacept.
Required Medical Information	N/A
Age Restrictions	Individual is 12 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

AVASTIN

Products Affected

- AVASTIN

PA Criteria	Criteria Details
Covered Uses	**Under CMS Review**
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

BANZEL

Products Affected

- BANZEL ORAL SUSPENSION
- BANZEL ORAL TABLET 200 MG, 400 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	1 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

BARACLUDE

Products Affected

- BARACLUDE ORAL SOLUTION
- *entecavir*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Member has a diagnosis of Chronic Hepatitis B virus (HBV) infection with evidence of active viral replication AND either evidence of persistent elevations in serum aminotransferases (ALT or AST) or histologically active disease. And if member is co-infected with HIV, member is using in combination with highly active antiretroviral therapy (HAART)
Age Restrictions	2 years of age and older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

BAVENCIO

Products Affected

- BAVENCIO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Receiving treatment with another PD-1 agent (for example, Opdivo (nivolumab) or Keytruda (pembrolizumab)). Receiving therapy for an autoimmune disease or chronic condition requiring treatment with systemic immunosuppressant.
Required Medical Information	Current Eastern Cooperative Oncology Group (ECOG) performance status of 0-2 for metastatic merkel cell carcinoma
Age Restrictions	12 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

BELEODAQ

Products Affected

- BELEODAQ

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

BENLYSTA

Products Affected

- BENLYSTA INTRAVENOUS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For initial treatment, individual has a Clinical diagnosis of SLE per the American College of Rheumatology [ACR] criteria AND Unequivocally positive ANA (anti-nuclear antibody) titer greater than or equal to 1:80 or anti-dsDNA (double stranded DNA antibody) greater than or equal to 30 IU/mL AND SLE is active as documented by a SELENA-SLEDAI score greater than or equal to 6 while on current treatment regimen AND There is no evidence of severe renal disease (proteinuria greater than 6 gm/day, serum creatinine greater than 2.5 mg/dl, or requiring renal dialysis) AND There is no evidence of active central nervous system lupus (e.g. psychosis and seizures) AND SLE remains active while on corticosteroid, antimalarials, and/or immunosuppressants for at least the last 30 days. For continuation of therapy, individual has a clinical diagnosis of SLE per the American College of Rheumatology [ACR] criteria AND documentation of previous improvement in disease activity following treatment with belimumab indicating a therapeutic response AND there is no evidence of severe renal disease AND there is no evidence of active central nervous system lupus.
Age Restrictions	Individual is 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	1 year.
Other Criteria	N/A

BOSULIF

Products Affected

- BOSULIF ORAL TABLET 100 MG, 500 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Individual has Philadelphia chromosome positive Chronic Myeloid Leukemia (Ph+ CML) in chronic phase AND has documented resistance, intolerance, contraindication or warning to BOTH Gleevec and Sprycel. (Warnings may include, but not limited to pulmonary arterial hypertension, pleural or pericardial effusion, cardiac abnormalities).

BRIVIACT

Products Affected

- BRIVIACT INTRAVENOUS
- BRIVIACT ORAL SOLUTION
- BRIVIACT ORAL TABLET 10 MG, 100 MG, 25 MG, 50 MG, 75 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Individual is 16 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

BUPHENYL

Products Affected

- BUPHENYL ORAL TABLET
- *sodium phenylbutyrate*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Management of acute hyperammonemia
Required Medical Information	Using as adjunctive therapy for chronic management of hyperammonemia
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

CABOMETYX

Products Affected

- CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

CAPRELSA

Products Affected

- CAPRELSA ORAL TABLET 100 MG, 300 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

CARBAGLU

Products Affected

- CARBAGLU

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

CAYSTON

Products Affected

- CAYSTON

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Individual has a forced expiratory volume in 1 second (FEV1) of less than 25% or greater than 75% of predicted
Required Medical Information	N/A
Age Restrictions	7 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

CELEBREX

Products Affected

- *celecoxib*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Individual has failed to respond to, is intolerant of, or has a medical contraindication to ONE prescription Non-Steroidal Anti-Inflammatory Drugs (NSAID) or salicylates

CHANTIX

Products Affected

- CHANTIX
- CHANTIX CONTINUING MONTH BOX
- CHANTIX STARTING MONTH BOX

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	At least 18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	N/A

COMETRIQ

Products Affected

- COMETRIQ ORAL CAPSULE 100 MG/DAY(80 MG X1-20 MG X1), 140 MG/DAY(80 MG X1-20 MG X3), 60 MG/DAY (20 MG X 3/DAY)

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

COPAXONE

Products Affected

- COPAXONE SUBCUTANEOUS SYRINGE 20 MG/ML, 40 MG/ML
- GLATOPA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Individual with primary progressive MS (PPMS). Individual with secondary progressive MS (SPMS) without relapsing disease. Treatment of MS with glatiramer acetate (Copaxone) in combination with any IFN beta-1b (i.e., Betaseron, Extavia, Avonex, Rebif) or in combination with natalizumab
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For MSB Copaxone 20mg requests, Individual also has had a trial and inadequate response or intolerance to Glatopa (glatiramer acetate) 20 mg/mL.

CORLANOR

Products Affected

- CORLANOR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Individual has a heart rate maintained exclusively by a pacemaker. Individual has severe hypotension (blood pressure less than 90/50 mmgHg). Individual has severe hepatic impairment (Child-Pugh Class C).
Required Medical Information	N/A
Age Restrictions	18 years or older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Individual is using for the treatment of New York Heart Association (NYHA) class II, III or IV heart failure symptoms

COSENTYX

Products Affected

- COSENTYX (2 SYRINGES)

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Using Cosentyx in combination with a biologic DMARD such as Enbrel (etanercept), Humira (adalimumab), certolizumab pegol (Cimzia), Remicade (infliximab), or Stelara (ustekinumab). Using in combination with other immunosuppressive therapy such as phototherapy. Individuals with tuberculosis, invasive fungal infection, other active serious infections or a history of recurrent infections. Individual has not had a tuberculin skin test (TST) or a Centers of Disease Control and Prevention (CDC)-recommended equivalent test to evaluate for latent tuberculosis prior to initiating Cosentyx.
Required Medical Information	Individual has moderate to severe plaque psoriasis with either of the following: Individual has greater than 5% of body surface area with plaque psoriasis OR Less than or equal to 5% of body surface area with plaque psoriasis involving sensitive areas or areas that would significantly impact daily function (such as palms, soles of feet, head/neck, or genitalia).
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For plaque psoriasis, agent is being used to either reduce signs/symptoms OR induce/maintain clinical response AND individual has failed to respond to/intolerant of or has contraindication to phototherapy or other systemic therapy (such as acitretin, cyclosporine or methotrexate) AND Individual has had a trial of and an inadequate response or is intolerant to BOTH Enbrel and Humira. For active Ankylosing Spondylitis (AS) agent is being used to either reduce signs/symptoms or induce/maintain clinical response AND individual has failed to respond to/intolerant of or has a medical contraindication to ONE conventional therapy including (NSAIDs or nonbiologic DMARDs) AND Individual has had a trial of and an inadequate response or is intolerant to BOTH Enbrel AND Humira. For Psoriatic Arthritis (PsA) agent is being used to either reduce

PA Criteria	Criteria Details
	signs/symptoms OR induce/maintain clinical response AND individual has failed to respond to/intolerant of or has a medical contraindication to conventional drug therapy (such as non biologic DMARDs or TNF antagonist) AND Individual has had a trial of and an inadequate response or is intolerant to BOTH Enbrel AND Humira. For any of the above indications, if the TNF agent (Enbrel/Humira) tried and failed are not acceptable due to concomitant clinical conditions, such as but not limited to any of the following: (a) Known hypersensitivity or any active or inactive component which is not also associated with Cosentyx or (b) IndividualGÇÖs age or (c) Pregnant or planning or becoming pregnant or (d) Serious infections or concurrent sepsis OR mbr has either concomitant clinical condition: (a) Demyelinating disease or (b) Heart failure with documented left ventricular dysfunction, Cosentyx may be allowed without trial of preferred TNF agents (Enbrel/Humira).

COTELLIC

Products Affected

- COTELLIC

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Copy of the test results must be provided that document the BRAF V600E or V600K mutation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Individual is using Cotellic (cobimetinib) in combination with Zelboraf (vemurafenib).

CYRAMZA

Products Affected

- CYRAMZA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 Year
Other Criteria	N/A

DALIRESP

Products Affected

- DALIRESP

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Individual is using to treat acute bronchospasm OR moderate (Child-Pugh B) or severe (Child-Pugh C) hepatic impairment OR using concomitantly with strong cytochrome P450 enzyme inducer (such as but not limited to phenobarbital, carbamazepine or phenytoin)
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Individual is currently or will be concomitantly using with a long-acting bronchodilator.

DARZALEX

Products Affected

- DARZALEX

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Has received treatment with daratumumab or another anti-CD38 agent
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

DOXIL

Products Affected

- *doxorubicin, peg-liposomal*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

DURAGESIC PATCH

Products Affected

- *fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr*

PA Criteria	Criteria Details
Covered Uses	**Under CMS Review**
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

ELAPRASE

Products Affected

- ELAPRASE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documented deficiency in iduronate 2-sulfatase enzyme activity as measured in fibroblasts or leukocytes combined with normal enzyme activity level of another sulfatase OR Documented iduronate 2-sulfatase gene mutation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Individual has symptoms attributable to MPS II such as: (a) Developmental delay or cognitive impairment or (b) Frequent infections or (c) Hearing loss or (d) Hepatosplenomegaly or (e) Hernias or (f) Impaired respiratory function or (g) Joint pain or (h) Skeletal deformities or (i) Sleep apnea or (j) Valvular heart disease.

ELIDEL

Products Affected

- ELIDEL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Individual is 2 years of age and older.
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Individual had a trial of and inadequate response or intolerance to one topical prescription strength corticosteroid.

ELITEK

Products Affected

- ELITEK

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Individual has a diagnosis of glucose-6-phosphate dehydrogenase (G6PD) deficiency.
Required Medical Information	Individual is receiving treatment in a setting appropriate for providing necessary monitoring and supportive care for tumor lysis syndrome AND Individual has not received a course of Elitek therapy in the past.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	30 days
Other Criteria	Individual has been diagnosed with leukemia, lymphoma or other hematologic malignancy with risk factors for tumor lysis syndrome AND Individual is receiving chemotherapy.

EMPLICITI

Products Affected

- EMPLICITI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

EMSAM

Products Affected

- EMSAM

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Individuals with pheochromocytoma OR Individual is currently taking one of the following: (1) Selective serotonin reuptake inhibitors (SSRIs) (for example, fluoxetine) OR (2) Serotonin and norepinephrine reuptake inhibitors (SNRIs) (for example, venlafaxine) OR (3) Tricyclic antidepressants (clomipramine or imipramine) OR (4) Opiate analgesics (meperidine, tramadol, methadone, pentazocine) OR (5) Dextromethorphan OR (6) Carbamazepine.
Required Medical Information	Individual has no known contraindications to the use of a monoamine oxidase inhibitor (MAOI).
Age Restrictions	Individual is 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

ENBREL

Products Affected

- ENBREL SUBCUTANEOUS RECON SOLN
- ENBREL SUBCUTANEOUS SYRINGE 25 MG/0.5ML (0.51), 50 MG/ML (0.98 ML)
- ENBREL SURECLICK

PA Criteria	Criteria Details
Covered Uses	**Under CMS Review**
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

ENTRESTO

Products Affected

- ENTRESTO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Individual is pregnant/ wishing to become pregnant OR breastfeeding OR has a history of angioedema related to previous ACE inhibitor or ARB therapy OR has severe hepatic impairment (Child-Pugh C). OR Individual will be utilizing an angiotensin-converting enzyme (ACE) inhibitor OR angiotensin receptor blocker (ARB) in combination with Entresto (sacubitril/valsartan). Individual will be utilizing Entresto (sacubitril/valsartan) in combination with Tekturna (aliskiren)/Tekturna HCT (aliskiren/hydrochlorothiazide) and has a diagnosis of diabetes or renal impairment (eGFR less than 60 mL/min/1.73 m2).
Required Medical Information	Individual has a left ventricular ejection fraction less than or equal to 40%.
Age Restrictions	Individual is 18 years or older.
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

EPCLUSA

Products Affected

- EPCLUSA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	A copy of the baseline quantitative hepatitis C virus (HCV) RNA test result is provided to document baseline level of viremia AND One of the following: (1) Documentation is provided for a diagnosis of chronic hepatitis C (CHC) infection, which includes a positive HCV RNA test result at least 6 months following either a baseline positive HCV RNA result or reactive HCV antibody test (AASLD/IDSA 2016, CDC 2013). OR (2) Individual is unable to delay treatment for 6 months owing to concurrent factors [such as but not limited to, advanced liver disease (Metavir fibrosis stage of F3 or F42), post-liver transplant recipients, co-infection with human immunodeficiency virus (HIV) or hepatitis B virus (HBV), coexistent liver diseases (such as nonalcoholic steatohepatitis), chronic HCV infection-associated extrahepatic manifestations (such as membranoproliferative glomerulonephritis, glomerular disease, cryoglobulinemia syndrome)] (AASLD/IDSA 2016) AND Documentation is provided for a diagnosis of chronic CHC infection, which includes a reactive HCV antibody (CDC 2013) and a subsequent positive HCV RNA result (CDC 2013). Individual does not have a short life expectancy (less than 12 months owing to non-liver related comorbid conditions) that cannot be remediated by treating HCV, by transplantation or other directed therapy (AASLD/IDSA 2016).
Age Restrictions	Individual is 18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Criteria will be applied consistent with current AASLD/IDSA guidance.
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance.

EPOGEN AND PROCRIT

Products Affected

- PROCRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML, 40,000 UNIT/ML

PA Criteria	Criteria Details
Covered Uses	**Under CMS Review**
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

ERBITUX

Products Affected

- ERBITUX INTRAVENOUS SOLUTION 100 MG/50 ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Erbitux is used in combination with other anti-VEGF agents (e.g., bevacizumab). Erbitux is used in more than one line of therapy.
Required Medical Information	For stage IV, kras wild type colon, rectal, colorectal, small bowel, or anal adenocarcinoma when used as a single agent or as part of combination therapy. For squamous cell carcinoma of the Head and/or Neck cancer, Erbitux is used in combination with radiation therapy, for the treatment of locally or regionally advanced disease. Or as a single agent for the treatment of patients with recurrent or metastatic disease for whom prior platinum-based therapy has failed. Or in combination with platinum-based therapy with 5-FU (fluorouracil) as first-line treatment for individuals with recurrent locoregional disease or metastatic SCCHN. OR as a single agent or in combination therapy with or without radiation therapy for any of the following indications, unresectable locoregional recurrence or second primary in individuals who have received prior radiation therapy OR resectable locoregional recurrence in individuals who have not received prior radiation therapy OR distant metastases.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

ERIVEDGE

Products Affected

- ERIVEDGE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

ERWINASE

Products Affected

- ERWINAZE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	History of serious thrombosis with prior L-asparaginase therapy. History of pancreatitis with prior L-asparaginase therapy. History of serious hemorrhagic events with prior L-asparaginase therapy.
Required Medical Information	Individual is using Erwinase as a component of a multi-agent chemotherapeutic regimen AND is using for Acute lymphoblastic lymphoma or acute lymphocytic leukemia (ALL) or Extranodal natural killer T-cell lymphoma, nasal type (ENKL). Individual has developed a documented systemic allergic reaction or anaphylaxis to prior treatment with Oncaspar (Pegaspargase).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

ESBRIET

Products Affected

- ESBRIET ORAL CAPSULE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Individuals using in combination with Ofev (nintedanib). Individuals currently taking fluvoxamine. Individuals with end-stage renal disease (ESRD). Individuals with severe hepatic impairment (child pugh class C) or end-stage liver disease.
Required Medical Information	Diagnosis of idiopathic pulmonary fibrosis (IPF) is confirmed by: Exclusion of other known causes of interstitial lung disease (ILD) such as domestic and occupational environmental exposures, connective tissue disease, and drug toxicity AND High resolution computed tomography (HRCT) with or without surgical lung biopsy. Individual has documented pulmonary function tests within prior 60 days with a Forced Vital Capacity (% FVC) greater than or equal to 50%.
Age Restrictions	18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

EXJADE

Products Affected

- EXJADE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Individual is 2 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

FABRAZYME

Products Affected

- FABRAZYME INTRAVENOUS RECON SOLN 35 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of Fabry disease is confirmed with either of the following: (a) Documentation of complete deficiency or less than 5% of mean normal alpha-galactosidase A enzyme activity in leukocytes, dried blood spots or serum (plasma) analysis or (b) Documented galactosidase alpha gene mutation by gene sequencing.
Age Restrictions	Individual is 8 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Individual has one or more symptoms or physical findings attributable to Fabry disease, such as: (a) Acroparesthesias or (b) Angiokeratomas or (c) Corneal verticillata (whorls) or (d) Decreased sweating (anhidrosis or hypohidrosis) or (e) Personal or family history of exercise, heat, or cold intolerance or (f) Personal or family history of kidney failure.

