



## **2018 AlohaCare Advantage Plus Formulary (HMO SNP) Drugs with Prior Authorization Requirements**

You may need prior authorization for certain drugs that are on the formulary or drugs that are not on the formulary. Below is a drug that requires prior authorization with the prior authorization requirements.

# ACTEMRA

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## Products Affected

- Actemra

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus patients already started on tocilizumab (IV or SC) for a Covered Use.
<b>Exclusion Criteria</b>	Concurrent Use with a Biologic Disease-Modifying Antirheumatic Drug (DMARD) or Targeted Synthetic DMARD.
<b>Required Medical Information</b>	Diagnosis, concurrent medications, previous drugs tried
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	RA, SJIA, PJIA - Prescribed by or in consultation with a rheumatologist.
<b>Coverage Duration</b>	RA/SJIA 3 mos, 4 mos PJIA. Cont - RA, SJIA, PJIA - 3 years.
<b>Other Criteria</b>	RA, approve if the patient meets ONE of the following criteria: 1) Patient has had a trial with Enbrel or Humira. [Note: the patient does not have to have a trial with Enbrel or Humira if they have had a trial with Cimzia, infliximab, Simponi (IV/SC), Orenzia (IV/SC), or Xeljanz/XR in the past.], OR 2) According to the prescribing physician, the patient has heart failure or a previously treated lymphoproliferative disorder. Systemic-onset JIA, approve for patients who have tried one other systemic agent for SJIA (eg, a corticosteroid [oral, IV], a conventional synthetic DMARD [eg, MTX, leflunomide, sulfasalazine], or a biologic DMARD [eg, Kineret, a TNF inhibitor such as Enbrel, Humira or Remicade, or Ilaris (canakinumab for SC injection)], or a 1-month trial of a nonsteroidal anti-inflammatory drug [NSAID]). PJIA, approve if the patient has tried etanercept or adalimumab. [Note: the patient does not have to have a trial with Enbrel or Humira if they have had a trial with Orenzia IV or infliximab in the past.] Cont tx - pt must have had a response as determined by the prescriber.

# ACTEMRA SQ

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## Products Affected

- Actemra

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus patients already started in tocilizumab (IV/SC) for a Covered Use.
<b>Exclusion Criteria</b>	Concurrent use with a Biologic DMARD or Targeted Synthetic DMARD.
<b>Required Medical Information</b>	Diagnosis, concurrent medications, previous drugs tried.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	RA - Prescribed by or in consultation with a rheumatologist.
<b>Coverage Duration</b>	GCA-12 months initial, 3 years cont. All other diagnoses-3 months initial, 3 years cont.
<b>Other Criteria</b>	RA initial - approve if the patient has tried TWO of the following: Enbrel, Humira, Orencia (IV/SC) , or Xeljanz/XR (Note: if the patient has not tried TWO of these drugs listed, previous trial(s) with the following drugs can count towards meeting the try TWO requirement: Cimzia, infliximab, Simponi SC/IV) OR if, according to the prescribing physician, the patient has heart failure or a previously treated lymphoproliferative disorder. Cont tx - pt must have had a response as determined by the prescriber.

# ACYCLOVIR (TOPICAL)

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## Products Affected

- acyclovir topical
- Zovirax topical cream

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Medication history
<b>Age Restrictions</b>	Zovirax 5% cream, 12 yrs or older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	If the request is for brand name Zovirax 5% ointment, the patient is required to have tried generic acyclovir 5% ointment prior to approval.

# ADEMPAS

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## Products Affected

- Adempas

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	PAH and CTEPH- must be prescribed by or in consultation with a cardiologist or a pulmonologist.
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	For PAH - must have PAH (WHO Group 1) and had a right heart catheterization to confirm the diagnosis of PAH (WHO Group 1). Right heart catheterization is not required in pts who are currently receiving Adempas or another agent indicated for WHO group 1.

# AFINITOR

## Products Affected

- Afinitor Disperz
- Afinitor oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus patients already taking Afinitor for a Covered Use. Advanced, unresectable or metastatic neuroendocrine tumors. Perivascular Epitheloid Cell Tumors (PEComa), Recurrent Angiomyolipoma, Lymphangiomyomatosis, relapsed or refractory classical Hodgkin lymphoma, Waldenstrom's Macroglobulinemia/Lymphoplasmacytic Lymphoma (WM/LPL), Osteosarcoma, Thymomas and Thymic carcinomas, Differentiated (i.e. papillary, follicular, and Hurthle cell) Thyroid Carcinoma.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	HER2 status. Advanced HER2-negative breast cancer, hormone receptor (HR) status.
<b>Age Restrictions</b>	Relapsed or refractory classical Hodgkin lymphoma-18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	Advanced HER2-negative breast cancer, approve if the patient is postmenopausal and has HR+ [that is, estrogen receptor positive (ER+) or progesterone positive (PR+)] disease and Afinitor will be used in combination with exemestane or tamoxifen and the patient has tried letrozole or anastrozole. Renal cell carcinoma (RCC), approve if patient meets one of the following: 1) patient has advanced RCC with predominant clear cell histology AND the patient has tried Inlyta, Votrient, Sutent, or Nexavar OR 2) patient has relapsed or medically unresectable RCC with non-clear cell histology. Tuberous sclerosis complex (TSC) for the treatment of subependymal giant cell astrocytoma (SEGA), approve if the patient requires therapeutic intervention but cannot be curatively resected. NET-approve. Osteosarcoma, approve if the patient has tried standard

<b>PA Criteria</b>	<b>Criteria Details</b>
	<p>chemotherapy for osteosarcoma AND the patient has relapsed/refractory or has metastatic disease. Thymomas and Thymic Carcinomas, approve if the patient has tried chemotherapy. Renal angiomyolipoma with TSC-approve. WM/LPL - approve if 1. patient has progressive or relapsed disease OR 2. patient has not responded to primary therapy (e.g., Velcade+/- Rituxan, Velcade with dexamethasone +/-Rituxan, Kyprolis with Rituxan and dexamethasone, cyclophosp/doxorubicin/vincristine/pred/Rituxan, Imbruvica, Rituxan, Rituxan with cyclophosphamide and dexamethasone, Thalomid+/- Rituxan. Differentiated (i.e. papillary, follicular, and Hurthle cell) Thyroid Carcinoma-approve if the patient's differentiated thyroid carcinoma is refractory to radioactive iodine therapy.</p>

# ALECENSA

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## Products Affected

- Alecensa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	metastatic NSCLC - is anaplastic lymphoma kinase (ALK)-positive.

# ALUNBRIG

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## Products Affected

- Alunbrig oral tablet 180 mg, 30 mg, 90 mg
- Alunbrig oral tablets, dose pack

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus patients already started on brigatinib for a Covered Use.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	ALK status, treatment history and results
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	Metastatic NSCLC, patient new to therapy must be ALK-positive AND experienced progression or intolerance while on Xalkori, Zykadia or Alecensa.

# AMPYRA

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## Products Affected

- Ampyra

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus patient already started on dalfampridine extended-release for Multiple Sclerosis (MS).
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	MS. If prescribed by, or in consultation with, a neurologist or MS specialist.
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	N/A

# ANABOLIC STEROIDS

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## Products Affected

- Anadrol-50
- oxandrolone

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Girls w/Turner's Syndrome or Ullrich-Turner Syndrome (oxandrolone only), management of protein catabolism w/burns or burn injury (oxandrolone only), AIDS wasting and cachexia.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	N/A

# ARANESP

## Products Affected

- Aranesp (in polysorbate) injection solution • Aranesp (in polysorbate) injection syringe
- 100 mcg/mL, 200 mcg/mL, 25 mcg/mL,
- 300 mcg/mL, 40 mcg/mL, 60 mcg/mL

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D worded as anemia associated with chronic renal failure (CRF), including patients on dialysis and not on dialysis, and worded as anemia secondary to myelosuppressive anticancer chemotherapy in solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia. Anemia due to myelodysplastic syndrome (MDS).
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Anemia w/CRF on and not on dialysis. A hemoglobin (Hb) of less than 10.0 g/dL for adults and less than or equal to 11 g/dL for children required for start, Hb has to be less than or equal 11.5 g/dL adults or less than or equal to 12 g/dL in children if previously receiving epoetin alfa (EA) or Aranesp or less than or equal to 11.5 g/dL in adults currently receiving Mircera. Anemia due to myelosuppressive chemotx, Hb is 10.0 g/dL or less to start or less than or equal to 12.0 g/dL if previously on EA or Aranesp AND currently receiving myelosuppressive chemo. MDS, approve tx if Hb is 10 g/dL or less or serum erythropoietin level is 500 mU/mL or less to start. If the pt has previously been receiving Aranesp or EA, approve only if Hb is 12.0 g/dL or less. All conds, deny if Hb exceeds 12.0 g/dL.
<b>Age Restrictions</b>	MDS anemia = 18 years of age and older.
<b>Prescriber Restrictions</b>	MDS anemia, prescribed by or in consultation with, a hematologist or oncologist.
<b>Coverage Duration</b>	Anemia w/myelosuppressive = 4 mos, Other=6 mos.
<b>Other Criteria</b>	For all covered uses, the patient is required to try Procrit first line.

# ARCALYST

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## Products Affected

- Arcalyst

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Concurrent biologic therapy
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	Initial tx CAPS-Greater than or equal to 12 years of age.
<b>Prescriber Restrictions</b>	Initial tx CAPS-prescribed by, or in consultation with, a rheumatologist, geneticist, allergist/immunologist, or dermatologist.
<b>Coverage Duration</b>	3 mos initial, 3 years cont
<b>Other Criteria</b>	CAPS renewal - approve if the patient has had a response as determined by the prescriber.

# AUBAGIO

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## Products Affected

- Aubagio

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Concurrent use of Aubagio with other disease-modifying agents used for multiple sclerosis (MS)
<b>Required Medical Information</b>	MS, patient must have a relapsing form of MS (RRMS, SPMS with relapses, or PRMS). MS, previous MS therapies tried.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist or MS specialist.
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	For patients already taking Aubagio, approve.

# AVONEX

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## Products Affected

- Avonex (with albumin)
- Avonex intramuscular syringe kit
- Avonex intramuscular pen injector kit

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Concurrent use of other disease-modifying agent used for multiple sclerosis
<b>Required Medical Information</b>	Multiple Sclerosis (MS) diagnosis worded or described as patients with a diagnosis of MS or have experienced an attack and who are at risk of MS.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or after consultation with a neurologist or an MS specialist.
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	N/A

# BETASERON/EXTAVIA

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## Products Affected

- Betaseron subcutaneous kit
- Extavia subcutaneous kit

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Concurrent use with other disease-modifying agent used for multiple sclerosis
<b>Required Medical Information</b>	Multiple Sclerosis (MS) diagnosis worded or described as patients with a diagnosis of MS or have experienced an attack and who are at risk of MS.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or after consultation with a neurologist or an MS specialist.
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	For patients requesting Extavia, approve if the patient has tried two of the following: interferon beta-1a intramuscular (Avonex), interferon beta-1a subcutaneous (Rebif), interferon beta-1b (Betaseron), pegylated interferon beta-1a (Plegridy) or glatiramer acetate (Copaxone).

# BONIVA INJECTION

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## Products Affected

- ibandronate intravenous solution

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	Treatment of postmenopausal osteoporosis, must meet ONE of the following 1. T-score (current or at any time in the past) at or below -2.5 at the lumbar spine, femoral neck, or total hip, 2. has had osteoporotic fracture, 3. had a T-score (current or at any time in the past) at or below -2.0 at the lumbar spine, femoral neck, or total hip and the physician believes the patient is at high risk for fracture AND has had an inadequate response to oral bisphosphonate therapy after a trial duration of 12 months as determined by the prescribing physician (e.g., ongoing and significant loss of bone mineral density (BMD), lack of BMD increase), had an osteoporotic fracture while receiving oral bisphosphonate therapy, or experienced intolerability to an oral bisphosphonate (e.g., severe GI-related adverse effects) OR pt cannot take an oral bisphosphonate because the pt cannot swallow or has difficulty swallowing or the pt cannot remain in an upright position post oral bisphosphonate administration or pt has a pre-existing GI medical condition (eg, patient with esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]), OR pt has tried an IV bisphosphonate (ibandronate or zoledronic acid).

# BOSULIF

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## Products Affected

- Bosulif oral tablet 100 mg, 400 mg, 500 mg

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D. Plus patients with Philadelphia chromosome positive Acute Lymphoblastic Leukemia. Plus patients already started on Bosulif for a Covered Use.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis. For CML, the Philadelphia chromosome (Ph) status of the leukemia must be reported. For CML, prior therapies tried
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	For CML, patient must have Ph-positive CML. For ALL, patient must have Ph-positive ALL and has tried ONE other tyrosine kinase inhibitors that are used for Philadelphia chromosome positive ALL (e.g., Gleevec, Sprycel, etc).

# BOTOX

## Products Affected

- Botox

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus Achalasia. Anal Fissure. BPH. Chronic facial pain/pain associated with TMJ dysfunction. Chronic low back pain. Headache (chronic tension HA, whiplash, chronic daily HA). Palmar hyperhidrosis. Myofascial pain. Salivary hypersecretion. Spasticity (eg, due to cerebral palsy, stroke, brain injury, spinal cord injury, MS, hemifacial spasm). Essential tremor. Dystonia other than cervical (eg, focal dystonias, tardive dystonia, anismus). Frey's syndrome (gustatory sweating). Ophthalmic disorders (eg, esotropia, exotropia, nystagmus, facial nerve paresis). Speech/voice disorders (eg, dysphonias). Tourette's syndrome.
<b>Exclusion Criteria</b>	Use in the management of cosmetic uses (eg, facial rhytides, frown lines, glabellar wrinkling, horizontal neck rhytides, mid and lower face and neck rejuvenation, platysmal bands, rejuvenation of the peri-orbital region), allergic rhinitis, gait freezing in Parkinsons disease, vaginismus, interstitial cystitis, trigeminal neuralgia, or Crocodile tears syndrome.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Headache and chronic migraine - if prescribed by, or after consultation with, a neurologist or HA specialist.
<b>Coverage Duration</b>	Authorization will be for 12 months
<b>Other Criteria</b>	BPH after trial with at least 2 other therapies (eg, alpha1-blocker, 5 alpha-reductase inhibitor, TURP, transurethral microwave heat treatment, TUNA, interstitial laser therapy, stents, various forms of surgery). Chronic low back pain after trial with at least 2 other pharmacologic therapies (eg, NSAID, antispasmodics, muscle relaxants, opioids, antidepressants) and if being used as part of a multimodal therapeutic pain management program. Headache (eg, chronic tension headache, whiplash, chronic daily headache) after a trial with at least 2 other pharmacologic therapies (eg,

<b>PA Criteria</b>	<b>Criteria Details</b>
	<p>anticonvulsants, antidepressants, beta-blockers, calcium channel blockers, non-steroidal anti-inflammatory drugs). Essential tremor after a trial with at least 1 other pharmacologic therapy (eg, primidone, propranolol, benzodiazepines, gabapentin, topiramate). Tourette's syndrome if after a trial with at least 1 more commonly used pharmacologic therapy (eg, neuroleptics, clonidine, SSRIs, psychostimulants). Chronic migraine-must have 15 or more migraine headache days per month with headache lasting 4 hours per day or longer AND have tried at least two other prophylactic pharmacologic therapies, each from a different pharmacologic class (eg, beta-blocker, anticonvulsant, tricyclic antidepressant). OAB and urinary incontinence associated with a neurological condition (eg, spinal cord injury, multiple sclerosis), approve after a trial with at least one other pharmacologic therapy (eg, anticholinergic medication).</p>

# C1 ESTERASE INHIBITORS

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## Products Affected

- Cinryze
- Haegarda

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus patients already started on the prescribed drug for a covered use.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	prescribed by or in consultation with an allergist/immunologist or a physician that specializes in the treatment of HAE or related disorders
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	N/A

# CABOMETYX

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## Products Affected

- Cabometyx

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus patients with Non-Small Cell Lung Cancer with RET Gene Rearrangements. Plus patients already taking Cabometyx for a Covered Use.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, histology, RET gene rearrangement status
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	Advance Renal Cell Carcinoma (Predominant Clear Cell or Non-Clear Cell Histology)-Approve

# CALQUENCE

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## Products Affected

- Calquence

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D. Plus Chronic Lymphocytic Leukemia (CLL). Plus Small Lymphocytic Lymphoma (SLL).
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Previous medications/therapies tried
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	CLL and SLL-approve if the patient has tried one prior therapy.

# CAPRELSA

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## Products Affected

- Caprelsa oral tablet 100 mg, 300 mg

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus Differentiated (i.e., papillary, follicular, and Hurthle) Thyroid Carcinoma. Plus Non-Small Cell Lung Cancer with RET Gene Rearrangements
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	MTC - approve. DTC - approve if refractory to radioactive iodine therapy.

# CHEMET

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## Products Affected

- Chemet

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Blood lead level
<b>Age Restrictions</b>	Approve in patients between the age of 12 months and 18 years
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a professional experienced in the use of chelation therapy (eg, a medical toxicologist or a poison control center specialist)
<b>Coverage Duration</b>	Approve for 2 months
<b>Other Criteria</b>	Approve if Chemet is being used to treat acute lead poisoning (not as prophylaxis) and prior to starting Chemet therapy the patient's blood lead level was greater than 45 mcg/dL.

# CHENODAL

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## Products Affected

- Chenodal

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	For the treatment of gallstones, approve if the patient has tried or is currently using an ursodiol product.

# CHOLBAM

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## Products Affected

- Cholbam oral capsule 250 mg, 50 mg

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Combination Therapy with Chenodal
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with hepatologist, metabolic specialist, or GI
<b>Coverage Duration</b>	3 mos initial, 12 mos cont
<b>Other Criteria</b>	Bile acid synthesis d/o due to SEDs initial - Diagnosis based on an abnormal urinary bile acid as confirmed by Fast Atom Bombardment ionization - Mass Spectrometry (FAB-MS) analysis. Cont - responded to initial Cholbam tx with an improvement in LFTs AND does not have complete biliary obstruction. Bile-Acid Synthesis Disorders Due to Peroxisomal Disorders (PDs), Including Zellweger Spectrum Disorders initial - PD with an abnormal urinary bile acid analysis by FAB-MS AND has liver disease, steatorrhea, or complications from decreased fat soluble vitamin absorption (e.g., rickets). Cont - responded to initial Cholbam therapy as per the prescribing physician (e.g., improvements in liver enzymes, improvement in steatorrhea) AND does not have complete biliary obstruction.

# CIALIS

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## Products Affected

- Cialis oral tablet 2.5 mg, 5 mg

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Indication for which tadalafil is being prescribed.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 mos.
<b>Other Criteria</b>	Benign prostatic hyperplasia (BPH), after confirmation that tadalafil is being prescribed as once daily dosing, to treat the signs and symptoms of BPH and not for the treatment of erectile dysfunction (ED).