FARYDAK

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

FASLODEX

Products Affected

- FASLODEX

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

FETZIMA

Products Affected

- FETZIMA ORAL CAPSULE,EXT REL 24HR DOSE PACK
- FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR 120 MG, 20 MG, 40 MG, 80 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	May not be approved for treatment of fibromyalgia
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For MDD, individual has had a trial of TWO of the following: Desvenlafaxine ER, desvenlafaxine Fumerate ER, fluoxetine, fluvoxamine, escitalopram, citalopram, paroxetine, sertraline, mirtazapine, immediate-release venlafaxine, extended-release venlafaxine or bupropion.

FIRAZYR

Products Affected

- FIRAZYR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Prophylaxis for HAE attacks.
Required Medical Information	HAE Type I/II to be confirmed by a C4 level below the lower limit of normal (as defined by the laboratory performing the test) and either a C1 inhibitor antigenic level below the lower limit of normal (as defined by the lab performing test) or a C1 inhibitor functional level below the lower limit of normal (as defined by the lab performing the test). HAE Type III was confirmed by: C1 inhibitor (C1-INH) antigenic level is normal as defined by the laboratory performing the test AND C4 level is normal as defined by the laboratory performing the test.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Individual has a history of moderate or severe attacks (for example, airway swelling, severe abdominal pain, facial swelling, nausea and vomiting, painful facial distortion)and using Firazyr for acute HAE attacks.

FIRMAGON

Products Affected

- FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 120 MG, 80 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For Prostate cancer: Clinically localized disease with intermediate (T2b to T2c cancer, Gleason score of 7, or prostate specific antigen (PSA) value of 10-20 ng/mL) OR higher risk of recurrence as neoadjuvant therapy with radiation therapy or cryosurgery OR Following radical prostatectomy as adjuvant therapy when lymph node metastases are present OR Locally advanced disease OR Other advanced, recurrent, or metastatic disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

FORTEO

Products Affected

- FORTEO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Individual is not using Forteo (teriparatide) in combination with any of the following: Prolia (denosumab), Bisphosphonates, Evista (raloxifene),Miacalcin/Fortical (calcitonin nasal spray), or Recalst (zolendronic acid).
Required Medical Information	A Bone Mineral Density (BMD) and a T-score must be provided with all requests. Osteoporosis is defined as a BMD T-Score of less than or equal to -2.5 as compared to young adult reference population OR a Clinical diagnosis based on a history of a low trauma fracture (fragility fracture) at high risk for fracture OR associated with sustained systemic glucocorticoid therapy (daily dosage equivalent to 5mg or greater of prednisone for at least 3 months) at high risk for fracture. In the absence of fragility fracture, BMD T-Scores greater than -2.5 (closer to 0 or positive) are not considered osteoporotic. High risk for fracture is defined as follows: Hx of osteoporotic fracture, OR multiple risk factors for fractures (including but not limited to prior low-trauma fracture as an adult, advanced age, gender, ethnicity, low bone mineral density, low body weight, family history of osteoporosis, use of glucocorticoids (daily dosage equivalent to 5mg or greater of prednisone for at least 3 months), cigarette smoking, excessive alcohol consumption [3 or more drinks/day], secondary osteoporosis (such as, rheumatoid arthritis), early menopause, height loss or kyphosis, fall risk and low calcium intake, OR Failure or intolerance to other osteoporosis therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	2 years. Requests to continue therapy beyond 24 months (2 years) should not be approved.
Other Criteria	Individual has one of the following: (A) Individual has had a trial of an oral bisphosphonate therapy OR (B) Intolerance or contraindications to oral bisphosphonate as defined by having at least one of the following: 1. Hypersensitivity to TWO oral bisphosphonates (one of which must be alendronate) 2. Inability to sit or stand upright for at least 30 minutes, 3.

PA Criteria	Criteria Details
	Pre-existing gastrointestinal disorders (Barrett's esophagus, hypersecretory disorders, delayed esophageal emptying, etc.). 4. Uncorrected hypocalcemia.

GATTEX

Products Affected

- GATTEX 30-VIAL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Individual is 18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For diagnosis of Short Bowel Syndrome (SBS) defined as having less than 200 cm of functional small intestine remaining as a result of one of the following (label, AGA 2003, Buchman et al. 2003): Acquired through surgical bowel resection OR Congenital (jejunal or ileal intestinal atresia) AND individual is has been dependent on parenteral nutrition/intravenous (PN/IV) support. For at least 12 months AND requires PN at least 3 times per week.

GAUCHERS

Products Affected

- CEREZYME INTRAVENOUS RECON SOLN 400 UNIT
- VPRIV

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Use of enzyme replacement therapy (ERT) agents in conjunction with one another or in conjunction with a substrate reduction therapy (SRT) agent. Use of ERT agents for the treatment of type 2 gaucher disease.
Required Medical Information	Type 1 Gaucher is confirmed by: Glucocerebrosidase activity in white blood cells or skin fibroblasts less than or equal to 30% of normal activity, OR genotype tests indicating mutation of two alleles of the glucocerebrosidase genome. And mbr has clinically significant manifestations of gauchers including any of the following for type 1,3: [Adults] skeletal disease (demonstrated by ANY of the following: avascular necrosis, erlenmeyer flask deformity, lytic disease, marrow infiltration, osteopenia, osteosclerosis, pathological fracture, radiological evidence of joint deterioration) OR mbr presents with at least 1 of the following: clinically significant hepatomegaly/splenomegaly, hgb less than or equal to 11.5 gm/dl for females and less than 12.5 gm/dl for males or 1 gm/dl below lower limit for normal for age and sex, platelet counts less than or equal to 120,000 mm3. [Children] abdominal or bone pain, hepatosplenomegaly, documented growth fx not associated with other conditions, cachexia, exertional limitation, fatigue, evidence of skeletal involvement including but not limited to erlenmeyer flask deformity, anemia with hgb less than 2 grams per dl below lower limit of normal for age and sex, platelet count less than 60,000 mm3 and or documented abnormal bleeding episodes. Type 3 gauchers is confirmed by genotype testing indicating presence of 2 homopathic alleles for neuropathic gaucher disease. And mbr has clinically significant manifestations of gauchers listed above in type 1 AND Neurological findings are consistent with the presence of type 3 gaucher disease: Neurological examination, eye movement examination, neuro-ophthalmological investigation with direct opthalmoloscopy, measurement of peripheral hearing (electro-acoustical emission in small children, pure tone audiometry in older patients), brain imaging preferably by MRI or CT, diagnostic brain stem evoked responses, EEG, intelligence quotient testing when appropriate and reasonable.
Age Restrictions	N/A

Prior Authorization

PA Criteria	Criteria Details
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

GILOTRIF

Products Affected

- GILOTRIF

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For individuals with metastatic non-small cell lung cancer (NSCLC), a Copy of the test results from a FDA-approved companion diagnostic test must be provided that document the exon 19 deletions or exon 21 (L858R) substitution mutation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

GLEEVEC

Products Affected

- *imatinib oral tablet 100 mg, 400 mg*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

GLEOSTINE

Products Affected

- GLEOSTINE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

HALAVEN

Products Affected

- HALAVEN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Halven is used as a single agent and in a single line of therapy for recurrent or metastatic breast cancer. Member has previously received at least two chemotherapeutic regimens for locally recurrent or metastatic disease. Individual is using in combination with trastuzumab (Herceptin) in the treatment of locally recurrent or metastatic HER2+ breast cancer with: (a) Symptomatic visceral disease OR (b) Either hormone receptor-negative disease or hormone receptor-positive and endocrine refractory disease. For soft tissue sarcoma, agent is used as a single agent in a single line of therapy and has previously received at least 2 chemotherapeutic regimens for locally recurrent or metastatic disease.

HARVONI

Products Affected

- HARVONI

PA Criteria	Criteria Details
Covered Uses	**Under CMS Review**
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

HEPSERA

Products Affected

- *adefovir*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	12 years of age and older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

HETLIOZ

Products Affected

- HETLIOZ

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

HRM AGE

Products Affected

- *amitriptyline*
- *chlorpromazine*
- *clomipramine*
- COMPRO
- *desipramine*
- *imipramine hcl*
- *phenobarbital oral elixir*
- *phenobarbital oral tablet 100 mg, 15 mg, 16.2 mg, 30 mg, 32.4 mg, 60 mg, 64.8 mg, 97.2 mg*
- *prochlorperazine*
- *prochlorperazine edisylate injection solution 10 mg/2 ml (5 mg/ml)*
- *prochlorperazine maleate*
- SURMONTIL
- *trimipramine*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	The physician has indicated the requested medication is not causing adverse effects OR individual has a contraindication or has a clinical reason not to use a safer alternative (prescriber acknowledgement that medication benefits outweigh potential risks is sufficient).
Age Restrictions	Members that are 64 years of age or younger are NOT subject to the prior authorization requirements. Prior Authorization applies to members that are 65 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

HRM AGE AU

Products Affected

- *benztropine*
- *clemastine oral tablet 2.68 mg*
- *cyclobenzaprine oral tablet*
- *cyproheptadine oral tablet*
- DIGITEK ORAL TABLET 250 MCG
- *digoxin injection solution*
- *digoxin oral tablet 250 mcg*
- *diphenhydramine hcl injection solution 50 mg/ml*
- *disopyramide phosphate oral capsule*
- *ergoloid*
- *estradiol oral*
- *estradiol transdermal patch weekly*
- *estropipate*
- *glyburide micronized oral tablet 1.5 mg, 3 mg, 6 mg*
- *glyburide oral tablet 1.25 mg, 2.5 mg, 5 mg*
- *glyburide-metformin oral tablet 1.25-250 mg, 2.5-500 mg, 5-500 mg*
- *guanfacine oral tablet*
- *hydroxyzine hcl intramuscular*
- *hydroxyzine hcl oral solution 10 mg/5 ml*
- *hydroxyzine hcl oral tablet*
- JINTELI
- *ketorolac oral*
- LANOXIN ORAL TABLET 250 MCG
- MENEST ORAL TABLET 0.3 MG, 0.625 MG, 1.25 MG
- *methyldopa*
- *nitrofurantoin macrocrystal oral capsule 100 mg, 50 mg*
- *nitrofurantoin monohyd/m-cryst*
- PREMARIN ORAL
- PREMPRO
- *promethazine injection solution*
- *promethazine oral tablet*
- *trihexyphenidyl*
- *zaleplon oral capsule 10 mg, 5 mg*
- *zolpidem oral tablet*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	The physician has indicated the requested medication is not causing adverse effects OR individual has a contraindication or has a clinical reason not to use a safer alternative (prescriber acknowledgement that medication benefits outweigh potential risks is sufficient).
Age Restrictions	Members that are 64 years of age or younger are NOT subject to the prior authorization requirements. Prior Authorization applies to members that are 65 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	1 year

Prior Authorization

PA Criteria	Criteria Details
Other Criteria	N/A

HUMAN GROWTH HORMONE

Products Affected

- NORDITROPIN FLEXPRO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Use of GH tx when applicable criteria have not been met may not be approved for, but not limited to, the following: Renal transplant, Anabolic tx, except for AIDS, provided to counteract acute or chronic catabolic illness (e.g. surgery, trauma, cancer,chronic hemodialysis) producing catabolic (protein wasting) changes in both adult and ped. Anabolic tx to enhance body mass or strength for professional, recreational or social reasons, Constitutional delay of growth and development. Cystic fibrosis, GH Tx in combo with GnRH agonist (Lupron-leuprolide) as a Tx of precocious puberty. Hypophosphatemic rickets, osteogenesis imperfecta, osteoporosis, Short Stature associated with GH insensitivity (Laron Syndrome). Therapy in older adults with normally occurring decrease in GH, who are not congenitally GH deficient and who have no evidence of organic pituitary dz (this is referred to as age-related GH deficiency). Tx of CHF, burn patients, fibromyalgia, glucocorticoid-induced growth failure. Tx of HIV lipodystrophy (fat redistribution syndrome), also referred to as altered body habitus (e.g. buffalo hump), associated with antiviral therapy in HIV-infected patients. Tx of intrauterine growth restriction (IUGR)or Russell-Silver Syndrome that does not result in SGA. Tx of obesity. Other etiologies of SS where GH has not been shown to be associated with an increase in final height, including but not limited to achondrodoplasia and other skeletal dysplasias. GH tx used for reconstruction is terminated when BA =16 yr (M), or = 14 yr (F) is reached OR Epiphyseal fusion has occurred OR Mid-parenteral height is achieved. For individuals being treated for GHD due to trauma or aneurysmal subarachnoid hemorrhage, GHD must be reconfirmed at 12 months after the event for therapy to continue. If retesting is not confirmatory for GHD, continued Tx is considered not medically necessary. Child over 12: an X-ray report with evidence that epiphyses have closed or SMR of 3 or more
Required Medical Information	For idiopathic GHD, has signs/sym of GHD, GV 2 SD below age-appropriate mean or ht 2.25 SD below age-appropriate mean and A subnormal (SubNL) response (less than10ng/ml)to 2GH stim tests OR Neonates with hypoglycemia and clinical/hormone evidence of hypopit and low GH (less than 10ng/ml)OR 2other pit hormone deficiencies and low IGF-1 OR mbr has cranial irradiation with low IGF1 and normal thyroid tests.Child born SGA(birth wt or length 2 or more SD below the

PA Criteria	Criteria Details
	mean for gest age),Child fails to manifest catch up growth by age 4 yr(ht 2 or more SD below the mean for age,gender)AND Other causes for SS have been ruled out.Transitioning adolescent:GH tx has been stopped for at least a month, and GHD has been reconfirmed:idiopathic isolated GHD(SubNL response to 2 GH stim tests, OR SubNL response (GH conc of less than10 ng/mL)to 1 provocative test and low IGF-I/IGFBP-3)OR multiple pit hormone deficiency,(SubNL response to 1 provocative GH test and/or low IGF-I/IGFBP-3)or for mbr with cranial irradiation, low IGF with normal thyroid or any of the following, known genetic mutation associated with def GH production or secretion or Hypothalamic-pit tumor or structural defect or 3 other pit hormone deficiencies.Adult GHD must be confirmed/reconfirmed:SubNL response in adults to 2 GH stim tests (GH conc of less than or equal to 5ng/ml when using insulin induced hypoglycemia OR GH conc of less than or equal to 4.1ng/ml when using arginine)OR SubNL response to 1 stim test for adults with hypothalamic or pit dz and 1 pit hormone deficits OR 3 other pit hormone deficiencies.Reconstructive GH tx who dont have GHD may be approved if either mean ht is at least 2.25 but less than 2.5SD below the mean for age, gender and GV is less than the 10th percentile over 1yr or mean ht is at least 2.5SD below the mean for age, gender for conditions known responsive to GH.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Cont of GH tx in child is approved when doubling of pre-tx growth rate or an inc in pre-tx growth rate of 3cm/yr or more seen in the first yr of tx, for tx continuing past the 1st yr, growth remains above 2.5cm/yr (doesnt apply to child with prior hypopit). GH may be approved for Adolescents with childhood onset GHD who have completed linear growth. GH for Short bowel syndrome in individuals receiving specialized nutritional support.