# CIMZIA

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## Products Affected

- Cimzia
- Cimzia Powder for Reconst

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D plus patients already started on certolizumab pegol for Covered use.
<b>Exclusion Criteria</b>	Concurrent use with a Biologic DMARD or Targeted Synthetic DMARD
<b>Required Medical Information</b>	Diagnosis, concurrent medications, previous therapies tried
<b>Age Restrictions</b>	Adults for CD.
<b>Prescriber Restrictions</b>	RA/AS, prescribed by or in consultation with a rheumatologist. Crohn's disease, prescribed by or in consultation with a gastroenterologist. PsA prescribed by or in consultation with a rheumatologist or dermatologist
<b>Coverage Duration</b>	3 months initial, 3 years cont.
<b>Other Criteria</b>	AS, approve if the patient has tried TWO of the following: Enbrel, Humira, Cosentyx. PsA, approve if the patient has tried TWO of the following: Enbrel, Humira, Cosentyx, Stelara, Otezla. RA, approve if the patient has tried two of the following: Enbrel, Humira, Orencia, or Xeljanz/XR. CD, approve if patient has previously tried Humira. Cont tx - approve if the patient has had a response to therapy, as according to the prescribing physician

# COMETRIQ

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## Products Affected

- Cometriq

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D. Plus Non-Small Cell Lung Cancer with RET Gene Rearrangements, Differentiated (i.e., papillary, follicular, and Hurthle) Thyroid Carcinoma and patients already started on Cometriq for a Covered Use.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	MTC - approve. Non-Small Cell Lung Cancer with RET Gene Rearrangements - approve. Differentiated (i.e., papillary, follicular, and Hurthle) Thyroid Carcinoma-approve if the patient's carcinoma is refractory to radioactive iodine therapy.

# COPAXONE

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## Products Affected

- Copaxone subcutaneous syringe 40 mg/mL
- glatiramer subcutaneous syringe 20 mg/mL, 40 mg/mL
- Glatopa subcutaneous syringe 20 mg/mL, 40 mg/mL

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Concurrent use with other disease-modifying agent used for multiple sclerosis
<b>Required Medical Information</b>	Multiple Sclerosis (MS) diagnosis worded or described as patients with a diagnosis of MS or have experienced an attack and who are at risk of MS.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or after consultation with a neurologist or an MS specialist.
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	N/A

# CORLANOR

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## Products Affected

- Corlanor

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Previous use of a Beta-blocker, LVEF, sinus rhythm, and resting HR
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	HF in pts not currently receiving Corlanor - must all of the following 1. have LVEF of less than or equal 35 percent, 2. have sinus rhythm and a resting HR of greater than or equal to 70 BPM, AND 3. tried or is currently receiving a Beta-blocker for HF (e.g., metoprolol succinate sustained-release, carvedilol, bisoprolol, carvedilol ER) unless the patient has a contraindication to the use of beta blocker therapy (e.g., bronchospastic disease such as COPD and asthma, severe hypotension or bradycardia). HF in pts currently receiving Corlanor - had a LVEF of less than or equal to 35 percent prior to initiation of Corlanor therapy AND has tried or is currently receiving a Beta-blocker for HF unless the patient has a contraindication to the use of beta blocker therapy.

# COSENTYX

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## Products Affected

- Cosentyx (2 Syringes)
- Cosentyx Pen (2 Pens)

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus patients already taking Cosentyx for a Covered Use.
<b>Exclusion Criteria</b>	Concurrent Use with other Biologics or Targeted Synthetic Disease-Modifying Antirheumatic Drugs (DMARDs)
<b>Required Medical Information</b>	Diagnosis and previous medications use
<b>Age Restrictions</b>	PP/AS/PSA initial - 18 years of age and older
<b>Prescriber Restrictions</b>	PP initial - prescribed by or in consultation with a dermatologist or rheumatologist. AS initial- by or in consultation with rheumatologist, PsA initial- by or in consultation with rheumatologist or dermatologist.
<b>Coverage Duration</b>	PP/AS - initial tx 3 mos, PsA-initial tx 3 mos, cont tx 3 years
<b>Other Criteria</b>	PP initial-approve if the patient meets one of the following criteria: 1) pt has tried at least one traditional systemic agent (eg, MTX, cyclosporine, acitretin, PUVA) for at least 3 months, unless intolerant (note: pts who have already tried a biologic for psoriasis are not required to step back and try a traditional agent first) OR 2) pt has a contraindication to MTX as determined by the prescribing physician. PP/AS/PsA cont - patient must have responded, as determined by the prescriber.

# COTELLIC

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## Products Affected

- Cotellic

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Melanoma initial - must have BRAF V600 mutation.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	Melanoma - being prescribed in combination with Zelboraf.

# CRINONE GEL

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## Products Affected

- Crinone vaginal gel 8 %

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus, secondary amenorrhea, support of an established pregnancy.
<b>Exclusion Criteria</b>	Use in patients to supplement or replace progesterone in the management of infertility.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Secondary amenorrhea, 12 months.Support of an established pregnancy, 9 months.
<b>Other Criteria</b>	N/A

# DALIRESP

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## Products Affected

- Daliresp

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Chronic Obstructive Pulmonary Disease (COPD), medications tried.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	COPD, approve in patients who meet all of the following conditions: Patients has severe COPD or very severe COPD, AND Patient has a history of exacerbations, AND Patient has tried a medication from two of the three following drug categories: long-acting beta2-agonist (LABA) [eg, salmeterol, indacaterol], long-acting muscarinic antagonist (LAMA) [eg, tiotropium], inhaled corticosteroid (eg, fluticasone).

# DARAPRIM

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## Products Affected

- Daraprim

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Patient's immune status
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Toxoplasma gondii Encephalitis, Chronic Maintenance and Prophylaxis (Primary)-prescribed by or in consultation with an infectious diseases specialist. Toxoplasmosis Treatment-prescribed by or in consultation with an infectious diseases specialist, a maternal-fetal medicine specialist, or an ophthalmologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Toxoplasma gondii Encephalitis, Chronic Maintenance, approve if the patient is immunosuppressed. Toxoplasma gondii Encephalitis Prophylaxis (Primary), approve if the patient is immunosuppressed.

# DESOXYN

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## Products Affected

- methamphetamine

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Weight loss.
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A

# DOPTELET

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## Products Affected

- Doptelet

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, platelet count, date of procedure
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	5 days
<b>Other Criteria</b>	Approve if the patient has a current platelet count less than 50 x 10 <sup>9</sup> /L AND the patient is scheduled to undergo a procedure within 10 to 13 days after starting Doptelet therapy.

# DUPIXENT

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## Products Affected

- Dupixent

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, prescriber specialty, other medications tried and length of trials
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a an allergist, immunologist or dermatologist
<b>Coverage Duration</b>	Initial-16 weeks, Continuation-1 year
<b>Other Criteria</b>	Initial Therapy- Patient meets both of the following criteria: a. Patient has used at least one medium-, medium-high, high-, and/or super-high-potency prescription topical corticosteroid for at least 28 consecutive days OR patient has atopic dermatitis affecting ONLY the face, eyes/eyelids, skin folds, and/or genitalia and has tried tacrolimus ointment for at least 28 consecutive days, AND b. Inadequate efficacy was demonstrated with these previously tried topical prescription therapies, according to the prescribing physician. Continuation- Approve if the patient has responded to Dupixent therapy as determined by the prescribing physician (e.g., marked improvements erythema, induration/papulation/edema, excoriations, and lichenification, reduced pruritus, decreased requirement for other topical or systemic therapies, reduced body surface area (BSA) affected with atopic dermatitis, or other responses observed).

# ENBREL

## Products Affected

- Enbrel subcutaneous recon soln
- Enbrel SureClick
- Enbrel subcutaneous syringe

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D plus patient already on etanercept for a Covered Use. Graft versus host disease (GVHD). Behcet's disease. Uveitis
<b>Exclusion Criteria</b>	Concurrent use with biologic therapy or targeted synthetic DMARD
<b>Required Medical Information</b>	Diagnosis, concurrent medications, previous therapies tried.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	RA/Ankylosing spondylitis/JIA/JRA,prescribed by or in consult w/ rheumatologist. Psoriatic arthritis, prescribed by or in consultation w/ rheumatologist or dermatologist.Plaque psoriasis (PP), prescribed by or in consult w/ dermatologist.GVHD,prescribed by or in consult w/ oncologist,hematologist,or physician affiliated w/ transplant center.Behcet's disease,prescribed by or in consult w/ rheumatologist,dermatologist,ophthalmologist,gastroenterologist,or neurologist.
<b>Coverage Duration</b>	FDA approved indications - 3 months initial, 3 years cont, others 12 months.
<b>Other Criteria</b>	RA initial, patient has tried one conventional synthetic DMARD for at least 3 months (note: patients who have already had a 3-month trial of a biologic for RA are not required to step back and try a conventional synthetic DMARD). JIA/JRA, approve if the pt has aggressive disease, as determined by the prescriber, or the pt has tried one other agent for this condition (eg, MTX, sulfasalazine, leflunomide, NSAID, biologic DMARD or the pt will be started on Enbrel concurrently with MTX, sulfasalazine, or leflunomide or the pt has an absolute contraindication to MTX (eg, pregnancy, breast feeding, alcoholic liver disease, immunodeficiency syndrome, blood dyscrasias), sulfasalazine, or leflunomide.Plaque psoriasis (PP) initial approve if the patient meets one of the following conditions: 1) patient has tried at least one traditional systemic agent for at least 3 months

PA Criteria	Criteria Details
	<p>for plaque psoriasis, unless intolerant (eg, MTX, cyclosporine, Soriatane, oral methoxsalen plus PUVA, (note: pts who have already tried a biologic for psoriasis are not required to step back and try a traditional agent first) OR 2) the patient has a contraindication to one oral agent for psoriasis such as MTX. GVHD. Tried or currently is receiving with etanercept 1 conventional GVHD tx (high-dose systemic corticosteroid, CSA, tacrolimus, MM, thalidomide, antithymocyte globulin, etc.). Behcet's. Has tried at least 1 conventional tx (eg, systemic corticosteroid, immunosuppressant, interferon alfa, MM, etc) or adalimumab or infliximab. Uveitis-tried one of the following: periocular, intraocular, or systemic corticosteroid, immunosuppressives, Humira or an infliximab product. RA/AS/JIA/PP/PsA Cont - must have a response to tx according to the prescriber. Clinical criteria incorporated into the Enbrel 25 mg quantity limit edit, approve additional quantity (to allow for 50 mg twice weekly dosing) if one of the following is met: 1) Patient has plaque psoriasis, OR 2) Patient has RA/JIA/PsA/AS and is started and stabilized on 50 mg twice weekly dosing, OR 3) Patient has RA and the dose is being increased to 50 mg twice weekly and patient has taken MTX in combination with Enbrel 50 mg once weekly for at least 2 months, unless MTX is contraindicated or intolerant, OR 4) Patient has JIA/PsA/AS and the dose is being increased to 50 mg twice weekly after taking 50 mg once weekly for at least 2 months.</p>

# EPCLUSA

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## Products Affected

- Epclusa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus patients started on Epclusa for a Covered Use.
<b>Exclusion Criteria</b>	Combination use with other direct acting antivirals, excluding ribavirin.
<b>Required Medical Information</b>	Genotype, prescriber specialty, other medications tried or used in combination with requested medication
<b>Age Restrictions</b>	18 years or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician, or a liver transplant physician
<b>Coverage Duration</b>	Will be c/w AASLD guidance and inclusive of treatment already received for the requested drug
<b>Other Criteria</b>	Criteria will be applied consistent with current AASLD/IDSA guidance. Patients with genotype 4 must have a trial with Harvoni prior to approval of Epclusa, unless Harvoni is not specifically listed as an alternative therapy for a specific patient population in the guidelines.

# EPOETIN/PROCRIT

## Products Affected

- Epogen injection solution 2,000 unit/mL, 20,000 unit/2 mL, 20,000 unit/mL, 3,000 unit/mL, 4,000 unit/mL
- 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
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus anemia in patients with HIV who are receiving zidovudine. Anemic patients (Hb of 13.0 g/dL or less) at high risk for perioperative transfusions (secondary to significant, anticipated blood loss and are scheduled to undergo elective, noncardiac, nonvascular surgery to reduce the need for allogeneic blood transfusions). Plus anemia due to myelodysplastic syndrome (MDS).
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	CRF anemia in patients on and not on dialysis. Hemoglobin (Hb) of less than 10.0 g/dL for adults or less than or equal to 11 g/dL for children to start. Hb less than or equal to 11.5 g/dL for adults or 12 g/dL or less for children if previously on epoetin alfa or Aranesp or less than or equal to 11.5 g/dL if currently receiving Mircera. Anemia w/myelosuppressive chemotx. pt must be currently receiving myelosuppressive chemo and Hb 10.0 g/dL or less to start. Hb less than or equal to 12.0 g/dL if previously on epoetin alfa or Aranesp. MDS, approve if Hb is 10 g/dL or less or serum erythropoietin level is 500 mU/mL or less to start. Previously receiving Aranesp or EA, approve if Hb is 12.0 g/dL or less. Anemia in HIV with zidovudine, Hb is 10.0 g/dL or less or endogenous erythropoietin levels are 500 mU/mL or less at tx start. Previously on EA approve if Hb is 12.0 g/dL or less. Surgical pts to reduce RBC transfusions - pt is unwilling or unable to donate autologous blood prior to surgery
<b>Age Restrictions</b>	MDS anemia = 18 years of age and older
<b>Prescriber Restrictions</b>	MDS anemia, prescribed by or in consultation with, a hematologist or oncologist.
<b>Coverage Duration</b>	Anemia w/myelosuppressive = 4 mos. Transfus=1 mo. Other=6mo. HIV + zidovudine = 4 mo
<b>Other Criteria</b>	For all covered uses, if the request is for Epogen, then the patient is

<b>PA Criteria</b>	<b>Criteria Details</b>
	required to try Procrit first line.

# ERIVEDGE

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## Products Affected

- Erivedge

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus, patient already started on Erivedge for a covered use.
<b>Exclusion Criteria</b>	BCC (La or Met) - must not have had disease progression while on Odomzo.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months
<b>Other Criteria</b>	Locally advanced basal cell carcinoma (LABCC), approve if 1. the patient's BCC has recurred following surgery or radiation, OR 2. the patient is not a candidate for surgery and radiation therapy.

# ERLEADA

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## Products Affected

- Erleada

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	N/A

# ESBRIET

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## Products Affected

- Esbriet oral capsule
- Esbriet oral tablet 267 mg, 801 mg

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Combination use with nintedanib
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	IPF baseline - must have FVC greater than or equal to 50 percent of the predicted value AND IPF must be diagnosed with either findings on high-resolution computed tomography (HRCT) indicating usual interstitial pneumonia (UIP) or surgical lung biopsy demonstrating UIP.

# EXJADE/JADENU

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## Products Affected

- Exjade
- Jadenu Sprinkle
- Jadenu

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D worded as transfusion-related chronic iron overload and non-transfusion-dependent thalassemia syndromes chronic iron overload
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Serum ferritin level
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a hematologist
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Transfusion-related chronic iron overload, initial therapy - approve if the patient is receiving blood transfusions at regular intervals for various conditions (eg, thalassemia syndromes, myelodysplastic syndrome, chronic anemia, sickle cell disease) AND prior to starting therapy, the serum ferritin level is greater than 1,000 mcg/L. Non-transfusion-dependent thalassemia syndromes chronic iron overload, initial therapy - approve if prior to starting therapy the serum ferritin level is greater than 300 mcg/L. Continuation therapy - approve if the patient is benefiting from therapy as confirmed by the prescribing physician.

# FARYDAK

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## Products Affected

- Farydak oral capsule 10 mg, 15 mg, 20 mg

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	MM - must be used in combination with Velcade and dexamethasone AND previously tried Velcade and one immunomodulatory drug (i.e., Thalomid, Revlimid, or Pomalyst).

# FASENRA

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## Products Affected

- Fasenra

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Concurrent use with Xolair or another IL Antagonist Monoclonal Antibody
<b>Required Medical Information</b>	Diagnosis, severity of disease, peripheral blood eosinophil count, previous therapies tried and current therapies, FEV1/FVC
<b>Age Restrictions</b>	12 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an allergist, immunologist, or pulmonologist
<b>Coverage Duration</b>	Authorization will be for 6 months initial, 12 months continuation.
<b>Other Criteria</b>	Initial - must have peripheral blood eosinophil count of greater than or equal to 150 cells per microliter within the previous 6 weeks (prior to treatment with an IL-5 antagonist monoclonal antibody) AND meet both of the following criteria: 1) Patient has received at least 3 consecutive months of combination therapy with an inhaled corticosteroid AND one of the following: inhaled LABA, inhaled long-acting muscarinic antagonist, Leukotriene receptor antagonist, or Theophylline, AND 2) Patient's asthma is uncontrolled or was uncontrolled prior to starting any IL-antagonist therapy as defined by ONE of the following: a) patient experienced two or more asthma exacerbations requiring treatment with systemic corticosteroids in the previous year, OR b) patient experienced one or more asthma exacerbation requiring hospitalization or an Emergency Department (ED) visit in the previous year, OR c) patient has a FEV1 less than 80 percent predicted, OR d) Patient has an FEV1/FVC less than 0.80, OR e) Patient's asthma worsens upon tapering of oral corticosteroid therapy. Continuation - The patient has responded to Fasenra therapy as determined by the prescribing physician (e.g., decreased asthma exacerbations, decreased asthma symptoms, decreased hospitalizations, emergency department (ED)/urgent care, or physician visits due to asthma, decreased requirement for oral corticosteroid therapy) AND patient continues to

<b>PA Criteria</b>	<b>Criteria Details</b>
	receive therapy with an inhaled corticosteroid.

# FERRIPROX

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## Products Affected

- Ferriprox

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D worded as transfusion-related due to thalassemia syndromes chronic iron overload
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Serum ferritin level
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a hematologist
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Initial therapy - approve if prior to starting therapy the serum ferritin level was greater than 2,500 mcg/L. Continuation therapy - approve is the patient is benefiting from therapy as confirmed by the prescribing physician.

# FIRAZYR

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## Products Affected

- Firazyr

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, an allergist/immunologist or a physician that specializes in the treatment of HAE or related disorders
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	N/A

# FLECTOR

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## Products Affected

- Flector

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 mos.
<b>Other Criteria</b>	Patients must try a generic oral NSAID or Voltaren gel.

# FORTEO

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## Products Affected

- Forteo

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Concomitant use with other medications for osteoporosis (eg, denosumab [Prolia], bisphosphonates, raloxifene, calcitonin nasal spray [Miacalcin, Fortical]), except calcium and Vitamin D.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 2 years
<b>Other Criteria</b>	Treatment of PMO, approve if pt has tried one oral bisphosphonate OR pt cannot take an oral bisphosphonate because the pt cannot swallow or has difficulty swallowing or the pt cannot remain in an upright position post oral bisphosphonate administration or pt has a pre-existing GI medical condition (eg, patient with esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]), OR pt has tried an IV bisphosphonate (ibandronate or zoledronic acid), OR pt has severe renal impairment (creatinine clearance less than 35 mL/min) or CKD or pt has had multiple osteoporotic fractures. Increase bone mass in men (a man is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression) with primary or hypogondal osteoporosis/Treatment of GIO, approve if pt tried one oral bisphosphonate OR pt cannot take an oral bisphosphonate because the patient cannot swallow or has difficulty swallowing or the patient cannot remain in an upright position post oral bisphosphonate administration or has a pre-existing GI medical condition (eg, patient with esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]), OR pt has tried zoledronic acid (Reclast), OR pt has severe renal impairment

<b>PA Criteria</b>	<b>Criteria Details</b>
	(CrCL less than 35 mL/min) or has CKD or has had multiple osteoporotic fractures.

# GILENYA

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## Products Affected

- Gilenya oral capsule 0.5 mg

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Concurrent use of Gilenya with other disease-modifying agents used for multiple sclerosis (MS).
<b>Required Medical Information</b>	For use in MS, patient has a relapsing form of MS.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, a neurologist or an MS specialist.
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	N/A

# GILOTRIF

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## Products Affected

- Gilotrif oral tablet 20 mg, 30 mg, 40 mg

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Additional coverage is provide for NSCLC - squamous cell carcinoma and NSCLC - HER2 positive.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For NSCLC - EGFR exon deletions or mutations HER2 status, or if NSCLC is squamous cell type
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	NSCLC EGFR pos - For the treatment of metastatic non small cell lung cancer (NSCLC) must be used in tumors with non-resistant EGFR mutation positive NSCLC. NSCLC squamous cell must have disease progression with first line treatment with platinum based chemotherapy. NSCLC HER2 pos - if HER2 positive NSCLC approve.