HUMIRA

Products Affected

- HUMIRA PEDIATRIC CROHN'S START SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML, 40 MG/0.8 ML (6 PACK)
- HUMIRA PEN
- HUMIRA PEN CROHN'S-UC-HS START
- HUMIRA PEN PSORIASIS-UVEITIS
- HUMIRA SUBCUTANEOUS SYRINGE KIT 10 MG/0.2 ML, 20 MG/0.4 ML, 40 MG/0.8 ML

PA Criteria	Criteria Details
Covered Uses	**Under CMS Review**
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

IBRANCE

Products Affected

- IBRANCE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

ICLUSIG

Products Affected

- ICLUSIG ORAL TABLET 15 MG, 45 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Individual has T315I-positive Chronic Myeloid Leukemia in chronic phase AND has documented resistance, intolerance, contraindication or warning to BOTH Gleevec and Sprycel. (Warnings may include, but not limited to pulmonary arterial hypertension, pleural or pericardial effusion, cardiac abnormalities).

ILARIS

Products Affected

- ILARIS (PF) SUBCUTANEOUS RECON SOLN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Tuberculosis, invasive fungal infection, other active serious infection, or a history of recurrent infection. Individual who have not had a tuberculin skin test or a CDC-recommended equivalent to evaluate for latent tuberculosis prior to initiating Ilaris (canakinumab). Using Ilaris in combination with other biologic disease-modifying antirheumatic drugs (DMARDs), tumor necrosis factor (TNF) antagonists, IL-1R antagonists, Janus kinase inhibitors, or an IL-6 receptor antagonist.
Required Medical Information	N/A
Age Restrictions	For cryopyrin-associated periodic syndromes age 4 years and older and for systemic juvenile idiopathic arthritis 2 years of age and older.
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For SIJA, agent is being used to reduce signs/symptoms or induce/maintain clinical response and individual has failed to respond to, intolerant of, or has a medical contraindication to ONE corticosteroids or nonsteroidal anti-inflammatory drugs (NSAIDs). For FMF, individual has active type 1 FMF disease with genetic confirmation of the diagnosis (MEFV gene exon 10 mutation) and documented recurrent, active disease (that is, at least one flare per month) and has failed to respond to, or is intolerant of colchicine therapy. For HIDS/MKD, individual has HIDS with genetic confirmation of the diagnosis by deoxyribonucleic acid (DNA) analysis or enzymatic studies (that is, mutations in the MVK gene or markedly reduced mevalonate kinase activity) and documented prior history of greater than or equal to three febrile acute flares within a 6-month period when not receiving prophylactic treatment. For TRAPS, genetic confirmation of the diagnosis (TNFRSF1A gene mutation) and has chronic or recurrent disease activity defined as six flares in a 12-month period.

IMBRUVICA

Products Affected

- IMBRUVICA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

IMFINZI

Products Affected

- IMFINZI

PA Criteria	Criteria Details
Covered Uses	**Under CMS Review**
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

INCRELEX

Products Affected

- INCRELEX

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Individual has an active or suspected malignancy. Individual has closed epiphyses (closed bone growth plates signifying end of potential growth). Individual has a diagnosis of secondary forms of IGFD (such as but not limited to, GH deficiency, untreated malnutrition, untreated hypothyroidism). Growth velocity is less than 2 cm total growth in 1 year. Final adult height has been reached.
Required Medical Information	For initial treatment of growth failure associated with one of the following (1) Growth failure with severe primary IGFD as defined by: Height standard deviation score of less than or equal to -3.0 AND Basal IGF-1 standard deviation score of less than or equal to -3.0 AND normal or elevated growth hormone levels (greater than 10ng/mL on standard GH stimulation tests) are present OR (2) GH gene deletion who have development of neutralizing antibodies to GH.
Age Restrictions	2 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For Continuation of treatment with Increlex (mecasermin), Growth velocity is greater than or equal to 2cm (greater than equal to 2.0 cm) total growth in 1 year AND Final adult height has not been reached.

INLYTA

Products Affected

- INLYTA ORAL TABLET 1 MG, 5 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

INTERFERONS FOR MS

Products Affected

- BETASERON SUBCUTANEOUS KIT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Members with primary progressive MS. Members with secondary progressive MS without relapsing disease. Treatment of MS with IFN beta-1a (for example, Avonex, Rebif, Plegridy) or IFN beta-1b (for example Betaseron, Extavia) in combination with glatiramer acetate (Copaxone) or in combination with natalizumab (Tysabri).
Required Medical Information	Members with a single demyelinating episode with consistent MRI findings, considered at high risk for clinically definite MS OR Member with MS with relapsing or remitting disease (RRMS) OR Members with secondary progressive MS (SPMS) with a history of superimposed relapses.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

INTUNIV

Products Affected

- *guanfacine oral tablet extended release 24 hr*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Individual is using for Attention Deficit Hyperactivity Disorder/Attention Deficit Disorder (ADHD/ADD).
Age Restrictions	Individual is 6 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Individual has had a trial of ONE generic stimulant medication unless either of the following applies: individual or individuals family has a history of substance diversion/abuse OR Individual has a diagnosis of anxiety or a tic disorder (such as, Tourettes Syndrome)

ISTODAX

Products Affected

- ISTODAX

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

ITRACONAZOLE

Products Affected

- *itraconazole*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	For fingernail/toenail onychomycosis 12 weeks. For all other indications 1 year.
Other Criteria	For second-line non-onychomycosis indications include tinea infections (including, but limited to tinea versicolor, tinea cruris, tinea corporis, tinea pedis, tinea manuum, and tinea capitis) where the individual has received at least one prior topical therapy: clotrimazole, ketoconazole, econazole, or nystatin.

IVIG

Products Affected

- GAMUNEX-C INJECTION SOLUTION 1 GRAM/10 ML (10 %)
- OCTAGAM

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For Chronic Inflammatory Demyelinating Polyneuropathy (CIDP), medical records must indicate clinical presentation is not consistent with other polyneuropathies (Igm neuropathy, hereditary neuropathy, diabetic neuropathy) and ONE of the following clinical and electrodiagnostic criteria are met: proximal weakness or sensory dysfunction caused by neuropathy and nerve conduction studies confirm electodiagnostic evidence of a demyelinating neuropathy in at least 2 limbs. OR distal muscle weakness and results of diagnostic testing meet recognized set of diagnostic criteria as established by AAN, Saperstien, or INTAC. Continued use of IG for CDIP requires clinically significant improvement in neurological symptoms as documented on physical exam AND continued need is demonstrated by documentation that attempts on an annual basis to titrate the dose or the interval of therapy result in worsening symptoms. For Multifocal Motor Neuropathy (MMN) patient presents with asymmetric weakness that predominantly affects distal muscles AND nerve conduction studies confirm a demyelinating neuropathy is present (conduction block, slowing, or abnormal temporal dispersion in at least one nerve) OR clinical history or exam do not suggest upper motor neuron disease (no bulbar weakness, no upper motor neuron signs) and GM-1 antibody titers are elevated. OR after initial exam and electrodiagnostic testing clinical presentation suggests MMN but the diagnosis remains uncertain. Continued use for MMN requires clinical results document an improvement in strength and function within 3 weeks of start of infusion and need is demonstrated by documentation that attempts on an annual basis to titrate the dose or interval of therapy result in worsening of symptoms.
Age Restrictions	N/A
Prescriber Restrictions	N/A

Prior Authorization

PA Criteria	Criteria Details
Coverage Duration	1 year
Other Criteria	To reduce the risk of graft-versus-host disease associated with interstitial pneumonia (infectious or idiopathic) and infections (cytomegalovirus infections, Varicella-zoster virus infection, and recurrent bacterial infection) in allogeneic bone marrow transplant (BMT) recipients in the first 100 days after transplantation. Dermatomyositis, refractory (IVIG is used as a second line treatment of dermatomyositis. Corticosteroids are first-line treatments of dermatomyositis.). Myasthenia Gravis, severe refractory. Polymyositis, routine use of IG is not recommended. IG may be considered in patients with severe polymyositis for whom other treatments have been unsuccessful, have become intolerable, or are contraindicated. Stiff-person syndrome not controlled by other therapies. Toxic shock syndrome caused by staphylococcal or streptococcal organisms refractory to several hours of aggressive therapy. Tx of chronic parvovirus B19 infection and severe anemia associated with bone marrow suppression. Refractory auto-immune mucocutaneous blistering diseases including: pemphigus vulgaris, pemphigus foliaceus, bullous pemphigoid, mucous membrane pemphigoid, epidermolysis bullosa acquisita. Tx of primary humoral immunodeficiency (PI) when: hx of recurrent sinopulmonary infection req antibiotic tx AND lack of, or inadequate response to immunization AND no evidence of renal (nephrotic syndrome) and gastrointestinal (e.g. protein losing enteropathy) as causes of hypogammaglobulinemia (HGG) AND initial pre-tx total serum IgG is below the lower limit of age adj lab ref range or more than 2 SD below adj mean. Tx of other PI when: no evidence of renal/GI causes of HGG AND initial pre-tx total serum IgG is more than 2 SD below adj mean. Tx of IgG sub-class deficiency (IgG1, IgG2, IgG3, IgG4) when: One or more serum IgG subclasses are below lower limit of age adj lab ref range or more than 2 SD below age adj mean AND hx of recurrent sinopulmonary infections requiring antibiotic therapy AND Lack of, or inadequate response to immunization. Tx of Kawasaki Syndrome when: within 10 days of onset and tx for no more than 5 days. For ITP when: symptomatic thrombocytopenia (for example, but not limited to hematuria, petechiae, bruising, gastrointestinal bleeding, gingival bleeding) or platelet count less than 20,000 (adult) or 30,000 (child). For hypogammaglobulinemia and recurrent bacterial infection associated with B-cell chronic lymphocytic leukemia (CLL) that includes both: Documented hx of recurrent bacterial infection or an active infection not responding to antimicrobial therapy AND Documentation that total IgG is less than 500mg/dL.

JAKAFI

Products Affected

- JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

JARDIANCE

Products Affected

- JARDIANCE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Individual has had a trial and inadequate response or intolerance to metformin OR Individual has a contraindication to metformin therapy [such as but not limited to, renal insufficiency (eGR is less than 45mL/minute/1.73m2)].

JEVTANA

Products Affected

- JEVTANA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For hormone-refractory metastatic prostate cancer, individual has a Eastern Cooperative Oncology Group (ECOG) performance status is 0-2.

KADCYLA

Products Affected

- KADCYLA INTRAVENOUS RECON SOLN 100 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Tumor(s) have been evaluated with an assay validated to predict HER2 positive (HER2+) protein overexpression. Individuals are considered HER2 positive (HER2+) as documented by one of the following, immunohistochemistry (IHC) 3+ or In Situ hybridization (ISH) positive by any of the following: Single probe average HER2 copy number greater than or equal to 6.0 signals/cell OR Dual-probe HER2/CEP 17 ratio greater than or equal to 2.0 OR Dual-probe HER2/CEP 17 ratio less than 2.0 with an average HER2 copy number greater than or equal to 6.0 signals/cell.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For metastatic breast cancer, individual has previously received trastuzumab and a taxane, separately or in combination. AND has either received prior therapy for metastatic disease OR developed disease recurrence during or within six (6) months of completing adjuvant therapy. Kadcyla is only used in a single line of therapy.

KALYDECO

Products Affected

- KALYDECO ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	**Under CMS Review**
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

KEYTRUDA

Products Affected

- KEYTRUDA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Previous treatment with another programmed death receptor-1 (PD-1) blocking antibody agent. OR Presence of human immunodeficiency virus (HIV) infection, hepatitis B virus infection, or hepatitis C virus infection. Receiving therapy for an autoimmune disease or chronic condition requiring treatment with an immunosuppressant.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	A)For the treatment of unresectable or metastatic melanoma, Keytruda is being used as a single agent AND first line therapy in untreated disease or as second line or subsequent therapy for documented disease progression while receiving or since completing most recent therapy and Current Eastern Cooperative Oncology Group (ECOG) performance status of 0-2. B) For first line tx of metastatic NSCLC, used as a single agent, cytologically confirmed stage IV NSCLC and Tumor expresses D_L1 gene on at least 50% of tumor cells and No sensitizing epidermal growth factor receptor (EGFR) mutations or anaplastic lymphoma kinase (ALK) translocations and has not undergone previous systemic therapy for metastatic disease and ECOG status of 0-2. C) For metastatic non-small cell lung cancer (NSCLC) as a second or subsequent line of therapy, Keytruda is being used as a single agent AND Tumors with PD-L1 gene expression level greater than or equal to 1% with demonstrated disease progression on or after platinum-containing chemotherapy AND when ALK or EGFR genomic tumor aberrations are present, must have demonstrated has disease progression on U.S. Food and Drug Administration (FDA) approved therapy for the aberrations prior to receiving pembrolizumab OR Being used in combination with

PA Criteria	Criteria Details
	pemetrexed (Alimta) and carboplatin as first-line treatment for metastatic nonsquamous NSCLC AND ECOG performance status of 0-2. D) For the tx of recurrent, unresectable or metastatic head and neck squamous cell carcinoma (HNSCC), used as a single agent and tumor expresses PD-L1 gene and demonstrated disease progression on or after platinum-containing chemotherapy and ECOG performance status of 0-2. E) For the tx of Merkel-cell carcinoma (MCC), being used as a single agent and Presence of metastatic or recurrent locoregional MCC determined to be not amendable to definitive surgery or radiation therapy and ECOG performance status of 0-2.

KISQALI

Products Affected

- KISQALI FEMARA CO-PACK ORAL TABLET 200 MG/DAY(200 MG X 1)-2.5 MG, 400 MG/DAY(200 MG X 2)-2.5 MG, 600 MG/DAY(200 MG X 3)-2.5 MG
- KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1), 400 MG/DAY (200 MG X 2), 600 MG/DAY (200 MG X 3)

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

KLONOPIN

Products Affected

- *clonazepam oral tablet 0.5 mg, 1 mg, 2 mg*
- *clonazepam oral tablet,disintegrating 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis (all ages) and if over 65 years of age or older, the physician has indicated the requested high risk medication (HRM) is not causing adverse effects OR Individual has a contraindication or has a clinical reason not to use safer alternatives(prescriber acknowledgement that medication benefits outweigh potential risks is sufficient).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

KORLYM

Products Affected

- KORLYM

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	History of unexplained vaginal bleeding. Current endometrial hyperplasia with atypia or endometrial carcinoma. Diagnosis of severe hepatic impairment (Child Pugh Class C). Concomitant use with any of the following: (1) Long term systemic corticosteroids for serious medical conditions or illnesses OR (2) Simvastatin or lovastatin OR (3) CYP3A substrates with narrow therapeutic ranges (such as but not limited to cyclosporine, fentanyl, sirolimus, tacrolimus) OR (4) Agents or co-morbid conditions which prolong the QT interval
Required Medical Information	N/A
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Initial therapy: Individual is not a candidate for surgery that is expected to correct the cause of endogenous CushingGÇÖs Syndrome OR disease persists or recurs following surgery intended to correct the cause of endogenous CushingGÇÖs Syndrome. For continuation of therapy: Individual continues to meet the initial request approval criteria AND has experienced an improvement in or stabilization of glucose control as assessed by fasting serum glucose test, oral glucose tolerance test or hemoglobin A1c test.

KUVAN

Products Affected

- KUVAN ORAL TABLET,SOLUBLE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	If blood phenylalanine levels do not decrease from baseline at a dose of 10mg/kg/day administered for up to one month. The dose may be increased up to 20mg/kg/day. Individuals are non-responders if phenylalanine levels do not decrease after 1 month and tx should be discontinued
Required Medical Information	For initial requests, Individual has Dx of Hyperphenylalaninemia (HPA) due to tetrahydrobiopterin-(BH4) responsive PKU. For continued use, individual is showing signs of continuing improvement as evidenced by blood phenylalanine levels.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial 8 weeks, 1 year for continuation
Other Criteria	N/A

KYPROLIS

Products Affected

- KYPROLIS

PA Criteria	Criteria Details
Covered Uses	**Under CMS Review**
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

LARTRUVO

Products Affected

- LARTRUVO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Individual is 18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Individual has a histologically confirmed diagnosis of late stage soft tissue sarcoma (locally advanced or metastatic) not previously treated with an anthracycline and Olaratumab is used in combination with doxorubicin and Radiotherapy or surgery is not a treatment option and Individual's current Eastern Cooperative Oncology Group (ECOG) performance status is 0-2. Individual has a histologically confirmed diagnosis of late stage soft tissue sarcoma (locally advanced or metastatic) not previously treated with an anthracycline and Olaratumab is used as monotherapy after eight cycles in combination with doxorubicin or after disease progression with doxorubicin and Radiotherapy or surgery is not a treatment option and Individual's current Eastern Cooperative Oncology Group (ECOG) performance status is 0-2.

LATUDA

Products Affected

- LATUDA ORAL TABLET 120 MG, 20 MG, 40 MG, 60 MG, 80 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	For Schizophrenia, 13 years of age or older. For all other indications, age 18 or older.
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For schizophrenia, individual has had a trial of one of the following generic oral atypical antipsychotic agents: Risperidone, Olanzapine, Quetiapine fumarate, Paliperidone, or Ziprasidone.

LENVIMA

Products Affected

- LENVIMA ORAL CAPSULE 10 MG/DAY (10 MG X 1/DAY), 14 MG/DAY(10 MG X 1-4 MG X 1), 18 MG/DAY (10 MG X 1-4 MG X2), 20 MG/DAY (10 MG X 2), 24 MG/DAY(10 MG X 2-4 MG X 1), 8 MG/DAY (4 MG X 2)

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

LETAIRIS

Products Affected

- LETAIRIS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Individual has idiopathic pulmonary fibrosis (IPF). Individual has a diagnosis of moderate (Child-Pugh Class B) or severe (Child-Pugh Class C) hepatic impairment. Individual is initiating therapy and has a diagnosis of clinically significant anemia.
Required Medical Information	Individual has catheterization-proven diagnosis of pulmonary arterial hypertension (PAH) (WHO Group 1) AND individual has WHO Functional Class II-IV symptoms.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

LIDODERM PATCH

Products Affected

- *lidocaine topical adhesive patch,medicated*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

LONSURF

Products Affected

- LONSURF

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

LOTRONEX

Products Affected

- *alosetron*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Individual is a Female with Severe diarrhea-predominant Irritable Bowel Syndrome (IBS) defined as including diarrhea and 1or more of the following: Frequent and severe abdominal pain/discomfort, Frequent bowel urgency or fecal incontinence, Disability or restriction of daily activities due to IBS. Member is female AND Member has chronic symptoms of IBS that have persisted for 6 months or longer AND does not have an anatomic or biochemical abnormality of the gastrointestinal tract.
Age Restrictions	18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Individual has a documented trial of, an inadequate response or intolerance TWO (2) of the following medications: (a) Loperimide (b) antispasmodics (for example, dicyclomine), or (c) tricyclic antidepressants (AGA 2014).

LOVAZA

Products Affected

- *omega-3 acid ethyl esters*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Using to reduce triglyceride (TG) levels AND TG must be greater than or equal to 500 mg/dL.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

LUPRON DEPOT

Products Affected

- LUPRON DEPOT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For Prostate cancer: Clinically localized disease with intermediate (T2b to T2c cancer, Gleason score of 7, or prostate specific antigen (PSA) value of 10-20 ng/mL) or higher risk of recurrence as neoadjuvant therapy with radiation therapy or cryosurgery OR following radical prostatectomy as adjuvant therapy when lymph node metastases are present OR Locally advanced disease OR Other advanced, recurrent, or metastatic disease. For Gynecology Uses: Initial treatment/retreatment of endometriosis (not to continue beyond 6 months) OR Dysfunctional uterine bleeding OR Preoperative treatment as adjunct to surgical treatment of uterine fibroids (leiomyoma uteri). May be used to reduce size of fibroids to allow for a vaginal procedure, prior to surgical treatment (myomectomy or hysterectomy) in patients with documented anemia. To induce amenorrhea in women in certain populations including menstruating women diagnosed with severe thrombocytopenia or aplastic anemia. For Endocrine Uses: Precocious puberty, defined as beginning of secondary sexual characteristics before age 8 in girls and before age 9 in boys. Ovarian Cancer (including fallopian tube cancer and primary peritoneal cancer):Hormonal therapy for clinical relapse in individuals with stage II-IV granulosa cell tumors or Hormonal therapy for treatment of epithelial ovarian cancer, fallopian tube cancer, primary peritoneal cancer as a single agent for persistent dz or recurrence.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year, except for Endometriosis:6months, Uterine Fibroids:3months
Other Criteria	For Gender Dysphoria in Adolescents: Fulfills the DSM V criteria for gender dysphoria AND has experienced puberty to at least Tanner stage 2 AND has (early) pubertal changes that have resulted in an increase of their gender dysphoria AND does not suffer from a psychiatric

PA Criteria	Criteria Details
	comorbidity that interferes with the diagnostic work-up or treatment AND has psychological and social support during treatment AND demonstrates knowledge and understanding of the expected outcomes of GnRH analog treatment.

LUPRON KIT IR

Products Affected

- *leuprolide subcutaneous kit*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For Prostate cancer: Clinically localized disease with intermediate (T2b to T2c cancer, Gleason score of 7, or prostate specific antigen (PSA) value of 10-20 ng/mL) or higher risk of recurrence as neoadjuvant therapy with radiation therapy or cryosurgery OR following radical prostatectomy as adjuvant therapy when lymph node metastases are present OR Locally advanced disease OR Other advanced, recurrent, or metastatic disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

LYNPARZA

Products Affected

- LYNPARZA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Copy of the test results from a FDA-approved test must be provided that document the BRCA mutation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

LYRICA

Products Affected

- LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 225 MG, 25 MG, 300 MG, 50 MG, 75 MG
- LYRICA ORAL SOLUTION

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For neuropathic pain associated with diabetic peripheral neuropathy (DPN), individual had a trial of one of the following: (1) SNRI (such as, Cymbalta (duloxetine HCl) or venlafaxine IR/ER ((AACE 2015, ADA 2017)) (2) Tricyclic antidepressants (such as, amitriptyline, clomipramine, desipramine, nortriptyline) (AACE 2015, AAFP 2010, ADA 2017, NICE 2013) OR (3) Gabapentin (AACE 2015, ADA 2017, NICE 2013). For post herpetic neuralgia, member had a trial of one of the following: (1) Gabapentin (2) Lidocaine patch (Lidoderm) or (3) Gralise (may require PA) or (4) Tricyclic antidepressants (such as, amitriptyline, desipramine, nortriptyline) (IASP 2015, EFNS 2010). For Fibromyalgia, Individual had a Trial of and insufficient response or intolerance to TWO of the following: (1) Savella (milnacipran) (2) Cymbalta (duloxetine HCl) (3)Gabapentin (CFCG 2012) (4) Tricyclic antidepressants (CFCG 2012) (5) Cyclobenzaprine (CFCG 2012) OR (6) Fluoxetine (CFCG 2012).

MEGACE SUSPENSION HRM

Products Affected

- *megestrol oral suspension 400 mg/10 ml (40 mg/ml)*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Individual has been on the requested medication and the prescriber would like to continue member on the requested high risk medication. OR individual is using for the treatment of anorexia, cachexia, or unexplained weight loss in individuals with HIV/AIDS.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

MEGACE TABS HRM

Products Affected

- *megestrol oral tablet*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Individual has been on the requested medication and the prescriber would like to continue member on the requested high risk medication.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

MEKINIST

Products Affected

- MEKINIST ORAL TABLET 0.5 MG, 2 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Copy of the test results must be provided that document the BRAF V600E or V600K mutation for unresectable or metastatic melanoma OR a copy of the test results must be provided that document BRAF V600E mutation for non-small cell lung cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 Year
Other Criteria	N/A

MEPRON

Products Affected

- *atovaquone*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Intolerance to trimethoprim-sulfamethoxazole (TMP-SMX)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

METHOXSALEN

Products Affected

- *methoxsalen*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

MODAFINIL

Products Affected

- *modafinil oral tablet 100 mg, 200 mg*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For Narcolepsy type 1: confirmed by the presence of daily periods of irrepressible need to sleep or daytime lapses into sleep occurring for at least 3 months and at least one of the following: 1. Clear cataplexy (defined as more than one episode of generally brief) usually bilaterally symmetrical, sudden loss of muscle tone with retained consciousness) AND 2.Multiple Sleep Latency Test (MSLT) showing one of the following: a. Mean sleep latency of less than 8 minutes with evidence of two sleep-onset rapid eye movement periods (SOREMPs) (ICSD-3, 2014)OR b. At least one SOREMP on MSLT and a SOREMP (less than 15 minutes) on the preceding overnight polysomnography (PSG) OR 3.Cerebrospinal fluid hypocretin-1 deficiency (less than 110 pg/mL or less than one-third of the normative values with the same standardized assay). For Narcolepsy type 2: confirmed by 1.Multiple sleep latency test (MSLT) with one of the following: a.Mean sleep latency of less than 8 minutes with and evidence of two sleep-onset rapid eye movement periods (SOREMPs) ICSD-3, 2014) OR b. At least one SOREMP on MSLT and a SOREMP (less than 15 minutes) on the preceding overnight polysomnography (PSG) AND 2.The absence of cataplexy AND 3.Exclusion of alternative causes of excessive daytime sleepiness by history, physical exam and Polysomnography.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For obstructive sleep apnea/hypopnea syndrome objectively confirmed by polysomnography (PSG) or home testing with portable monitor showing one of the following (AASM 2009): (1).Greater than 15 obstructive events (defined as apneas, hypopneas plus respiratory event related arousal) per hour of sleep OR (2)Greater than 5 obstructive events per

PA Criteria	Criteria Details
	hour of sleep and individual reports any of the following: a.Unintentional sleep episodes during wakefulness or b. Daytime sleepiness or c. Unrefreshing sleep or d. Fatigue or e. Insomnia or f.Waking up breath holding, gasping or choking or g.Bed partner describing loud snoring, breathing interruptions or both or h. Presence of comorbid conditions including hypertension, mood disorder, cognitive dysfunction, coronary artery disease, stroke, congestive heart failure, atrial fibrillation or type 2 diabetes mellitus. And has an Epworth Sleepiness Scale score greater than or equal to 10. For Shift-Work Sleep Disorder (SWSD) confirmed by all of the following: (1)No other medical disorder or mental disorder accounts for the symptoms AND (2)Symptoms do not meet criteria for any other sleep disorder (i.e. jet lag) AND (3)Symptoms have occurred for at least 3 months, AND (4)Individual has one of the following: a.Individual has excessive sleepiness or insomnia associated with a work period that occurs during the usual sleep phase OR b.Polysomnography demonstrates loss of a normal sleep-wake pattern (such as, disturbed chronobiological rhythmicity).

MOZOBIL

Products Affected

- MOZOBIL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Using as a mobilizing agent for an allogeneic stem cell donor, mobilizer of leukemic cells or as a component of a conditioning regimen prior to an allogeneic hematopoietic stem cell transplant.
Required Medical Information	Using in combination with granulocyte colony stimulating factor (G-CSF) and after stem cell mobilization and collection, a subsequent autologous hematopoietic stem cell transplant is anticipated.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	Individual may use a maximum of up to four consecutive doses of plerixafor (Mozobil) injections per cycle for up to 2 cycles.

NAGLAZYME

Products Affected

- NAGLAZYME

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Mucopolysaccharidosis VI is confirmed by: (a) with an increase in dermatan sulfate in the urine and (b) Decrease in the activity of 4-sulphatase enzyme in the blood.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

NAMENDA LINE

Products Affected

- *memantine oral solution*
- *memantine oral tablet 10 mg, 5 mg*
- NAMENDA XR ORAL CAP,SPRINKLE,ER 24HR DOSE PACK
- NAMENDA XR ORAL CAPSULE,SPRINKLE,ER 24HR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Members that are 50 years of age or older are NOT subject to the prior authorization requirements. Prior Authorization applies to members that are 49 years of age or younger.
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Individual has a diagnosis of moderate to severe dementia of the AlzheimerGÇÖs type.

NAMZERIC

Products Affected

- NAMZARIC

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Individual has a diagnosis of moderate to severe dementia of the AlzheimerGÇÖs type AND is stabilized on donepezil (Aricept) 10 mg and memantine (Namenda)/memantine XR concomitantly AND Individual is unable to utilize donepezil and memantine/XR separately for reasons such as but not limited to caregiver or administration concerns.

NATPARA

Products Affected

- NATPARA

PA Criteria	Criteria Details
Covered Uses	**Under CMS Review**
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

NEULASTA

Products Affected

- NEULASTA SUBCUTANEOUS SYRINGE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Individuals who are at high risk for infection-associated complications by any of the following: Expected prolonged (greater than 10 day) and profound (less than 0.1 x 10 to the power of 9/L) neutropenia, Age greater than 65 years, Uncontrolled primary disease, Pneumonia, Hypotension and multi organ dysfunction (sepsis syndrome), Invasive fungal infection, Hospitalized at the time of the development of fever. Primary prophylaxis of FN in patients who have a risk of FN of 20% or greater based on chemotherapy regimens. OR when the risk of developing FN is greater than or equal to 10% and less than 20% based on chemotherapy in patients who have other patient specific risk factors for FN including any of the following: Individual age greater than 65 years, Poor performance status (ECOG status 3-4), Previous episodes of FN, Bone marrow involvement by tumor producing cytopenias, preexisting neutropenia (ANC less than 1500mm3), Poor nutritional status (baseline albumin less than or equal to 3.5g/dL or body mass index [BMI] less than 20), poor renal function (GFR less than 60mL/min) , liver dysfunction, The presence of open wounds, advanced cancer or Other serious comorbidities.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Secondary Prophylaxis for patients who experienced a neutropenic complication from a prior cycle of chemotherapy (for which primary prophylaxis was not received), in which a reduced dose may compromise disease-free or overall survival or treatment outcome. Adjunctive use in neutropenic patients who are at high risk for infection-associated complications. In an individual with acute lymphocytic leukemia (ALL) after completion of the first few days of initial induction chemotherapy or

PA Criteria	Criteria Details
	first post-remission course of chemotherapy. For myelodysplastic syndromes (MDS) with severe neutropenia (absolute neutrophil count (ANC) less than or equal to 500 mm3 or experiencing recurrent infection. For dose dense therapy (treatment given more frequently, such as every two weeks instead of every three weeks) for adjuvant treatment of breast cancer. After a hematopoietic progenitor stem cell transplant (HPCT/HSCT) to promote myeloid reconstitution OR when engraftment is delayed or has failed.

NEUPOGEN

Products Affected

- NEUPOGEN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Febrile neutropenic individuals who are at risk for infection-associated complications or have any of the following: Expected prolonged (greater than 10 day) and profound (less than 0.1 x 10to the power of 9/L) neutropenia, Age greater than 65 years, Uncontrolled primary disease, Pneumonia, Hypotension and multi organ dysfunction (sepsis syndrome), Invasive fungal infection, or Hospitalized at the time of the development of fever. Primary prophylaxis of FN in patients who have a risk of FN of 20% or greater based on chemotherapy regimens. OR when the risk of developing FN is greater than or equal to 10% and less than 20% based on chemotherapy in patients who have other patient specific risk factors for FN including any of the following: Individual age greater than 65 years, Poor performance status (ECOG status 3-4), Previous episodes of FN, Bone marrow involvement by tumor producing cytopenias, preexisting neutropenia (ANC less than 1500mm3), Poor nutritional status (baseline albumin less than or equal to 3.5g/dL or body mass index [BMI] less than 20), poor renal function (GFR less than 60mL/min) , liver dysfunction, The presence of open wounds, advanced cancer or Other serious comorbidities
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Secondary Prophylaxis for patients who experienced a neutropenic complication from a prior cycle of chemotherapy (for which primary prophylaxis was not received), in which a reduced dose may compromise disease-free or overall survival or treatment outcome. Adjunctive use in neutropenic patients who are at high risk for infection-associated complications. Use in acute lymphocytic leukemia (ALL) after completion of the first few days of initial induction chemotherapy or first

PA Criteria	Criteria Details
	post-remission course of chemotherapy. Use in individuals with acute myeloid leukemia (AML) shortly after the completion of induction or repeat induction chemotherapy, or after the completion of consolidation chemotherapy for AML. For tx of moderate to severe aplastic anemia. Tx of severe neutropenia in individuals with hairy cell leukemia. For myelodysplastic syndromes (MDS) with severe neutropenia (absolute neutrophil count (ANC) less than or equal to 500 mm3 or experiencing recurrent infection. For dose dense therapy (treatment given more frequently, such as every two weeks instead of every three weeks) for adjuvant treatment of breast cancer. For chronic administration to reduce the incidence and duration of sequelae of neutropenia (e.g., fever, infections, oropharyngeal ulcers) in symptomatic individuals with congenital neutropenia, cyclic neutropenia, or idiopathic neutropenia. For tx of (non-chemotherapy) drug-induced neutropenia. For tx of low neutrophil counts in individuals with glycogen storage disease type 1b. For tx of neutropenia associated with human immunodeficiency virus (HIV) infection and antiretroviral therapy. In individuals receiving radiation therapy in the absence of chemotherapy if prolonged delays secondary to neutropenia are expected. After accidental or intentional total body radiation of myleosuppressive doses (greater than 2 Grays [Gy] (such as Hematopoietic Syndrome of Acute Radiation Syndrome). After hematopoietic progenitor stem cell transplant (HPCT/HSCT) to promote myeloid reconstitution or when engraftment is delayed or has failed. To mobilize progenitor cells into peripheral blood for collection by leukapheresis, as an adjunct to peripheral blood/hematopoietic stem cell transplantation (PBSCT/PHSCT). Use as an alternate or adjunct to donor leukocyte infusions (DLI) in individuals with leukemic relapse after an allogeneic hematopoietic stem cell transplant.