# GLUCAGON-LIKE PEPTIDE-1 AGONISTS

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## Products Affected

- Bydureon
- Bydureon BCise
- Byetta subcutaneous pen injector 10 mcg/dose(250 mcg/mL) 2.4 mL, 5 mcg/dose (250 mcg/mL) 1.2 mL
- Ozempic
- Tanzeum
- Trulicity
- Victoza 3-Pak

PA Criteria	Criteria Details
Covered Uses	All FDA-approved 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	Authorization will be for 3 years.
Other Criteria	N/A

# GRALISE/HORIZANT

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## Products Affected

- Gralise 30-Day Starter Pack
- Gralise oral tablet extended release 24 hr 300 mg, 600 mg

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	Authorize use if the patient has tried gabapentin for their current condition.

# GRANIX

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## Products Affected

- Granix

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA -approved indications not otherwise excluded from Part D. Plus patients undergoing peripheral blood progenitor cell (PBPC) Collection and Therapy.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist, infectious disease specialist, or hematologist
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	Cancer patients receiving Myelosuppressive Chemotherapy-Must meet ONE of the following - 1. be receiving myelosuppressive anti-cancer medications that are associated with a high risk of febrile neutropenia (the risk is at least 20 percent based on the chemotherapy regimen) 2. be receiving myelosuppressive anti-cancer medications that are associated with a risk of febrile neutropenia but the risk is less than 20 percent based on the chemotherapy regimen and the patient has one or more risk factors for febrile neutropenia according to the prescribing physician (e.g., at least 65 years, prior chemotherapy or radiation therapy, persistent neutropenia, bone marrow involvement by tumor, recent surgery and/or open wounds, liver and/or renal dysfunction, poor performance status, HIV infection) 3. have had a neutropenic complication from prior chemotherapy and did not receive prophylaxis with a CSF (e.g., Granix, Neulasta, Zarxio, Neupogen, or Leukine) and a reduced dose or frequency of chemotherapy may compromise treatment OR 4. has received chemotherapy has febrile neutropenia and has at least one risk factor for poor clinical outcomes or for developing infection-associated complications according to the prescribing physician (e.g., sepsis syndrome, older than 65 years, severe

<b>PA Criteria</b>	<b>Criteria Details</b>
	neutropenia - ANC less than 100 cells/mm <sup>3</sup> , neutropenia expected to be more than 10 days in duration, invasive fungal infection, other clinically documented infections, or prior episode of febrile neutropenia).

# GROWTH HORMONES

## Products Affected

- Norditropin FlexPro
- Omnitrope

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	GHD in children/adolescents initial must meet ONE of the following - 1. had hypophysectomy, 2. has congenital hypopituitarism AND had growth hormone response to one preferred GH test of less than 10 ng/mL (preferred tests are levodopa, insulin-induced hypoglycemia, arginine, clonidine, or glucagon), 3. has panhypopituitarism AND had growth hormone response to one preferred GH test of less than 10 ng/mL, has 3 or more pituitary hormone deficiencies (ACTH, TSH, LH/FSH, or prolactin), or pituitary stalk agenesis, empty sella, sellar or supra-sellar mass lesion, or ectopic posterior "bright spot" on MRI or CT, 4. pt had brain radiation, had growth hormone response to one preferred GH test of less than 10 ng/mL, AND meets one of these a. pretreatment growth rate (GR) is less than 7 cm/yr in children younger than 3 or b. GR is less than 4 cm/yr in 3 y/o or older, c. or if 18 y/o or younger with growth velocity that is less than 10th percentile for age/gender on last 6 months of data, OR 5. had growth hormone response to one preferred GH test of less than 10 ng/mL, ht less than the 10th percentile for age/gender, AND meets one of these a. pretreatment growth rate (GR) is less than 7 cm/yr in children younger than 3 or b. GR is less than 4 cm/yr in 3 y/o or older, c. or if 18 y/o or younger with growth velocity that is less than 10th percentile for age/gender on last 6 months of data. Continuation of tx-approve if the patient has experienced improvement, according to the prescribing physician.
<b>Age Restrictions</b>	ISS 5 y/o or older, SGA 2 y/o or older, SBS 18 y/o or older
<b>Prescriber Restrictions</b>	GHD (Initial tx children or adolescents w/o hypophysectomy), GHD adults or transitional adolescents, Noonan (initial), Prader Willi (initial for child/adult and cont tx in adults), SHOX (initial), SGA (initial) - prescribed by or in consultation with an endocrinologist. CKD (initial) endocrinologist or nephrologist.
<b>Coverage Duration</b>	ISS - 6 mos intial, 12 months cont tx, SBS 4 weeks, others 12 mos

PA Criteria	Criteria Details
Other Criteria	<p>GHD initial in adults and adolescents 1. endocrine must certify not being prescribed for anti-aging or to enhance athletic performance, 2. has either childhood onset or adult onset resulting from GHD alone, multiple hormone deficiency from pituitary dx, hypothalamic dz, pituitary surgery, cranial radiation tx, tumor treatment, TBI or subarachnoid hemorrhage, AND 3. meets one of the following - A. childhood onset has known mutations, embryonic lesions, congenital defects or irreversible structural hypothalamic pituitary lesion/damage, B. 3 or more pituitary hormone def (ACTH, TSH, LH/FSH, or prolactin, IGF1 less than 84 mcg/L (Esoterix RIA), AND other causes of low serum IGF-1 have been excluded, C. Neg response to ONE preferred GH stim test (insulin peak response less than or equal to 5 mcg/L, Glucagon peak less than or equal to 3 mcg/L, if insulin and glucagon contraindicated then Arginine alone test with peak of less than or equal to 0.4 mcg/L, GHRH plus arginine peak of less than or equal to 11 mcg/L if BMI is less than 25, peak less than 8 mcg/L if BMI is more than 25 but less than 30, or peak less than 4 mcg/L if BMI if more than 30) AND if a transitional adolescent must be off tx for at least one month before retesting. Cont tx - endocrine must certify not being prescribed for anti-aging or to enhance athletic performance. ISS initial - baseline ht less than the 1.2 percentile or a standard deviation score (SDS) less than -2.25 for age and gender, open epiphyses, does not have CDGP and height velocity is either growth rate (GR) is a. less than 4 cm/yr for pts older than 5 or b. growth velocity is less than 10th percentile for age/gender. Cont tx - 1. 5 y/o old or older doubled annualized GR or 2. ht increase by 4 or more cm/yr. Additionally, pts older than 12 must also have open epiphyses and pts older than 18 must also have not attained midparental height. CKD initial - CKD defined by abnormal CrCl. Noonan initial - baseline height less than 5th percentile. PW cont tx in adults or adolescents who don't meet child requir - physician certifies not being used for anti-aging or to enhance athletic performance. SHOX initial - SHOX def by chromo analysis, open epiphyses, height less than 3rd percentile for age/gender. SGA initial -baseline ht less than 5th percentile for age/gender and born SGA (birth weight/length that is more than 2 SD below mean for gestational age/gender and didn't have sufficient catch up growth by 2-4 y/o). Cont tx - ht increase by 4 or more cm/yr. Additionally, pts older than 12 must also have open epiphyses and pts older than 18 must also have not attained midparental height. Cont Tx for CKD, Noonan, PW in child/adolescents, SHOX, and TS - ht increased by 2.5 cm/yr or more and epiphyses open. SBS initial pt receiving specialized nutritional support. Cont tx - 2nd course if pt responded to tx with a decrease in the requirement for specialized nutritional support.</p>

# HARVONI

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## Products Affected

- Harvoni

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus patients with recurrent HCV post-liver transplant. Plus patients started on Harvoni for a covered use
<b>Exclusion Criteria</b>	Combination use with other direct acting antivirals, excluding ribavirin
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	12 years or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation w/ GI, hepatologist, ID, or a liver transplant MD
<b>Coverage Duration</b>	Will be c/w AASLD guidance and inclusive of treatment already received for the requested drug
<b>Other Criteria</b>	Criteria will be applied consistent with current AASLD/IDSA guidance.

# HETLIOZ

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## Products Affected

- HetlioZ

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	patient is totally blind with no perception of light
<b>Age Restrictions</b>	18 years or older
<b>Prescriber Restrictions</b>	prescribed by, or in consultation with, a neurologist or a physician who specializes in the treatment of sleep disorders
<b>Coverage Duration</b>	6 mos initial, 12 mos cont
<b>Other Criteria</b>	Initial - dx of Non-24 is confirmed by either assessment of one physiologic circadian phase marker (e.g., measurement of urinary melatonin levels, dim light melatonin onset, assessment of core body temperature), or if assessment of physiologic circadian phase marker cannot be done, the diagnosis must be confirmed by actigraphy performed for at least 1 week plus evaluation of sleep logs recorded for at least 1 month. Cont - Approve if pt has received at least 6 months of continuous therapy (i.e., 6 consecutive months of daily treatment) with HetlioZ under the guidance of a physician who specializes in the treatment of sleep disorders AND has achieved adequate results with HetlioZ therapy according to the prescribing physician (e.g., entrainment, clinically meaningful or significant increases in nighttime sleep, clinically meaningful or significant decreases in daytime sleep).

# HIGH RISK MEDICATIONS - BENZODIAZEPINES

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## Products Affected

- clonazepam
- clorazepate dipotassium
- Diazepam Intensol
- diazepam oral solution 5 mg/5 mL (1 mg/mL)
- diazepam oral tablet
- lorazepam oral
- Onfi oral suspension
- Onfi oral tablet 10 mg, 20 mg

PA Criteria	Criteria Details
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Procedure-related sedation = 1mo. All other conditions = 12 months.
<b>Other Criteria</b>	All medically accepted indications other than insomnia, authorize use. Insomnia, may approve lorazepam if the patient has had a trial with two of the following: ramelteon, doxepin 3mg or 6 mg, eszopiclone, zolpidem, or zaleplon. Prior to approval, the physician must have assessed risk versus benefit in prescribing the requested HRM for the patient and must confirm that he/she would still like to initiate/continue therapy.

## HIGH RISK MEDICATIONS - BENZTROPINE

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### Products Affected

- benztropine oral

PA Criteria	Criteria Details
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For all medically-accepted indications, approve if the prescriber confirms he/she has assessed risk versus benefit in prescribing benztropine for the patient and he/she would still like to initiate/continue therapy

# HIGH RISK MEDICATIONS - CYCLOBENZAPRINE

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## Products Affected

- cyclobenzaprine oral tablet

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	Patients aged less than 65 years, approve.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	The physician has assessed risk versus benefit in using this High Risk Medication (HRM) in this patient and has confirmed that he/she would still like to initiate/continue therapy.

# HIGH RISK MEDICATIONS - FIRST GENERATION ANTIHISTAMINES

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## Products Affected

- hydroxyzine HCl oral tablet
- promethazine oral

PA Criteria	Criteria Details
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	For hydroxyzine hydrochloride, authorize use without a previous drug trial for all FDA-approved indications other than anxiety. Approve hydroxyzine hydrochloride if the patient has tried at least two other FDA-approved products for the management of anxiety. Prior to approval of promethazine and hydroxyzine, approve if the physician must have assessed risk versus benefit in prescribing the requested HRM for the patient and must confirm that he/she would still like to initiate/continue therapy.

# HIGH RISK MEDICATIONS - PHENOBARBITAL

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## Products Affected

- phenobarbital

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Coverage is not provided for use in sedation/insomnia.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	For the treatment of seizures, approve only if the patient is currently taking phenobarbital.

# HIGH RISK MEDICATIONS - TERTIARY TRICYCLIC ANTIDEPRESSANTS

## Products Affected

- amitriptyline
- clomipramine
- doxepin oral
- imipramine HCl
- imipramine pamoate
- trimipramine

PA Criteria	Criteria Details
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	For the treatment of depression, approve if the patient has tried at least two of the following agents (brand or generic): citalopram, escitalopram, fluoxetine, paroxetine, sertraline, venlafaxine, desvenlafaxine, duloxetine, bupropion, mirtazapine, nortriptyline, desipramine, or trazodone. For the treatment of pain, may approve amitriptyline (single-entity only, not amitriptyline combination products) or imipramine (brand or generic) if the patient has tried at least two of the following agents: duloxetine, pregabalin, gabapentin, venlafaxine, venlafaxine Er, desipramine, or nortriptyline. For the treatment of obsessive compulsive disorder (OCD), may approve clomipramine (brand or generic) if the patient has tried at least two of the following medications: fluoxetine, fluvoxamine, paroxetine, sertraline, citalopram, escitalopram, or venlafaxine. Prior to approval, the physician must have assessed risk versus benefit in prescribing the requested HRM for the patient and must confirm that he/she would still like to initiate/continue therapy.

# HIGH RISK MEDICATIONS- ESTROGENS

## Products Affected

- estradiol oral
- estradiol transdermal patch semiweekly
- estradiol transdermal patch weekly
- estradiol-norethindrone acet
- Menest oral tablet 0.3 mg, 0.625 mg, 1.25 mg
- norethindrone ac-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg

PA Criteria	Criteria Details
Covered Uses	All medically-accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Previous medication use
Age Restrictions	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months
Other Criteria	For the treatment of Vulvar Vaginal Atrophy, approve if the patient has had a trial of one of the following for vulvar vaginal atrophy (brand or generic): Estrace Vaginal Cream, Estring, or estradiol valerate. For prophylaxis of Postmenopausal Osteoporosis, approve if the patient has had a trial of one of the following (brand or generic): alendronate, ibandronate, risidronate, Raloxifene, or Prolia. The physician has assessed risk versus benefit in using this High Risk medication (HRM) in this patient and has confirmed that he/she would still like to initiate/continue therapy.

# HUMIRA

## Products Affected

- Humira Pediatric Crohn's Start subcutaneous syringe kit 40 mg/0.8 mL, 40 mg/0.8 mL (6 pack), 80 mg/0.8 mL, 80 mg/0.8 mL-40 mg/0.4 mL
- Humira Pen
- Humira Pen Crohn's-UC-HS Start subcutaneous pen injector kit 40 mg/0.8 mL
- Humira Pen Psoriasis-Uveitis subcutaneous pen injector kit 40 mg/0.8 mL
- Humira subcutaneous syringe kit 10 mg/0.1 mL, 10 mg/0.2 mL, 20 mg/0.2 mL, 20 mg/0.4 mL, 40 mg/0.4 mL, 40 mg/0.8 mL

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D plus patients already started on adalimumab for a Covered Use.
<b>Exclusion Criteria</b>	Concurrent use with another biologic DMARD or targeted synthetic DMARD.
<b>Required Medical Information</b>	Diagnosis, concurrent medications, previous therapies tried
<b>Age Restrictions</b>	Crohn's disease (CD), 6 or older. Ulcerative colitis (UC), adults.
<b>Prescriber Restrictions</b>	RA/JIA/JRA/Ankylosing spondylitis, prescribed by or in consultation with rheumatologist. Psoriatic arthritis (PsA), prescribed by or in consultation with a rheumatologist or dermatologist. Plaque psoriasis (PP), prescribed by or in consultation with a dermatologist. UC/ CD, prescribed by or in consultation with a gastroenterologist. HS - dermatologist. UV-ophthalmologist
<b>Coverage Duration</b>	initial 3 mo, cont tx 3 years.
<b>Other Criteria</b>	RA initial, patient has tried one conventional synthetic DMARD for at least 3 months (note: patients who have already had a 3-month trial of a biologic for RA are not required to step back and try a conventional synthetic DMARD). JIA/JRA initial. Tried another agent (e.g MTX, sulfasalazine, leflunomide, NSAID, or biologic DMARD (eg, etanercept, abatacept, infliximab, anakinra, tocilizumab) or will be starting on adalimumab concurrently with MTX, sulfasalazine, or leflunomide. Approve without trying another agent if pt has absolute contraindication to MTX, sulfasalazine, or leflunomide or if pt has aggressive disease. PP

PA Criteria	Criteria Details
	<p>initial-approve if the patient meets one of the following criteria: 1) pt has tried at least one traditional systemic agent (eg, MTX, cyclosporine, acitretin, PUVA) for at least 3 months, unless intolerant (note: pts who have already tried a biologic for psoriasis are not required to step back and try a traditional agent first) OR 2) pt has a contraindication to MTX as determined by the prescribing physician. CD initial. Tried corticosteroids (CSs) or if CSs are contraindicated or if pt currently on CSs or patient has tried one other agent for CD (eg, azathioprine, 6-mercaptopurine, MTX, certolizumab, infliximab, ustekinumab, or vedolizumab) OR pt had ileocolonic resection OR enterocutaneous (perianal or abdominal) or rectovaginal fistulas. UC initial. Pt has tried a systemic therapy (eg, 6-mercaptopurine, azathioprine, CSA, tacrolimus, infliximab, golimumab SC, or a corticosteroid such as prednisone or methylprednisolone) for 2 months or was intolerant to one of these agents, or the pt has pouchitis and has tried therapy with an antibiotic, probiotic, corticosteroid enema, or mesalamine (Rowasa) enema. FDA approve indications cont tx - must respond to tx as determined by prescriber. HS - tried ONE other therapy (e.g., intralesional or oral corticosteroids, systemic antibiotics, isotretinoin). Clinical criteria incorporated into the Humira 40 mg quantity limit edit allow for approval of additional quantities to accommodate induction dosing. The allowable quantity is dependent upon the induction dosing regimen for the applicable FDA-labeled indications as outlined in product labeling.</p>

# IBRANCE

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## Products Affected

- Ibrance

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus liposarcoma.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	Breast cancer - approve advanced (metastatic) hormone receptor positive (HR+) [i.e., estrogen receptor positive- (ER+) and/or progesterone receptor positive (PR+)] disease, and HER2-negative breast cancer when the pt meets ONE of the following 1. Pt is postmenopausal and Ibrance will be used as first line therapy in combination with anastrozole, exemestane, or letrozole 2, pt is premenopausal or perimenopausal and is receiving ovarian suppression/ablation with LHRH agonists, surgical bilateral oophorectomy, or ovarian irradiation AND it will be used as first line endocrine therapy in combination with anastrozole, exemestane, or letrozole, 3. pt is a man (a man is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression) who is receiving LHRH agonist AND Ibrance with be used as first line endocrine therapy in combination with anastrozole, exemestane or letrozole, 4. Pt is postmenopausal and has relapsed or progressed during endocrine therapy (e.g. anastrozole, exemestane, letrozole, tamoxifen) AND has not previously taken Ibrance in combination with letrozole, anastrozole, or exemestane AND will be used in combination with Faslodex, 5. Pt is premenopausal or perimenopausal and is receiving ovarian suppression/ablation with LHRH agonist, surgical bilateral oophorectomy,

<b>PA Criteria</b>	<b>Criteria Details</b>
	or ovarian irradiation, relapsed or progressed on prior endocrine therapy, has not previously taken Ibrance in combination with letrozole, anastrozole, or exemestane AND will be used in combination with Faslodex.

# ICLUSIG

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## Products Affected

- Iclusig oral tablet 15 mg, 45 mg

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D. Plus patients already started on Iclusig for a Covered Use.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis the Philadelphia chromosome (Ph) status of the leukemia must be reported. T315I status
<b>Age Restrictions</b>	CML/ALL - Adults
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	CML Ph+, T315I-positive or has tried TWO other TKIs indicated for use in Philadelphia chromosome positive CML (e.g., Gleevec, Sprycel, Tasigna). ALL Ph+, T315I-positive or has tried TWO other TKIs indicated for use in Ph+ ALL (e.g. Gleevec, Sprycel.)