NEUPRO

Products Affected

- NEUPRO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Individual has had a previous trial of or has a contraindication to either Mirapex (pramipexole) or Requip (ropinirole). OR Individual is unable to swallow or take oral medications.

NEXAVAR

Products Affected

- NEXAVAR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

NINLARO

Products Affected

- NINLARO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year.
Other Criteria	N/A

NON-PEGYLATED INTERFERONS

Products Affected

- INTRON A INJECTION RECON SOLN
- INTRON A INJECTION SOLUTION 6 MILLION UNIT/ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For Hepatitis B when: HBeAg is either positive or negative AND Detectable levels of Hepatitis B DNA AND member has Compensated liver disease AND ALT at least 2X upper limit of normal
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1yr
Other Criteria	N/A

NORTHERA

Products Affected

- NORTHERA ORAL CAPSULE 100 MG, 200 MG, 300 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Individual is 18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Individual has had a trial (resulting in inadequate response, therapeutic failure or intolerance) of at least one prior pharmacologic therapy (which may include midodrine or fludrocortisone) for treatment of symptoms of NOH.

NOXAFIL

Products Affected

- NOXAFIL ORAL SUSPENSION

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year.
Other Criteria	N/A

NP LA OPIOID

Products Affected

- DURAMORPH (PF)
- *hydromorphone (pf)*
- *hydromorphone injection syringe 2 mg/ml*
- *tramadol oral tablet extended release 24 hr 100 mg, 200 mg*

PA Criteria	Criteria Details
Covered Uses	**Under CMS Review**
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

NP TOPICAL ANDROGENS

Products Affected

- *testosterone transdermal gel in packet*

PA Criteria	Criteria Details
Covered Uses	**Under CMS Review**
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

NULOJIX

Products Affected

- NULOJIX

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

NUPLAZID

Products Affected

- NUPLAZID

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Initial therapy: Individual has a diagnosis of ParkinsonGÇÖs disease AND Symptoms of psychosis developed after the PD diagnosis AND Symptoms of psychosis include at least one of the following: (1) Visual hallucinations, (2) Auditory hallucination OR (3) Delusions AND Symptoms have been present for at least one month AND Individual has experienced symptoms at least once weekly. Psychiatric symptoms cannot be attributed to disorders such as schizophrenia, schizoaffective disorder, delusional disorder, or mood disorder with psychotic features, or a general medical condition including delirium. For continued therapy, the individual has had a reduction in symptoms of psychosis compared to baseline.

ODOMZO

Products Affected

- ODOMZO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 Year
Other Criteria	N/A

OFEV

Products Affected

- OFEV ORAL CAPSULE 150 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Using in combination with Esbriet (pirfenidone). Individuals with severe hepatic impairment (child pugh class C) or end-stage liver disease.
Required Medical Information	Diagnosis of idiopathic pulmonary fibrosis (IPF) is confirmed by: Exclusion of other known causes of interstitial lung disease (ILD) such as domestic and occupational environmental exposures, connective tissue disease, and drug toxicity AND High resolution computed tomography (HRCT) with or without surgical lung biopsy. Individual has documented pulmonary function tests within prior 60 days with a Forced Vital Capacity (% FVC) greater than or equal to 50%.
Age Restrictions	18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

ONFI

Products Affected

- ONFI ORAL SUSPENSION
- ONFI ORAL TABLET 10 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis (all ages) and if over 65 years of age or older, the physician has indicated the requested high risk medication (HRM) is not causing adverse effects OR Individual has a contraindication or has a clinical reason not to use safer alternatives (prescriber acknowledgement that medication benefits outweigh potential risks is sufficient).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

OPDIVO

Products Affected

- OPDIVO INTRAVENOUS SOLUTION 40 MG/4 ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Receiving therapy for an autoimmune disease or chronic condition requiring treatment with an immunosuppressant. Previous treatment with another programmed death receptor-1 (PD-1) blocking antibody agent.
Required Medical Information	Current ECOG performance status 0-2.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For unresectable or metastatic melanoma: Opdivo is used as a single agent or in combination with Yervoy, as first-line therapy for untreated melanoma OR used as a single agent or in combination with Yervoy, as second-line or subsequent therapy for documented disease progression while receiving or since completing most recent therapy if PD-1 (programed death receptor -1) agent not previously used. For metastatic non-small cell lung cancer (NSCLC): Opdivo is used as a single agent AND demonstrated disease progression on or after platinum-containing chemotherapy. For RCC: used as a single AND demonstrated progression after 1 or 2 prior anti-angiogenic regimens (for example, axitinib, bevacizumb, pazopanib, sorafenib, sunitinib, etc) for the treatment of advanced or metastatic disease.

ORFADIN

Products Affected

- ORFADIN ORAL CAPSULE 10 MG, 2 MG, 5 MG
- ORFADIN ORAL SUSPENSION

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

ORKAMBI

Products Affected

- ORKAMBI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Mutation testing indicates individual has two copies of the F508del mutation AND a copy of the CF mutation analysis test result must be provided.
Age Restrictions	Individual is 6 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

OXANDRIN

Products Affected

- *oxandrolone oral tablet 2.5 mg*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Carcinoma of the prostate or breast in male individuals OR Carcinoma of the breast in females with hypercalcemia. Using to enhance athletic performance or physique. Individual has a diagnosis of nephrosis (nephrotic phase of nephritis). Individual has a diagnosis of hypercalcemia.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

PEGYLATED INTERFERONS

Products Affected

- PEGASYS
- PEGASYS PROCLICK

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	A copy of the baseline quantitative hepatitis C virus (HCV) RNA test result is provided to document baseline level of viremia AND One of the following: (1) Documentation is provided for a diagnosis of chronic hepatitis C (CHC) infection, which includes a positive HCV RNA test result at least 6 months following either a baseline positive HCV RNA result or reactive HCV antibody test (AASLD/IDSA 2016, CDC 2013). OR (2) Individual is unable to delay treatment for 6 months owing to concurrent factors [such as but not limited to, advanced liver disease (Metavir fibrosis stage of F3 or F42), post-liver transplant recipients, co-infection with human immunodeficiency virus (HIV) or hepatitis B virus (HBV), coexistent liver diseases (such as nonalcoholic steatohepatitis), chronic HCV infection-associated extrahepatic manifestations (such as membranoproliferative glomerulonephritis, glomerular disease, cryoglobulinemia syndrome)] (AASLD/IDSA 2016) AND Documentation is provided for a diagnosis of chronic CHC infection, which includes a reactive HCV antibody (CDC 2013) and a subsequent positive HCV RNA result (CDC 2013). Individual does not have a short life expectancy (less than 12 months owing to non-liver related comorbid conditions) that cannot be remediated by treating HCV, by transplantation or other directed therapy (AASLD/IDSA 2016).
Age Restrictions	For use in combination with a protease/polymerase inhibitor and ribavirin (triple therapy) , age 18 or older.
Prescriber Restrictions	N/A
Coverage Duration	1 year.
Other Criteria	For Genotype 1, 2, 3, 4, 5, or 6, as part of a planned triple therapy (IFN plus RBV plus NS5B Protease Inhibitor). For Genotype 1, 2, 3, 4, 5, or 6, as part of a planned dual therapy (IFN plus RBV). For Genotype 1, 2, 3,

PA Criteria	Criteria Details
	4, 5, or 6, monotherapy therapy when individual has contraindications or significant intolerance to HCV antiviral agents/regimens.

PENLAC

Products Affected

- *ciclopirox topical solution*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Individual has a confirmed fungal infection by physical exam
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Individual has had a trial of and inadequate response or intolerance to oral itraconazole or terbinafine OR Individual has a contraindication, drug interaction or concomitant clinical condition (such as but not limited to history of liver disease or concerns over hepatotoxicity, history of CHF) which makes use of oral itraconazole or terbinafine unacceptable OR individual has used the requested product within the previous 6 months

PERJETA

Products Affected

- PERJETA

PA Criteria	Criteria Details
Covered Uses	**Under CMS Review**
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

POMALYST

Products Affected

- POMALYST ORAL CAPSULE 1 MG, 2 MG, 3 MG, 4 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

PRALUENT

Products Affected

- PRALUENT PEN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrent use with Juxtapid or Kynamro.
Required Medical Information	Individual is at High Risk for Acute Coronary Syndrome (ACS) as identified by one of the following: (A) Heterozygous Familial Hypercholesterolemia (HeFH) with provided documentation confirming: 1.Presence of a mutation in LDLR, apolipoprotein B (ApoB), PCSK9 or ARH adaptor protein gene (LDLRAP1) gene OR 2. World Health Organization (WHO)/Dutch Lipid Network Criteria with score of gtr than 8 points OR (B) History of Clinical Atherosclerotic Cardiovascular Disease (ASCVD), including one of the following (documentation must be provided): 1.Acute coronary syndromes 2.History of myocardial infarction (MI) 3.Stable or unstable angina 4.Coronary or other arterial revascularization 5.Stroke 6.Transient ischemic attack (TIA) 7.Peripheral arterial disease presumed to be of atherosclerotic origin.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Initial 3 month. Continuation 1 yr.
Other Criteria	For initial request, individual meets one of the following: (A) Individual is a on high intensity statin therapy, or statin therapy at the maximum tolerated dose, where high intensity statin is defined as atorvastatin 40 mg or higher OR rosuvastatin 20 mg or higher (documentation must be provided) OR (B) Individual is statin intolerant OR (C) Individual has a condition that is a contraindication for statin therapy including active liver disease, unexplained persistent elevation of serum transaminases, or pregnancy, which does not exist for the requested PCS-K9 agent (documentation must be provided). Individual also has had an adequate trial and titration of a Repatha (evolocumab) and has achieved suboptimal lipid lowering response despite at least 90 days of Repatha (evolocumab) therapy. For continuation, criteria outlined for initial Prior Authorization has been satisfied AND Documentation of LDL reduction has been

PA Criteria	Criteria Details
	provided.

PROLIA

Products Affected

- PROLIA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Bone Mineral Density (BMD) and T-Score must be provided with all requests. Osteoporosis is defined as a BMD T-Score of less than or equal to -2.5. For osteoporosis treatment, risk factors for osteoporotic fracture is defined as: Hypogonadism or premature ovarian failure, Low body mass, Smoking, Rheumatoid arthritis, Alcohol intake of 3 or more drinks/day, Vitamin D deficiency, Low calcium intake, Hyperkyphosis, Parental hip fracture, Multiple falls, Medication: Anticoagulants, anticonvulsants, aromatase inhibitors, cancer chemotherapeutic drugs, gonadotropin-releasing hormone agonists, (glucocorticoid daily dosage equivalent to 5 mg or greater of prednisone for at least 3 months). For the treatment of bone loss, risk factors for osteoporotic fracture is defined as: Low body mass, Smoking, Rheumatoid arthritis, Alcohol intake of 3 or more drinks/day, Vitamin D deficiency, Low calcium intake, Hyperkyphosis, Parental hip fracture, Multiple falls, Medication: Anticoagulants, anticonvulsants, (glucocorticoid daily dosage equivalent to 5 mg or greater of prednisone for at least 3 months).
Age Restrictions	For Osteoporosis 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For osteoporosis treatment, member has had at least ONE osteoporotic (minimal trauma) fracture OR has two or more risk factors for osteoporotic fracture OR Individual has failed or is intolerant to other available osteoporosis therapies (such as, bisphosphonates). For treatment of bone loss, member has had at least ONE osteoporotic (minimal trauma) fracture OR has one or more risk factors for osteoporotic fracture.

PROMACTA

Products Affected

- PROMACTA ORAL TABLET 12.5 MG, 25 MG, 50 MG, 75 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Using Promacta to normalize platelet counts. Use in individuals with ITP whose degree of thrombocytopenia and clinical condition (for example, platelet count greater than 30 x 109/L or active bleeding) do not increase the risk of bleeding. Use in individuals with chronic hepatitis C whose degree of thrombocytopenia does not prevent the initiation of peginterferon therapy or limits the ability to maintain an optimal peginterferon-based therapy. Used in individuals with chronic hepatitis C who are no longer on a peginterferon and ribavirin based regimen. Used concomitantly with other thrombopoietin receptor agonists such as romiplostim (Nplate). Used in individuals taking in combination with direct-acting antiviral agents used without concomitant use of a peginterferon agent for treatment of thrombocytopenia associated with chronic hepatitis C infection.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For initial therapy: 1) Diagnosis of chronic immune (idiopathic) thrombocytopenia (ITP) AND individual has platelet count of less than 30 x 109/L or active bleeding (ASH, 2011. Hicks et al., 2014) AND has had a prior trial and insufficient response to one of the following: a) corticosteroids or b) immunoglobulins [for example, intravenous, anti-D] or c) splenectomy. OR, 2) Diagnosis of severe aplastic anemia AND individual has a platelet count of less than or equal to 30 x 109/L (Olnes et al., 2012.Desmond et al., 2014) AND individual has had a prior trial and insufficient response to an immunosuppressive therapy [such as, anti-thymocte globulin (ATG)]. For maintenance therapy, individual has demonstrated a response to therapy as evidenced by increased platelet

PA Criteria	Criteria Details
	counts AND to maintain an adequate platelet count (50 GÇô 200 x 109/L) to decrease the risk of bleeding.

PURIXAN

Products Affected

- PURIXAN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

RAVICTI

Products Affected

- RAVICTI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Using for the management of acute hyperammonemia. Using to treat N-acetylglutamate synthase deficiency (NAGS).
Required Medical Information	N/A
Age Restrictions	2 months of age or older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

RECLAST

Products Affected

- *zoledronic acid-mannitol-water 5 mg/100 ml*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For Paget's disease of bone in men and women, treatment is indicated with elevations in serum alkaline phosphatase of two times or higher than the upper limit of the age-specific normal reference range, or those who are symptomatic, or those at risk for complications from their disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

RELISTOR

Products Affected

- RELISTOR SUBCUTANEOUS SOLUTION
- RELISTOR SUBCUTANEOUS SYRINGE 12 MG/0.6 ML, 8 MG/0.4 ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Individual has a known or suspected mechanical gastrointestinal obstruction.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Individual must have a previous trial of or insufficient response to polyethylene glycol (generic MiraLax) (AGA 2013) AND a trial and inadequate response or intolerance to a preferred agent (Movantik/Amitiza) OR the preferred agent (Movantik/Amitiza) is not acceptable due to concomitant clinical situations, warnings or contraindications, such as but not limited to the following: (1) individual is taking a diphenylheptane opioid (e.g., methadone), where effectiveness has not been established in the treatment of OIC (Amitiza) OR (2) individual has disruption to the blood-brain barrier and may be at increased risk for opioid withdrawal and/or reduced analgesia (Movantik) OR (3) individual is taking strong CYP3A4 inhibitors and may be at increased risk for opioid withdrawal and/or reduced analgesia (Movantik).