# IDHIFA

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## Products Affected

- Idhifa oral tablet 100 mg, 50 mg

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus patients already started on Idhifa for a Covered Use.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	IDH2-mutation status
<b>Age Restrictions</b>	Adults
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	AML - approve if relapsed or refractory-AND the patient is IDH2-mutation status positive as detected by an approved test

# ILARIS

## Products Affected

- Ilaris (PF) subcutaneous solution

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	When used in combination with concurrent biologic therapy (e.g. TNF antagonists, etanercept, adalimumab, certolizumab pegol, golimumab, infliximab), anakinra, or rilonacept.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	CAPS-4 years of age and older. SJIA-2 years of age and older.
<b>Prescriber Restrictions</b>	CAPS/MWS/FCAS initial- Prescribed by or in consultation with a rheumatologist, geneticist, allergist/immunologist, or dermatologist. SJIA initial- prescribed by or in consultation with a rheumatologist. FMF initial - rheumatologist, nephrologist, geneticist, gastroenterologist, oncologist, hematologist. HIDS/MKD/TRAPS initial - rheumatologist, nephrologist, geneticist, oncologist, hematologist.
<b>Coverage Duration</b>	CAPS/SJIA-3 mos initial, 3 years cont. FMF/HIDS/MKD/TRAPS-4 mos initial, 3 years cont.
<b>Other Criteria</b>	For renewal of CAPS/MWS/FCAS/SJIA/FMF/HIDS/MKD/TRAPS - After pt had been started on Ilaris, approve if the pt had a response to therapy as determined by prescribing physician. SJIA, initial therapy - approve if the pt meets one of the following: 1. has tried at least 2 other biologics for SJIA (tocilizumab, abatacept, TNF antagonists (e.g. etanercept, adalimumab, infliximab) OR 2. pt has features of poor prognosis (e.g. arthritis of the hip, radiographic damage, 6-month duration of significant active systemic disease, defined by fever, elevated inflammatory markers, or requirement for treatment with systemic glucocorticoids AND tried Actemra or Kineret OR 3. Pt as features of SJIA with active systemic features with concerns of progression to macrophage activation syndrome (MAS) [as determined by the prescribing physician] AND has tried Kineret.

# IMATINIB

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## Products Affected

- imatinib oral tablet 100 mg, 400 mg

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D. Plus chordoma, advanced or unresectable fibromatosis (desmoid tumors), cKit positive advanced/recurrent or metastatic melanoma, and pigmented Villonodular Synovitis/Tenosynovial Giant Cell Tumor. Plus patients already started on imatinib or Gleevec for a Covered Use.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis. For indications of CML and ALL, the Philadelphia chromosome (Ph) status of the leukemia must be reported.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	For ALL/CML, new patient must have Ph-positive for approval of imatinib.

# IMBRUVICA

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## Products Affected

- Imbruvica oral capsule 140 mg, 70 mg
- Imbruvica oral tablet 140 mg, 280 mg, 420 mg, 560 mg

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus patients already taking Imbruvica for a Covered Use.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	Marginal Zone Lymphoma - Approve if the patient has tried Rituxan (rituximab for intravenous infusion) or according to the prescribing physician, Rituxan is contraindicated for use in this patient.

# INFLECTRA

## Products Affected

- Inflectra

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus patients already started on infliximab (Remicade or Inflectra) for a covered use.
<b>Exclusion Criteria</b>	Concurrent use with Biologic DMARD or Targeted Synthetic DMARD.
<b>Required Medical Information</b>	Diagnosis, concurrent medication, medications previously tried
<b>Age Restrictions</b>	CD - Pts aged 6 years or more. UC - Pts aged 18 years or more
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with: RA/Ankylosing spondylitis-rheumatologist, Plaque Psoriasis-dermatologist, Psoriatic Arthritis-rheumatologist or dermatologist, Crohn's Disease/UC-gastroenterologist.
<b>Coverage Duration</b>	initial - 3 mos, cont 3 years
<b>Other Criteria</b>	Approve for RA if pt has tried Enbrel or Humira. [Note: the patient does not have to have a trial with one of the drugs listed if they have had a trial with Cimzia or Simponi SC in the past.] Approve for Ankylosing Spondylitis and PsA if the patient has tried Enbrel or Humira. [Note: the patient does not have to have a trial with etanercept or adalimumab if they have had a trial with Cimzia or Simponi SC in the past.] CD in patients aged greater than 6 years but less than 18 years, approve if the pt has tried corticosteroid (CS) or if CSs contraindicated or if currently on CS or if the patient has tried one other agent for CD (eg, azathioprine, 6-MP, MTX, certolizumab, adalimumab, Entyvio) OR the patient has enterocutaneous (perianal or abdominal) or rectovaginal fistulas OR the patient has had ileocolonic resection. CD in patients 18 years or more, approve if the patient has tried adalimumab [Note: the patient does not have to try adalimumab if they have tried Cimzia in the past.] Plaque psoriasis (PP)-Pt tried etanercept, adalimumab, or ustekinumab. Ulcerative colitis (UC)-Tried 2-mo trial of systemic CS, 6-MP, AZA, CSA or tacrolimus or was intolerant to one of these agents OR the patient has pouchitis AND has

<b>PA Criteria</b>	<b>Criteria Details</b>
	tried therapy with an antibiotic, probiotic, corticosteroid enema, or mesalamine enema. Cont tx - approve if patient has had a response, as determined by the prescriber.

# INLYTA

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## Products Affected

- Inlyta oral tablet 1 mg, 5 mg

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus, Differentiated (i.e., papillary, follicular, and Hurthle) Thyroid Carcinoma. Plus, patients already started on Inlyta for a Covered Use.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	Advanced renal cell carcinoma, approve. Differentiated thyroid cancer, approve if patient is refractory to radioactive iodine therapy.

# IRESSA

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## Products Affected

- Iressa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	Metastatic NSCLC - The patient has epidermal growth factor receptor (EGFR) exon 19 deletions OR has exon 21 (L858R) substitution mutations as detected by an FDA-approved test.

# IVIG

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## Products Affected

- Privigen

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	Part B versus D determination per CMS guidance to establish if drug used for PID in pt's home.

# JAKAFI

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## Products Affected

- Jakafi oral tablet 10 mg, 15 mg, 20 mg, 25 mg, 5 mg

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus, patients already started on Jakafi for a Covered Use.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	For polycythemia vera patients must have tried hydroxyurea

# JUXTAPID

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## Products Affected

- Juxtapid

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Combination use with Kynamro, Praluent, or Repatha.
<b>Required Medical Information</b>	LDL-C and response to other agents, prior therapies tried, medication adverse event history, medical history.
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a cardiologist, an endocrinologist, or a physician who focuses in the treatment of CV risk management and/or lipid disorders.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Patient must meet ALL of the following criteria: 1) Patient has had genetic confirmation of two mutant alleles at the LDL receptor, apolipoprotein B APOB, PCSK9, or LDLRAP1 gene locus OR the patient has an untreated LDL-C level greater than 500 mg/dL (prior to treatment with antihyperlipidemic agents) OR the patient has a treated LDL-C level greater than or equal to 300 mg/dL (after treatment with antihyperlipidemic agents but prior to agents such as Repatha or Kynamro) OR the patient has clinical manifestations of HoFH (e.g., cutaneous xanthomas, tendon xanthomas, arcus cornea, tuberous xanthomas or xanthelasma), AND 2) Patient has tried Repatha and had an inadequate response according to the prescribing physician OR the patient is known to have two LDL-receptor negative alleles, AND 3) Patient has tried one high-intensity statin therapy (i.e., atorvastatin greater than or equal to 40 mg daily, rosuvastatin greater than 20 mg daily [as a single-entity or as a combination product]) for greater than or equal to 8 continuous weeks and the LDL-C level remains greater than or equal to 70 mg/dL OR the patient has been determined to be statin intolerant defined by experiencing statin related rhabdomyolysis or patient experienced skeletal-related muscle symptoms while receiving separate trials of atorvastatin and rosuvastatin and during both trials the

<b>PA Criteria</b>	<b>Criteria Details</b>
	skeletal-related symptoms resolved during discontinuation.

# KADCYLA

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## Products Affected

- Kadcyla

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Use as adjuvant therapy.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist.
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	Part B versus Part D determination will be made at time of prior authorization review per CMS guidance.

# KALYDECO

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## Products Affected

- Kalydeco oral granules in packet
- Kalydeco oral tablet

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Combination use with Orkambi
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	two years of age and older
<b>Prescriber Restrictions</b>	prescribed by or in consultation with a pulmonologist or a physician who specializes in CF
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	CF - must have one of the following mutations in the cystic fibrosis transmembrane conductance regulator (CFTR) gene: E56K, P67L, R74W, D110E, D110H, R117C, E193K, L206W, R347H, R352Q, A455E, D579G, S945L, S977F, F1052V, K1060T, A1067T, G1069R, R1070Q, R1070W, F1074L, D1152H, D1270N, G551D, G178R, S549N, S549R, G551S, G1244E, S1251N, S1255P, G1349D, 2789+5G A, 3272-26A G, 3849+10kbC T, 711+3A G, E831X OR R117H AND must NOT be Homozygous for the F508del Mutation in the CFTR Gene or have unknown CFTR gene mutations.