REMICADE

Products Affected

- REMICADE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Tuberculosis, invasive fungal infection, other active serious infections or a history of recurrent infection. Individuals who have not had a tuberculin skin test or CDC-recommended equivalent to evaluate for latent tuberculosis prior to initiating infliximab. Using in combination with other TNF antagonists, abatacept, anakinra, tofacitinib or tocilizumab.
Required Medical Information	For chronic moderate to severe plaque psoriasis: Greater than 5% of body surface area with plaque psoriasis OR Less than or equal to 5% body surface area with plaque psoriasis involving sensitive areas or areas that would significantly impact daily function (such as palms, soles of feet, head/neck, or genitalia).
Age Restrictions	For Crohn's Disease or Ulcerative colitis, 6 yr of age or older. For all other indications 18 yr of age.
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For RA, agent is being used to reduce signs/symptoms OR induce/maintain clinical response OR inhibit the progression of structural damage OR improve physical function AND Infliximab is given in combination with methotrexate or with another immunosuppressive agent if the individual is intolerant to methotrexate AND individual has failed to respond to, is intolerant of, or has a medical contraindication to ONE nonbiologic DMARD. For Crohn's Disease, individual has failed to respond to, is intolerant of, or has a medical contraindication to ONE conventional therapy (such as 5-ASA products, sulfasalazine, systemic corticosteroids, or immunosuppressive drugs) and infliximab is being used to reduce signs/symptoms OR induce/maintain clinical remission OR individual has fistulizing Crohn's disease with draining enterocutaneous or rectovaginal fistulas, of at least 3 months duration OR individual has fistulizing or moderately to severely active Crohn's disease and has responded to previous therapy with infliximab. For moderately to severely active Ulcerative Colitis, agent is being used to reduce signs/symptoms

PA Criteria	Criteria Details
	OR induce/maintain clinical remission and mucosal healing AND individual has failed to respond to, is intolerant of, or has a medical contraindication to ONE conventional therapy (such as 5-ASA products, sulfasalazine, systemic corticosteroids, or immunosuppressive drugs). For Ankylosing Spondylitis individual has failed to respond to, is intolerant of, or has a medical contraindication to ONE conventional therapy (such as NSAIDs, or nonbiologic DMARDs). For Psoriatic Arthritis, agent is being used to reduce signs/symptoms OR induce/maintain clinical response OR inhibit the progression of structural damage OR improve physical function AND individual has failed to respond to, is intolerant of, or has a medical contraindication to ONE conventional therapy (such as nonbiologic DMARD). For chronic plaque psoriasis, agent is being used to reduce signs/symptoms OR induce/maintain clinical response AND individual has failed to respond to, is intolerant of, or has a medical contraindication to phototherapy or ONE other systemic therapy (such as methotrexate, acetretin, or cyclosporine). For Refractory Wegener's Granulomatosis, individual is using in combination with ONE corticosteroid. For JIA, agent is being used to reduce signs/symptoms OR induce/maintain clinical response AND individual has failed to respond to, is intolerant of, or has a medical contraindication to ONE nonbiologic DMARD. For chronic, recurrent, treatment-refractory or vision-threatening, non-infectious uveitis, individual has failed to respond to, is intolerant of, or has a medical contraindication to ONE conventional therapy (such as corticosteroids or immunosuppressive drugs [for example, azathioprine, cyclosporine, or methotrexate]).

REPATHA

Products Affected

- REPATHA PUSHTRONEX
- REPATHA SURECLICK
- REPATHA SYRINGE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrent use with Juxtapid or Kynamro.
Required Medical Information	Individual is at High Risk for Acute Coronary Syndrome (ACS) as identified by one of the following: A. Homozygous Familial Hypercholesterolemia (HoFH) with provided documentation confirming: 1.Presence of two (2) mutant alleles at the LDLR, apoB, PCSK9 or ARH adaptor gene locus OR 2.untreated LDL-C concentration greater than 500 mg/dL (13 mmol/L) or treated LDL-C greater than or equal to 300 mg/dL (7.76 mmol/L) AND one of the following: i.Cutaneous or tendonous xanthoma before age of 10 years OR ii.Untreated LDL-C levels consistent with heterozygous familial hypercholesterolemia in both parents (greater than190 mg/dL) OR B. Heterozygous Familial Hypercholesterolemia (HeFH) with provided documentation confirming: 1.Presence of a mutation in LDLR, apolipoprotein B (ApoB), PCSK9 or ARH adaptor protein gene (LDLRAP1) gene OR 2. World Health Organization (WHO)/Dutch Lipid Network Criteria with score of gtr than 8 points OR C. History of Clinical Atherosclerotic Cardiovascular Disease (ASCVD), including one of the following (documentation must be provided): 1.Acute coronary syndromes 2.History of myocardial infarction (MI) 3.Stable or unstable angina 4.Coronary or other arterial revascularization 5.Stroke 6.Transient ischemic attack (TIA) 7.Peripheral arterial disease presumed to be of atherosclerotic origin.
Age Restrictions	For Dx HeFH, 18 years of age or older. For Dx HoFH, 13 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Initial 3 month. Continuation 1 yr.
Other Criteria	For initial HoFH request, individual meets the following: (A) Individual is a on high intensity statin therapy, or statin therapy at the maximum tolerated dose, where high intensity statin is defined as atorvastatin 40

PA Criteria	Criteria Details
	mg or higher OR rosuvastatin 20 mg or higher (documentation must be provided) OR (B) Individual is statin intolerant OR (C) Individual has a condition that is a contraindication for statin therapy including active liver disease, unexplained persistent elevation of serum transaminases, or pregnancy, which does not exist for the requested PCS-K9 agent (documentation must be provided) AND Individual is on ezetimibe (applies to individuals on statin therapy only) with documentation. For initial HeFH or ASCVD requests, individual meets the following: (A) Individual is a on high intensity statin therapy, or statin therapy at the maximum tolerated dose, where high intensity statin is defined as atorvastatin 40 mg or higher OR rosuvastatin 20 mg or higher (documentation must be provided) OR (B) Individual is statin intolerant OR (C) Individual has a condition that is a contraindication for statin therapy including active liver disease, unexplained persistent elevation of serum transaminases, or pregnancy, which does not exist for the requested PCS-K9 agent (documentation must be provided). For continuation, criteria outlined for initial Prior Authorization has been satisfied AND Documentation of LDL reduction has been provided.

REVATIO

Products Affected

- *sildenafil oral*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Use in combination with phosphodiesterase-5 (PDE5) inhibitors [such as but not limited to, Viagra (sildenafil)]. Use in combination with organic nitrates, such as but not limited to, isosoribide mono/dinitrate or nitroglycerin. Use in combination with guanylate cyclase stimulators [such as but not limited to, Adempas (riociguat)]. Use in individuals requesting for the treatment of erectile dysfunction. Use in individuals with severe hepatic impairment (Child-Pugh Class C). Use in individual has a diagnosis of pulmonary veno-occlusive disease (PVOD). Use in individual has a known hereditary degenerative retinal disorder (such as but not limited to, retinitis pigmentosa).
Required Medical Information	Catheterization-proven diagnosis of Pulmonary Arterial Hypertension (PAH) World Health Organization (WHO Group I) and WHO Functional Class II-IV symptoms.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For sildenafil INJ, individual is temporarily unable to take oral dose forms and requires continued therapy.

REVLIMID

Products Affected

- REVLIMID ORAL CAPSULE 10 MG, 15 MG, 2.5 MG, 20 MG, 25 MG, 5 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

REXULTI

Products Affected

- REXULTI ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	1 Year
Other Criteria	N/A

RUBRACA

Products Affected

- RUBRACA ORAL TABLET 200 MG, 300 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Individual has deleterious BRCA mutation (verified by diagnostic testing)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

RUCONEST

Products Affected

- RUCONEST

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Individual is using for prophylaxis or in individuals with laryngeal attacks.
Required Medical Information	Hereditary Angioedema (HAE) Type I/II is confirmed by a C4 level below the lower limit of normal as defined by the laboratory performing the test AND ONE of the following (a or b): a. C1 inhibitor (C1-INH) antigenic level below the lower limit of normal as defined by the laboratory performing the test OR b.C1-INH functional level below the lower limit of normal as defined by the laboratory performing the test. AND Individual has a history of moderate or severe attacks (for example, airway swelling, severe abdominal pain, facial swelling, nausea and vomiting, painful facial distortion). HAE Type III was confirmed by: C1 inhibitor (C1-INH) antigenic level is normal as defined by the laboratory performing the test AND C4 level is normal as defined by the laboratory performing the test.
Age Restrictions	13 years and older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

RYDAPT

Products Affected

- RYDAPT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Individual has been treated previously for acute myeloid leukemia (AML).
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

SABRIL

Products Affected

- SABRIL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	For infantile spasm 1 month to 2yr old. For seizure 10 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

SAMSCA

Products Affected

- SAMSCA ORAL TABLET 15 MG, 30 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Individual has an acute, urgent need to raise serum sodium OR is unable to sense/appropriately respond to thirst OR is anuric. Diagnosis of hypovolemic hyponatremia. Individual has underlying liver disease, including cirrhosis OR is currently receiving a strong CYP3A inhibitor (such as clarithromycin, ketoconazole, itraconazole, ritonavir., indinavir., nelfinavir, saquinavir, nefazodone and telithromycin).
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

SANDOSTATIN IR

Products Affected

- *octreotide acetate injection solution 1,000 mcg/ml, 100 mcg/ml, 200 mcg/ml, 50 mcg/ml*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Individual has (A) diagnosis of carcinoid tumors for any of the following: Metastatic carcinoid tumors OR Carcinoid syndrome to suppress or inhibit severe diarrhea and flushing episodes associated with the disease OR Prophylactic administration prior to biopsy in an individual with a suspected functioning carcinoid tumor OR Prophylactic administration prior to induction of anesthesia in an individual with a functional carcinoid tumor OR Prophylactic administration to a surgical procedure in an individual with a functional carcinoid tumor. OR (B) Diagnosis of Bleeding gastroesophageal varices when GE varices are associated with liver disease AND octreotide acetate is used in combination with endoscopic therapy or alone if endoscopic therapy is not available. OR (C) Chemotherapy or radiation-induced diarrhea that is unresponsive to conventional antidiarrheal medications (for example, diphenoxylate and atropine or loperamide) OR (D) Malignant bowel obstruction to manage GI symptoms (such as nausea, vomiting or pain). Or supplemental treatment with short-acting octreotide acetate (Sandostatin)is approved for rapid relief of symptoms or for breakthrough symptoms in individuals taking long-acting octreotide acetate.

SAPHRIS

Products Affected

- SAPHRIS (BLACK CHERRY) SUBLINGUAL TABLET 10 MG, 2.5 MG, 5 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	For schizophrenia, 12 years of age or older. For Bipolar, 10 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

SERAX

Products Affected

- *oxazepam*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis (all ages) and if over 65 years of age or older, the physician has indicated the requested high risk medication (HRM) is not causing adverse effects OR Individual has a contraindication or has a clinical reason not to use safer alternatives (prescriber acknowledgement that medication benefits outweigh potential risks is sufficient).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

SEROQUEL LINE

Products Affected

- *quetiapine oral tablet extended release 24 hr 150 mg, 200 mg, 300 mg, 400 mg, 50 mg*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	For schizophrenia, 13 years of age or older. For bipolar disorder, 10 years of age or older. For MDD, 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For schizophrenia/bipolar use, the individual has had a trial of one of the following generic oral atypical antipsychotic: Risperidone, Olanzapine, Quetiapine fumarate, Paliperidone or Ziprasidone.

SIGNIFOR IR

Products Affected

- SIGNIFOR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Individual has a diagnosis of severe hepatic impairment (Child-Pugh C)
Required Medical Information	N/A
Age Restrictions	Individual is 18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

SIRTURO

Products Affected

- SIRTURO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Latent infection due to Mycobacterium tuberculosis OR Drug-sensitive tuberculosis OR Extra-pulmonary tuberculosis OR Infections caused by non-tuberculosis mycobacteria.
Required Medical Information	N/A
Age Restrictions	Individual is 18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Individual has a diagnosis of pulmonary multi-drug resistant tuberculosis AND is unable to use an effective regimen for treatment AND the individual is using Sirturo (bedaquiline) with at least 3 drugs to which the multi-drug resistant tuberculosis isolate is susceptible in vitro OR with at least 4 drugs to which the multi-drug resistant tuberculosis isolate is likely to be susceptible if in vitro testing results are unavailable.

SOLARAZE

Products Affected

- *diclofenac sodium topical gel 3 %*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Dx of Actinic Keratosis
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

SOMATULINE DEPOT

Products Affected

- SOMATULINE DEPOT SUBCUTANEOUS SYRINGE 120 MG/0.5 ML, 60 MG/0.2 ML, 90 MG/0.3 ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

SOMAVERT

Products Affected

- SOMAVERT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Dx of acromegaly AND member has had an inadequate response to surgery and/or radiation OR Surgery and/or radiation therapy are not an option (such as but not limited to, individual is an in appropriate candidate for surgical or radiation based therapy
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

SPRITAM

Products Affected

- SPRITAM ORAL TABLET FOR SUSPENSION 1,000 MG, 250 MG, 500 MG, 750 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Individual has a diagnosis of partial onset seizures OR primary generalized tonic-clonic seizures AND weighs more than 20 kg.
Age Restrictions	Partial onset seizures: 4 years old. Juvenile myoclonic epilepsy: 12 years old. Primary generalized tonic-clonic seizures: 6 years old.
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

SPRYCEL

Products Affected

- SPRYCEL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	approved for 18 years of age and older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

STIVARGA

Products Affected

- STIVARGA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

STRATTERA

Products Affected

- *atomoxetine oral capsule 10 mg, 100 mg, 18 mg, 25 mg, 40 mg, 60 mg, 80 mg*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For dx of ADHD/ADD, Individual has had a trial of ONE generic stimulant medication unless either of the following apply: (1) patient or family member has a history of substance diversion or abuse OR (2) patient has diagnosis of anxiety or a tic disorder (e.g. tourettes syndrome).
Age Restrictions	age 6 and up
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

SUTENT

Products Affected

- SUTENT ORAL CAPSULE 12.5 MG, 25 MG, 37.5 MG, 50 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

SYLATRON

Products Affected

- SYLATRON

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Member is being treated for melanoma with microscopic or gross nodal involvement AND Treatment is initiated within 84 days after definitive surgical resection.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

SYNAGIS

Products Affected

- SYNAGIS INTRAMUSCULAR SOLUTION 50 MG/0.5 ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Administration of more than 5 doses of palivizumab in one RSV season including Florida. Immunoprophylaxis for RSV for children who reach ages 24 months prior to the commencement of the RSV season. Treatment in children or infants with known RSV disease.
Required Medical Information	Immunoprophylaxis for respiratory syncytial virus (RSV) for the prevention of serious lower respiratory tract disease in infants and young children who are at high risk, when the following are met: A. Maximum of Five (5) doses of palivizumab within the RSV season which begins during the first year of life with any of the following clinical presentations: Born before 29 weeks 0 days gestation (up to and including 28 weeks, 6 days) and younger than 12 months of age at the start of the RSV season OR Chronic lung disease (CLD) of prematurity (defined as birth at less than 32 weeks, 0 days gestation and a requirement for greater than 21% oxygen for at least 28 days after birth) OR Hemodynamically significant congenital heart disease (CHD) (for example, but not limited to, infants with acyanotic heart disease who are receiving medication to control congestive heart failure and will require cardiac surgical procedures and infants with moderate to severe pulmonary hypertension OR infants with anatomic pulmonary abnormalities (i.e., tracheal ring) or a neuromuscular condition that impairs the ability to clear secretions from the upper airway because of ineffective cough. B. Maximum of five (5) doses of palivizumab for children younger than 24 months of age with any of the following clinical presentations during the RSV season: Profoundly immunocompromised, such as severe combined immunodeficiency, advanced acquired immunodeficiency syndrome undergoing organ or hematopoietic stem cell transplant, or an absolute lymphocyte count of less than 100 cell/mm3 OR undergoing cardiac transplantation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage	5 months

PA Criteria	Criteria Details
Duration	
Other Criteria	C. An additional dose of palivizumab may be allowed for children who undergo cardiopulmonary bypass for surgical procedures. If cardiac or pulmonary hemodynamic support remains unchanged after surgery or if any other medically necessary criteria are present (for example, prematurity). D. A second season of palivizumab prophylaxis may be approved for preterm infants born at less than 32 weeks, 0 days gestation who required at least 28 days of oxygen after birth and who continue to require medical intervention within 6 months of the start of the second RSV season (for example, supplemental oxygen, chronic systemic corticosteroid therapy, or diuretics). E. An infant with cystic fibrosis in the first year of life with clinical evidence of CLD and/or nutritional compromise, defined as weight for length less than tenth percentile. A second season may be considered for children with severe lung disease (history of hospitalization, abnormal chest x-ray or CT scan) or weight for length less than tenth percentile.

SYNAREL NASAL SOLUTION

Products Affected

- SYNAREL

PA Criteria	Criteria Details
Covered Uses	**Under CMS Review**
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

SYNJARDY

Products Affected

- SYNJARDY

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Individual has had a trial and inadequate response or intolerance to metformin OR Individual has a contraindication to metformin therapy [such as but not limited to, renal insufficiency (eGFR is less than 45mL/minute/1.73m2)]

SYNRIBO

Products Affected

- SYNRIBO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

TAFINLAR

Products Affected

- TAFINLAR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Tafinlar may not be approved for the treatment of individuals with wild type BRAF melanoma.
Required Medical Information	Documentation of BRAF V600E or V600K mutation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 Year
Other Criteria	N/A

TAGRISSO

Products Affected

- TAGRISSO ORAL TABLET 40 MG, 80 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	EGFR (epidermal growth factor receptor) T790M mutation is present and documentation is provided.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

TARCEVA

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For NSCLC tumors that have EGFR exon 19 deletions or exon 21 (L858R) substitution mutations, a copy of the test results must be provided
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

TARGRETIN

Products Affected

- *bexarotene*
- TARGRETIN TOPICAL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

TASIGNA

Products Affected

- TASIGNA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Individual has Philadelphia chromosome positive Chronic Myeloid Leukemia (Ph+ CML) in chronic phase AND has documented resistance, intolerance, contraindication or warning to BOTH Gleevec and Sprycel. (Warnings may include, but not limited to pulmonary arterial hypertension, pleural or pericardial effusion, cardiac abnormalities).

TASMAR

Products Affected

- *tolcapone*

PA Criteria	Criteria Details
Covered Uses	**Under CMS Review**
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

TAZORAC

Products Affected

- *tazarotene*
- TAZORAC

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	May not be approved for cosmetic purposes such as, but not limited to the following: Photoaging, Wrinkles, Hyperpigmentation, Sun damage, or Melasma.
Required Medical Information	For psoriasis, individual has up to 20% of body surface area involvement.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For psoriasis, individual has had a prior trial and inadequate response to either of the following (AAD 2009): Any two (2) topical corticosteroids or any one (1) topical corticosteroids plus calcipotriene. For psoriasis use greater than 1 year, efficacy must be documented for continued use. Documentation may include chart notes, consultation notes.

TECENTRIQ

Products Affected

- TECENTRIQ

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Individual has received treatment with another PD-1 agent (for example, nivolumab or pembrolizumab) and Individual is receiving therapy for an autoimmune disease or chronic condition requiring treatment with a systemic immunosuppressant.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For locally advanced or metastatic urothelial carcinoma, disease has progressed during or following platinum-containing chemotherapy (for example, cisplatin) or has progressed within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy and has a current Eastern Cooperative Oncology Group (ECOG) performance status of 0-2. For metastatic non-small cell lung cancer (NSCLC) disease has progressed during or following platinum-containing chemotherapy (for example, cisplatin) and when anaplastic lymphoma kinase (ALK) or epidermal growth factor receptor (EGFR) genomic tumor aberrations are present, must have demonstrated disease progression on U.S. Food and Drug Administration (FDA) approved therapy and has a current Eastern Cooperative Oncology Group (ECOG) performance status of 0-2.

TECFIDERA

Products Affected

- TECFIDERA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Using in combination with other immunomodulatory products (such as Aubagio, Gilenya, Tysabri, Copaxone/Glatopa, Extavia, Rebif, Avonex, Plegridy or Betaseron).
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

TECHNIVIE

Products Affected

- TECHNIVIE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	A copy of the baseline quantitative hepatitis C virus (HCV) RNA test result is provided to document baseline level of viremia AND One of the following: (1) Documentation is provided for a diagnosis of chronic hepatitis C (CHC) infection, which includes a positive HCV RNA test result at least 6 months following either a baseline positive HCV RNA result or reactive HCV antibody test (AASLD/IDSA 2016, CDC 2013). OR (2) Individual is unable to delay treatment for 6 months owing to concurrent factors [such as but not limited to, advanced liver disease (Metavir fibrosis stage of F3 or F42), post-liver transplant recipients, co-infection with human immunodeficiency virus (HIV) or hepatitis B virus (HBV), coexistent liver diseases (such as nonalcoholic steatohepatitis), chronic HCV infection-associated extrahepatic manifestations (such as membranoproliferative glomerulonephritis, glomerular disease, cryoglobulinemia syndrome)] (AASLD/IDSA 2016) AND Documentation is provided for a diagnosis of chronic CHC infection, which includes a reactive HCV antibody (CDC 2013) and a subsequent positive HCV RNA result (CDC 2013). Individual does not have a short life expectancy (less than 12 months owing to non-liver related comorbid conditions) that cannot be remediated by treating HCV, by transplantation or other directed therapy (AASLD/IDSA 2016).
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Criteria will be applied consistent with current AASLD/IDSA guidance.
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance. Individual has had a trial of Harvoni or Epclusa OR Individual is currently on and completing a course of therapy with the requested regimen.

TESTOSTERONE INJ

Products Affected

- *testosterone cypionate*
- *testosterone enanthate*

PA Criteria	Criteria Details
Covered Uses	**Under CMS Review**
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

THALOMID

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

TOPAMAX

Products Affected

- *topiramate oral capsule, sprinkle*
- *topiramate oral tablet 100 mg, 200 mg, 25 mg, 50 mg*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	For migraine headache prophylaxis, 12 years of age and older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

TOPICAL ANDROGENS

Products Affected

- ANDROGEL TRANSDERMAL GEL IN METERED-DOSE PUMP 20.25 MG/1.25 GRAM (1.62 %)
- ANDROGEL TRANSDERMAL GEL IN PACKET 1.62 % (20.25 MG/1.25 GRAM), 1.62 % (40.5 MG/2.5 GRAM)

PA Criteria	Criteria Details
Covered Uses	**Under CMS Review**
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

TOPICAL TRETINOIN AGENTS

Products Affected

- *tretinoin topical cream*
- *tretinoin topical gel 0.01 %, 0.025 %*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Topical tretinoin agents may not be approved for cosmetic purposes such as, but not limited to the following: Photoaging, Wrinkles, Hyperpigmentation, Sun damage, Melasma.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

TORISEL

Products Affected

- TORISEL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For advanced renal cell carcinoma, individual is using for either of the following (A or B): (A) As first-line therapy as a single agent (monotherapy) for (either i or ii): (i) Relapsed metastatic disease or (ii) Surgically unresectable stage IV renal carcinoma in individuals with a poor prognosis as manifested by having at least 3 of the following (1 through 6): 1. Lactate dehydrogenase greater than 1.5 times the upper limit of normal or 2. Hemoglobin less than the lower limit of normal or 3. Corrected calcium level greater than 10mg/dL (2.5mmol/liter) or 4. Interval of less than a year from original diagnosis to the start of systemic therapy or 5. Karnofsky performance status less than or equal to 70 or ECOG performance score of 2 - 4 or 6. Greater than or equal to 2 sites of metastases. OR (B) For subsequent (second-line) therapy as a single agent (monotherapy) for relapsed metastatic or for surgically unresectable stage IV disease.

TRANSMUCOSAL FENTANYL CITRATE

Products Affected

- *fentanyl citrate*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Using for the treatment of acute or postoperative pain. Using for treatment of migraine headache pain Using for non-cancer related breakthrough pain.
Required Medical Information	N/A
Age Restrictions	Individual is 16 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Individual has a diagnosis of active cancer with breakthrough cancer (such as, metastatic or locally invasive cancer for which the individual is currently seeking treatment) with breakthrough cancer pain AND Individual is already receiving opioid therapy and is TOLERANT to opioid therapy as defined as receiving around the clock medicine consisting of one of the following: At least 60mg morphine per day, OR At least 25mcg/hr transdermal fentanyl/hour, OR At least 30mg of oxycodone daily, OR At least 8mg of oral hydromorphone daily, OR At least 25mg of oral oxymorphone daily, OR An equianalgesic dose of another opioid for a week or longer. Individual will also continue around the clock opioids when taking transmucosal fentanyl Citrate for cancer related breakthrough pain.

TRELSTAR LINE

Products Affected

- TRELSTAR INTRAMUSCULAR SYRINGE 11.25 MG/2 ML, 22.5 MG/2 ML, 3.75 MG/2 ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For Prostate cancer: Clinically localized disease with intermediate (T2b to T2c cancer, Gleason score of 7, or prostate specific antigen (PSA) value of 10-20 ng/mL) OR higher risk of recurrence as neoadjuvant therapy with radiation therapy or cryosurgery OR Following radical prostatectomy as adjuvant therapy when lymph node metastases are present OR Locally advanced disease OR Other advanced, recurrent, or metastatic disease.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

TYKERB

Products Affected

- TYKERB

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Cancer has been confirmed HER2 positive
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

TYSABRI

Products Affected

- TYSABRI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Using for Types of MS other than relapsing forms. Currently responsive to and tolerating another treatment for MS or CD. Current or prior history of progressive multifocal leukoencephalopathy (PML). Medical condition which significantly compromises the immune system including HIV infection or AIDS, leukemia, lymphoma or organ transplantation. Receiving chronic antineoplastics or immunosuppressants (for example, azathioprine). Receiving any other immune system modifying drugs such as interferon beta-1 (for example, Avonex). Positive test results for anti-John Cunningham virus (JCV) antibodies
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Individual is using as monotherapy for relapsing forms of multiple sclerosis (MS) who have had an inadequate response to, or are unable to tolerate, alternative treatments for MS. For diagnosis of Crohns disease, individual is enrolled in and met all conditions of the CD or MS Touch Prescribing Program.

UPTRAVI

Products Affected

- UPTRAVI ORAL TABLET
- UPTRAVI ORAL TABLETS,DOSE PACK

PA Criteria	Criteria Details
Covered Uses	**Under CMS Review**
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

VALCHLOR

Products Affected

- VALCHLOR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

VALIUM

Products Affected

- DIAZEPAM INTENSOL
- *diazepam oral solution 5 mg/5 ml (1 mg/ml)*
- *diazepam oral tablet 10 mg, 2 mg, 5 mg*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis (all ages) and if over 65 years of age or older, the physician has indicated the requested high risk medication (HRM) is not causing adverse effects OR Individual has a contraindication or has a clinical reason not to use safer alternatives (prescriber acknowledgement that medication benefits outweigh potential risks is sufficient).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

VANCOCIN

Products Affected

- *vancomycin oral capsule 250 mg*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Individual is being treated for enterocolitis caused by Staphylococcal aureus including methicillin-resistant strains. Individual is being treated for clostridium difficile AND individual has had a trial and inadequate response or intolerance to oral metronidazole for mild to moderate Clostridium difficile infection. OR individual is being treated for a severe or severe, complicated Clostridium difficile infection.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	14 days
Other Criteria	N/A

VECTIBIX

Products Affected

- VECTIBIX INTRAVENOUS SOLUTION 100 MG/5 ML (20 MG/ML)

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Individual has received prior treatment with cetuximab (Erbitux) [Note: a course of cetuximab discontinued because of an adverse reaction is not considered prior treatment] OR Vectibix is used in combination with other anti-VEGF agents (e.g., bevacizumab) OR Vectibix is being used for more than one line (course) of therapy.
Required Medical Information	KRAS gene mutation testing is documented and the tumor is determined to be KRAS wild-type.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	Used as a single agent or as part of combination therapy for stage IV colon, rectal, colorectal, small bowel or anal adenocarcinoma.

VELCADE

Products Affected

- VELCADE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

VENCLEXTA

Products Affected

- VENCLEXTA ORAL TABLET 10 MG, 100 MG, 50 MG
- VENCLEXTA STARTING PACK

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

VENTAVIS

Products Affected

- VENTAVIS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnostic Criteria for PAH: right heart catheterization which shows a mean pulmonary artery pressure (mPAP) greater than or equal to 25mmhg, a pulmonary capillary wedge pressure (PCWP), left atrial pressure or left ventricular end diastolic pressure (LVEDP) less than or equal to 15mmhg AND a pulmonary vascular resistance (PVR) greater than 3 wood units. Criteria for Vasodilator Response: a favorable response is defined as a fall in mPAP of at least 10mmhg to an absolute mPAP of less than 40mmhg without a decrease in cardiac output, when challenged with inhaled nitric oxide, intravenous epoprostenol or intravenous adenosine.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For Ventavis , patient must meet all of the following: meets diagnostic criteria for PAH AND demonstrates an unfavorable acute response to vasodilators AND meets one of the following patient selection criteria with New York Heart Association (NYHA) functional class III, or IV symptoms: World health Organization (WHO) Group I idiopathic pulmonary arterial hypertension including all subtypes of WHO Group I PAH or Pulmonary hypertension associated with connective tissue disorders (scleroderma, systemic sclerosis, etc.) or pulmonary hypertension associated with congenital heart defects.

VFEND

Products Affected

- *voriconazole oral*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Transitioning from inpatient treatment with IV antifungal to an outpatient setting.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

VIDAZA

Products Affected

- *azacitidine*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

VOTRIENT

Products Affected

- VOTRIENT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

VRAYLAR

Products Affected

- VRAYLAR ORAL CAPSULE
- VRAYLAR ORAL CAPSULE,DOSE PACK

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

XALKORI

Products Affected

- XALKORI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

XELJANZ

Products Affected

- XELJANZ

PA Criteria	Criteria Details
Covered Uses	**Under CMS Review**
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

XENAZINE

Products Affected

- *tetrabenazine oral tablet 12.5 mg, 25 mg*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

XGEVA

Products Affected

- XGEVA

PA Criteria	Criteria Details
Covered Uses	**Under CMS Review**
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

XIIDRA

Products Affected

- XIIDRA

PA Criteria	Criteria Details
Covered Uses	**Under CMS Review**
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

XOLAIR

Products Affected

- XOLAIR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Mbr has Moderate Persistent to Severe Persistent Asthma AND has a positive skin test or in vitro reactivity to a perennial aeroallergen, AND Mbr has an FEV1 less than 80% predicted AND Mbr IgE level is equal to or greater than 30 IU/ml. Severe asthma as defined by the National Heart, Lung, and Blood Institute: Severe Persistent Asthma: symptoms throughout the day, extremely limited normal activity. Nocturnal symptoms are frequent, FEV1 or PEF is less than or equal to 60% predicted. Moderate Persistent Asthma as defined by the National Heart, Lung, and Blood Institute: Daily symptoms, daily use of inhaled short-acting beta2-agonist, somewhat limited activity, Nocturnal symptoms occur greater than 1 time per week, FEV1 or PEF is greater than 60% and less then 80% predicted, FEV1 FVC is reduced 5 percent or exacerbations requiring oral systemic corticosteroids use for more than or equal to 2 times per year.
Age Restrictions	Patient is 12 years of age or older for urticaria and 6 years of age or older for moderate to severe persistent asthma
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For moderate to severe persistent asthma, Mbr symptoms are inadequately controlled after a minimum of 3 months with combination controller therapy (medium to high doses of inhaled corticosteroids plus long acting beta-2 agonists or Leukotriene modifiers), or cannot tolerate these medications. Continued treatment beyond 12 months is allowed when treatment has resulted in clinical improvement as documented by one or more of the following: Decreased utilization of rescue medications OR Decreased frequency of exacerbations (defined as worsening of asthma that requires increase in inhaled corticosteroid dose or treatment with systemic corticosteroids) OR Increase in percent predicted FEV1 from

PA Criteria	Criteria Details
	pretreatment baseline OR Reduction in reported asthma-related symptoms, such as, but not limited to, wheezing, shortness of breath, coughing, fatigue, sleep disturbance, or asthmatic symptoms upon awakening. For chronic idiopathic urticaria, individual is refractory to prior treatment of ONE potent antihistamine at maximal FDA approved dosage.

XTANDI

Products Affected

- XTANDI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Individual has had a previous trial and inadequate response or intolerance to Zytiga (abiraterone) OR Individual has visceral metastases.

XYREM

Products Affected

- XYREM

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For initial tx of Narcolepsy type 1 (narcolepsy with cataplexy) confirmed by the presence of daily periods of irrepressible need to sleep or daytime lapses into sleep occurring for at least 3 months and at least one of the following: (1) Clear cataplexy (defined as more than one episode of generally brief [less than 2 min]) usually bilaterally symmetrical, sudden loss of muscle tone with retained consciousness) AND (2) Multiple Sleep Latency Test (MSLT) showing one of the following: (a) MSLT of less than 8 minutes with evidence of two sleep-onset rapid eye movement periods (SOREMPs) (ICSD-3, 2014) or (b) At least one SOREMP on MSLT and a SOREMP (less than 15 minutes) on the preceding overnight polysomnography (PSG) OR (3) Cerebrospinal fluid hypocretin-1 deficiency (less than 110 pg/mL or less than one-third of the normative values with the same standardized assay).
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Initial Request 3 months, Renewal is 6 months.
Other Criteria	For initial tx, of Narcolepsy type 2 (narcolepsy without cataplexy) confirmed by the following: (1) Daily periods of irrepressible need to sleep or daytime lapses into sleep occurring for at least 3 months AND (2) MSLT showing one of the following: (a) MSLT of less than 8 minutes with evidence of two SOREMPs (ICSD-3, 2014) or (b) At least one SOREMP on MSLT and a SOREMP (less than 15 minutes) on the preceding overnight PSG AND (3) absence of cataplexy AND (4) Exclusion of alternative causes of excessive daytime sleepiness by history, physical exam and PSG. AND (5) Mbr has had a previous trial of and inadequate response or intolerance to TWO of the following medications: (A) One of the following wakefulness promoting medications: (i) Modafinil or (ii) Nuvigil (armodafinil) AND (B) One of

PA Criteria	Criteria Details
	the following stimulants: (i) Methylphenidate (ii) Dextroamphetamine or (iii) Amphetamine/dextroamphetamine salt immediate-release OR (6) Trials of wakefulness promoting agents and stimulant agents are not acceptable due to concomitant clinical situations including but not limited to the following: (1) Cardiovascular disease or (2) Drug interactions. For Renewal of Narcolepsy type I or II, Xyrem (sodium oxybate) use has resulted in a reduction in frequency of cataplexy attacks OR use has resulted in a reduction in excessive daytime sleepiness (EDS) as measured by improvement in Epworth Sleepiness Scale (ESS) measurements or Maintenance of Wakefulness Test (MWT). For continuation, use has resulted in a reduction in frequency of cataplexy attacks compared to baseline OR use has resulted in a reduction in excessive daytime sleepiness (EDS) as measured by improvement in Epworth Sleepiness Scale (ESS) measurements or Maintenance of Wakefulness Test (MWT) compared to baseline

YERVOY

Products Affected

- YERVOY INTRAVENOUS SOLUTION 50 MG/10 ML (5 MG/ML)

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Individual has autoimmune disease which requires treatment with immunosuppressant drugs.
Required Medical Information	Individual has unresectable or metastatic melanoma AND individual has an Eastern Cooperative Oncology Group (ECOG) performance status of 0-2.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Used in combination with nivolumab (Opdivo) as: (a) First-line therapy or (b) Second-line or subsequent therapy for disease progression if nivolumab was not previously used or Ipilimumab is used as a single agent for one of the following: (a) First line therapy as a single course of 4 treatments or (b) Second-line or subsequent lines of therapy as a single course of 4 treatments or (c) Retreatment, consisting of a 4-dose limit, for an individual who had no significant systemic toxicity during prior ipilimumab therapy, and whose disease progressed after being stable for greater than 6 months following completion of a prior course of ipilimumab, and for whom no intervening therapy has been administered. OR used for the adjuvant treatment of cutaneous melanoma in individuals with pathologic involvement of regional lymph nodes of more than 1 millimeter who have undergone complete resection, including lymphadenetomy.

ZALTRAP

Products Affected

- ZALTRAP INTRAVENOUS SOLUTION 100 MG/4 ML (25 MG/ML)

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Diagnosis of metastatic anal adenocarcinoma or metastatic appendicle adenocarcinoma or metastatic small bowel adenocarcinoma or metastatic colorectal cancer AND used in combination with an irinotecan based regimen AND individual is resistant to or has disease progression following treatment with an oxaliplatin containing regimen AND Zaltrap will be used in a single line of therapy.

ZAVESCA

Products Affected

- ZAVESCA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	May not be approved for use in conjunction with Cerdelga (eliglustat) or enzyme replacement therapy (ERT) agents (Cerezyme, Elelyso or Vpriv). Severe Type 1 Gaucher disease (hemoglobin less than 9 g/dL, platelet count less than 50,000 mm3 or those at risk developing new bone complications) (Weinreb et al. 2005). Individual has severe renal impairment (less than 30 mL/min/1.73 m2). Individual has mild, moderate or severe hepatic impairment or cirrhosis.
Required Medical Information	Presence of type 1 (non-neuropathic) Gaucher disease is confirmed by either of the following (Weinreb et al. 2004, Wang et al. 2011): Glucocerebrosidase activity in the white blood cells or skin fibroblasts less than or equal to 30% of normal activity, OR genotype testing indicating mutation of two alleles of the glucocerebrosidase genome. And patient has clinically significant manifestations of Type 1 gauchers disease including any of the following: skeletal disease (demonstrated by radiologic evidence of ANY of the following (Weineb et al. 2004):: avascular necrosis, erlenmeyer flask deformity, lytic disease, marrow infiltration, osteopenia, osteosclerosis, pathological fracture, joint deterioration or replacement) OR patient presents with at least 2 of the following (Weinreb et al. 2004, Mistry et al. 2015): clinically significant hepatomegaly as confirmed by medical imaging (such as but limited to, volumetric MRI), clinically significant splenomegaly as confirmed by medical imaging (such as but limited to, volumetric MRI), hgb less than or equal to 11.5 grams per dl for females or 12.5 grams per deciliter for males or 1 gram per deciliter below lower limit for normal for age and sex, platelet counts less than or equal to 120,000 mm3.
Age Restrictions	Individual is 18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Enzyme replacement therapy with Cerezyme, ELELYSO or VPRIV is not a therapeutic option for reasons such as but limited to any of the following

PA Criteria	Criteria Details
	(Label, Weinreb et al. 2005): (a) Medically unmanageable hypersensitivity or (b) Development of therapy-limiting inhibitory antibodies or (c) Poor peripheral or central venous access.

ZEJULA

Products Affected

- ZEJULA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	In the last 8 weeks, the individual has had a complete or partial response to a platinum-based chemotherapy.

ZELBORAF

Products Affected

- ZELBORAF

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Individuals with wild-type BRAF melanoma.
Required Medical Information	Individual has BRAF mutation and a copy of the BRAF test results must be provided.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

ZOLINZA

Products Affected

- ZOLINZA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

ZOMETA

Products Affected

- *zoledronic acid intravenous solution*
- ZOMETA INTRAVENOUS PIGGYBACK

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Bone metastases documented on imaging or bone pain associated with imaging-documented metastases from breast, prostate, lung, kidney, thyroid, or other solid tumors.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For Breast cancer, prevention of bone loss secondary to adjuvant hormone therapy OR for early stage, premenopausal breast cancer, prevention of bone loss secondary to ovarian dysfunction induced by adjuvant chemotherapy therapy OR glucocorticoid-induced osteoporosis (OP) in men and women who are either initiating or continuing systemic glucocorticoids in a daily dosage equivalent to 7.5mg or greater of prednisone and who are expected to remain on glucocorticoids for at least 12 months OR OP treatment to increase bone mass in men OR OP treatment and prevention in postmenopausal women OR PagetGÇÖs disease of bone in men and women indicated with elevation in serum alkaline phosphatase of 2 times or higher than the upper limit of the age-specific normal reference range or those who are symptomatic or at risk for complication from their disease.

ZYDELIG

Products Affected

- ZYDELIG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

ZYKADIA

Products Affected

- ZYKADIA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

ZYTIGA

Products Affected

- ZYTIGA ORAL TABLET 250 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A

ZYVOX

Products Affected

- *linezolid oral suspension for reconstitution*
- *linezolid oral tablet*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Confirmed vancomycin-resistant enterococcus faecium (VRE) infection. Confirmed methicillin-resistant S. aureus (MRSA) infection AND individual has had a trial and inadequate response or intolerance to or has contraindications to an alternative antibiotic that the organism is susceptible to (depending on manifestation, severity of infection and culture or local sensitivity patterns, examples of alternative antibiotics may include, but are not limited to: vancomycin, TMP-SMX, clindamycin, doxycycline, tetracycline (Based on 2011 IDSA MRSA guideline recommendations)). Individual started treatment with Zyvox in the hospital and requires continued outpatient therapy. Isolates of MRSA have a vancomycin minimum inhibitory concentration (MIC) of greater than 2.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	30 days
Other Criteria	N/A

PART B VERSUS PART D

Products Affected

- ABELCET
- *acetylcysteine*
- *acyclovir sodium intravenous solution 50 mg/ml*
- ADRIAMYCIN INTRAVENOUS SOLUTION 20 MG/10 ML
- ADRUCIL INTRAVENOUS SOLUTION 500 MG/10 ML
- *albuterol sulfate inhalation solution for nebulization 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg /3 ml (0.083 %), 5 mg/ml*
- AMBISOME
- AMINOSYN 7 % WITH ELECTROLYTES
- AMINOSYN 8.5 %-ELECTROLYTES
- AMINOSYN II 10 %
- AMINOSYN II 15 %
- AMINOSYN II 7 %
- AMINOSYN II 8.5 %
- AMINOSYN II 8.5 %-ELECTROLYTES
- AMINOSYN-HBC 7%
- AMINOSYN-PF 10 %
- AMINOSYN-PF 7 % (SULFITE-FREE)
- AMINOSYN-RF 5.2 %
- *amiodarone intravenous solution*
- *amphotericin b*
- *aprepitant oral capsule 80 mg*
- *aprepitant oral capsule,dose pack*
- ARRANON
- ASTAGRAF XL
- *azathioprine*
- *azathioprine sodium*
- BICNU
- *bleomycin injection recon soln 30 unit*
- BONIVA INTRAVENOUS
- BROVANA
- *budesonide inhalation suspension for nebulization 0.25 mg/2 ml, 0.5 mg/2 ml, 1 mg/2 ml*
- *busulfan*
- BUSULFEX
- *calcitriol oral solution*
- CANCIDAS
- *carboplatin intravenous solution*
- CELLCEPT INTRAVENOUS
- *cisplatin*
- *cladribine*
- CLINIMIX 5%/D15W SULFITE FREE
- CLINIMIX 5%/D25W SULFITE-FREE
- CLINIMIX 2.75%/D5W SULFIT FREE
- CLINIMIX 4.25%/D10W SULF FREE
- CLINIMIX 4.25%/D5W SULFIT FREE
- CLINIMIX 4.25%-D20W SULF-FREE
- CLINIMIX 4.25%-D25W SULF-FREE
- CLINIMIX 5%-D20W(SULFITE-FREE)
- CLINIMIX E 2.75%/D10W SUL FREE
- CLINIMIX E 2.75%/D5W SULF FREE
- CLINIMIX E 4.25%/D10W SUL FREE
- CLINIMIX E 4.25%/D25W SUL FREE
- CLINIMIX E 4.25%/D5W SULF FREE
- CLINIMIX E 5%/D15W SULFIT FREE
- CLINIMIX E 5%/D20W SULFIT FREE
- CLINIMIX E 5%/D25W SULFIT FREE
- CLOLAR
- *colistin (colistimethate na)*
- COSMEGEN
- *cromolyn inhalation*
- *cyclophosphamide oral capsule*
- *cyclosporine intravenous*
- *cyclosporine modified*
- *cyclosporine oral capsule*
- *cytarabine (pf) injection solution 2 gram/20 ml (100 mg/ml)*
- *cytarabine injection solution 20 mg/ml*
- *dacarbazine intravenous recon soln 200 mg*
- *daunorubicin intravenous solution*
- *decitabine*
- *docetaxel intravenous solution 80 mg/4 ml (20 mg/ml), 80 mg/8 ml (10 mg/ml)*
- *doxercalciferol oral capsule 0.5 mcg*
- *doxorubicin intravenous solution 50 mg/25 ml*
- *dronabinol*

Prior Authorization

- ENGERIX-B (PF) INTRAMUSCULAR SYRINGE
- ENGERIX-B PEDIATRIC (PF)
- ENVARSUS XR
- *epirubicin intravenous solution 200 mg/100 ml*
- ETOPOPHOS
- *etoposide intravenous*
- *fludarabine intravenous recon soln*
- *fluorouracil intravenous solution 2.5 gram/50 ml*
- FOLOTYN INTRAVENOUS SOLUTION 40 MG/2 ML (20 MG/ML)
- *ganciclovir sodium*
- *gemcitabine intravenous recon soln 1 gram*
- GENGRAF
- *granisetron hcl oral*
- *heparin (porcine) injection solution 1,000 unit/ml, 10,000 unit/ml, 20,000 unit/ml, 5,000 unit/ml*
- HEPATAMINE 8%
- HERCEPTIN INTRAVENOUS RECON SOLN 440 MG
- *ibandronate intravenous solution*
- *idarubicin*
- *ifosfamide intravenous recon soln 1 gram*
- IMOVAX RABIES VACCINE (PF)
- INTRALIPID INTRAVENOUS EMULSION 20 %, 30 %
- *ipratropium bromide inhalation*
- *ipratropium-albuterol inhalation*
- *irinotecan intravenous solution 100 mg/5 ml*
- *levalbuterol hcl inhalation solution for nebulization 0.31 mg/3 ml, 0.63 mg/3 ml, 1.25 mg/0.5 ml, 1.25 mg/3 ml*
- *levocarnitine (with sugar)*
- *melphalan hcl*
- MIACALCIN INJECTION
- *mitomycin intravenous recon soln 20 mg, 40 mg*
- *mitoxantrone*
- *mycophenolate mofetil*
- *mycophenolate mofetil hcl*
- NEBUPENT
- NEPHRAMINE 5.4 %
- NIPENT
- *nitroglycerin intravenous*
- *ondansetron hcl oral solution*
- *ondansetron hcl oral tablet 24 mg, 4 mg, 8 mg*
- *ondansetron oral tablet, disintegrating*
- *oxaliplatin intravenous solution 100 mg/20 ml*
- *paclitaxel*
- *pamidronate intravenous solution 60 mg/10 ml (6 mg/ml)*
- PERFOROMIST
- PREMASOL 10 %
- PREMASOL 6 %
- PROCALAMINE 3%
- PROGRAF INTRAVENOUS
- PROLEUKIN
- PROSOL 20 %
- PULMOZYME
- RABAVERT (PF)
- RAPAMUNE ORAL SOLUTION
- RECOMBIVAX HB (PF) INTRAMUSCULAR SUSPENSION 10 MCG/ML, 40 MCG/ML
- RECOMBIVAX HB (PF) INTRAMUSCULAR SYRINGE
- RITUXAN
- SIMULECT INTRAVENOUS RECON SOLN 20 MG
- *sirolimus oral tablet 0.5 mg, 1 mg*
- *tacrolimus oral*
- *thiotepa*
- THYMOGLOBULIN
- *tobramycin in 0.225% nacl for nebulization*
- TOPOSAR
- *topotecan intravenous recon soln*
- TRAVASOL 10 %
- TREANDA INTRAVENOUS RECON SOLN 100 MG
- TRISENOX
- TROPHAMINE 10 %
- TROPHAMINE 6%
- *vinblastine intravenous solution 1 mg/ml*
- VINCASAR PFS INTRAVENOUS SOLUTION 1 MG/ML
- *vincristine intravenous solution 1 mg/ml*
- *vinorelbine intravenous solution 50 mg/5 ml*
- YONDELIS

- ZANOSAR
- 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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