# KEYTRUDA

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## Products Affected

- Keytruda intravenous solution

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus, patients already started on pembrolizumab for a Covered Use, Classical Hodgkin Lymphoma (cHL), and Merkel cell carcinoma (MCC).
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, previous medication therapies (past and/or concomitant), prescriber specialty, disease status, mutation status, transplant history
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist.
<b>Coverage Duration</b>	Initial approval, 6 months. Continuation, approve at 6 month intervals
<b>Other Criteria</b>	Part B versus Part D determination will be made at time of prior authorization review per CMS guidance. Head and Neck Squamous Cell Carcinoma (HNSCC)-approve if the patient meets BOTH of the following conditions: 1) patient has recurrent or metastatic disease, AND 2) patient has disease progression on or after trying platinum containing chemotherapy OR patient has tried chemotherapy for recurrent or metastatic disease OR platinum-containing chemotherapy or other chemotherapy regimen is contraindicated according to the prescribing physician. Melanoma-approve if the patient has unresectable, advanced, or metastatic melanoma AND pembrolizumab will not be used in combination with ipilimumab. Non-Small Cell Lung Cancer (NSCLC)-approve if the patient meets criteria ALL (1, 2 and 3) of the following conditions: 1) patient has metastatic disease, AND 2) if the patient has non-squamous cell carcinoma, testing has been completed for EGFR exon 19 deletion or exon 21 (L858R) substitution, ALK fusions or ROS1 rearrangements and the patient meets the ONE of the following conditions (a or b or c): a) if the patient's tumor has EGFR exon 19 deletion or exon 21 (L858R) substitution, prior targeted therapy with Tarceva (erlotinib), Gilotrif

PA Criteria	Criteria Details
	<p>(afatinib), or Iressa (gefitinib) has been tried, OR b) if the patient's tumor is positive for ALK fusions, prior targeted therapy with Xalkori (crizotinib) or Zykadia (ceritinib) or Alecensa (alectinib) has been tried, OR c) if the patient's tumor is positive for ROS1 rearrangements, prior targeted therapy with Xalkori (crizotinib) has been tried, AND 3) the patient's tumor expresses programmed death-ligand 1 (PD-L1) as determined by a FDA-approved test and ONE of the following applies (a or b): a) The tumor proportion score (TPS) is greater than or equal to 50%, OR b) the tumor proportion score (TPS) is greater than or equal to 1% and the patient has tried systemic chemotherapy and the patient has not previously been treated with Keytruda, Opdivo, or Tecentriq. cHL-approve if Keytruda is being used as single agent therapy and if the patient meets ONE of the follow conditions: 1) patient has relapsed after autologous hematopoietic stem-cell transplantation, OR 2) patient has relapsed after receiving brentuximab vedotin intravenous injection, OR 3) Keytruda will be used as palliative therapy. MCC-approve if the patient has distant metastatic disease or disseminated recurrence of disease.</p>

# KISQALI

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## Products Affected

- Kisqali
- Kisqali Femara Co-Pack

PA Criteria	Criteria Details
Covered Uses	All FDA approved 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	3 years
Other Criteria	Breast cancer - approve advanced or metastatic hormone receptor positive (HR+) [i.e., estrogen receptor positive (ER+) and/or progesterone receptor positive (PR+)]disease, and HER2-negative breast cancer when the pt meets ONE of the following 1. Pt is postmenopausal and Kisqali will be used as first line endocrine therapy in combination with anastrozole, exemestane, or letrozole 2. pt is premenopausal or perimenopausal and is receiving ovarian suppression/ablation with LHRH agonist, surgical bilateral oophorectomy, or ovarian irradiation AND Kisqali will be used as first line endocrine therapy in combination with anastrozole, exemestane, or letrozole 3. pt is a man (a man is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression) who is receiving LHRH agonist AND Kisqali with be used as first line endocrine therapy in combination with anastrozole, exemestane or letrozole.

# LENVIMA

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## Products Affected

- Lenvima oral capsule 10 mg/day (10 mg x 1), 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
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus patients with Medullary Thyroid Carcinoma (MTC).
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	DTC - must be refractory to radioactive iodine treatment for approval. RCC - approve if the pt meets ONE of the following criteria: 1) pt has RCC with predominant clear-cell histology AND the pt has tried one antiangiogenic therapy (eg, Inlyta, Votrient, Sutent, Nexavar) AND Lenvima will be used in combination with everolimus (Afinitor), OR 2) pt has RCC with non-clear cell histology AND Lenvima will be used in combination with everolimus (Afinitor). MTC-approve if the patient has tried Caprelsa or Cometriq.

# LETAIRIS/TRACLEER

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## Products Affected

- Letairis
- Tracleer oral tablet

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Chronic thromboembolic pulmonary hypertension (CTEPH) (Tracleer).
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Pulmonary arterial hypertension (PAH) WHO Group 1 patients not currently on Letairis or Tracleer or another agent indicated for WHO Group 1 PAH are required to have had a right-heart catheterization to confirm the diagnosis of PAH to ensure appropriate medical assessment. PAH WHO Group 1 patients currently on Letairis or Tracleer or another agent indicated for WHO Group 1 PAH may continue therapy without confirmation of a right-heart catheterization.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	For treatment of pulmonary arterial hypertension, Letairis or Tracleer must be prescribed by or in consultation with a cardiologist or a pulmonologist. CTEPH - prescribed by or in consultation with a cardiologist or pulmonologist
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	CTEPH - pt must have tried Adempas, has a contraindication to Adempas, or is currently receiving Tracleer for CTEPH.

# LEUPROLIDE (LONG ACTING)

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## Products Affected

- Lupron Depot
- Lupron Depot (3 month)
- Lupron Depot (4 month)
- Lupron Depot (6 Month)
- Lupron Depot-Ped (3 month) intramuscular syringe kit 30 mg
- Lupron Depot-Ped intramuscular kit 11.25 mg, 15 mg

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D but specific to the following drugs as follows: Prostate cancer (Lupron Depot), Endometriosis (Lupron Depot), Uterine leiomyomata (Lupron Depot), Treatment of central precocious puberty (Lupron Depot Ped). Ovarian cancer (Lupron Depot, Lupron Depot Ped). Breast cancer (Lupron Depot, Lupron Depot Ped). Prophylaxis or treatment of uterine bleeding in premenopausal patient with hematologic malignancy or prior to bone marrow/stem cell transplantation (BMT/SCT) (Lupron Depot, Lupron Depot Ped). Uterine bleeding (Lupron Depot, Lupron Depot Ped).
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	For abnormal uterine bleeding/endomet/uterine leiomyomata approve up to 6 months/all other dx 12 mo
<b>Other Criteria</b>	N/A

# LIDODERM

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## Products Affected

- lidocaine topical adhesive patch,medicated

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus diabetic neuropathic pain.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months
<b>Other Criteria</b>	N/A

# LONG ACTING OPIOIDS

## Products Affected

- Butrans
- hydromorphone oral tablet extended release 24 hr
- methadone oral solution 10 mg/5 mL, 5 mg/5 mL
- methadone oral tablet 10 mg, 5 mg
- morphine oral capsule, ER multiphase 24 hr
- morphine oral capsule, extend. release pellets
- morphine oral tablet extended release 100 mg, 15 mg, 200 mg, 30 mg, 60 mg
- OxyContin oral tablet, oral only, ext. rel. 12 hr 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 60 mg, 80 mg
- oxymorphone oral tablet extended release 12 hr
- tramadol oral tablet extended release 24 hr 100 mg, 200 mg
- tramadol oral tablet, ER multiphase 24 hr

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D worded as pain severe enough to require daily, around-the-clock, long-term opioid treatment. Plus patients with a cancer diagnosis, patients in a hospice program/end-of-life care/palliative care
<b>Exclusion Criteria</b>	Acute (ie, non-chronic) pain
<b>Required Medical Information</b>	Pain type (chronic vs acute), prior pain medications/therapies tried, concurrent pain medications/therapies
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	For pain severe enough to require daily, around-the-clock, long-term opioid treatment (with no cancer diagnosis and not in hospice), approve if all of the following criteria are met: 1) patient is not opioid naive, AND 2) non-opioid therapies have been optimized and are being used in conjunction with opioid therapy according to the prescribing physician, AND 3) the prescribing physician has checked the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP), unless unavailable in the state, AND 4) the prescribing physician

<b>PA Criteria</b>	<b>Criteria Details</b>
	has discussed risks (eg, addiction, overdose) and realistic benefits of opioid therapy with the patient, AND 5) according to the prescriber physician there is a treatment plan (including goals for pain and function) in place and reassessments are scheduled at regular intervals. Clinical criteria incorporated into the quantity limit edits for all oral long-acting opioids require confirmation that the indication is intractable pain (ie, FDA labeled use) prior to reviewing for quantity exception.

# LONSURF

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## Products Affected

- Lonsurf

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	Metastatic CRC - As per labeling, the patient has been previously treated with a fluoropyrimidine (e.g., capecitabine, 5-FU) AND oxaliplatin AND irinotecan AND if the tumor or metastases are wild-type KRAS and/or NRAS (that is, the tumors or metastases are KRAS and/or NRAS mutation negative) Erbitux or Vectibix has been tried.

# LYNPARZA

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## Products Affected

- Lynparza

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus patients already started on Lynparza.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	Ovarian cancer approve if the patient has a germline BRCA mutation AND as per product labeling, has progressed on three or more prior lines of chemotherapy.

# LYRICA/NEURONTIN

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## Products Affected

- Lyrica oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg
- Lyrica oral solution

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D. Plus, patients already started on Lyrica for a Covered Use.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	N/A

# MEGACE

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## Products Affected

- megestrol oral suspension 400 mg/10 mL (40 mg/mL), 625 mg/5 mL
- megestrol oral tablet

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Coverage is not provided for weight gain for cosmetic reasons.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A

# MEKINIST

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## Products Affected

- Mekinist oral tablet 0.5 mg, 2 mg

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus patients with Non-Small Cell Lung Cancer (NSCLC) and patients already started on Mekinist for a Covered Use.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis for which Mekinist is being used. For unresectable or metastatic melanoma and NSCLC must have documentation of BRAF V600 mutations
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	For unresectable or metastatic melanoma must be used in patients with BRAF V600 mutation. For NSCLC requires BRAF V600E Mutation and use in combination with Tafinlar.

# MEMANTINE

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## Products Affected

- memantine oral capsule, sprinkle, ER 24hr
- memantine oral solution
- memantine oral tablet
- Namenda XR
- Namzaric

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D. Plus patients with mild to moderate vascular dementia.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Indication for which memantine is being prescribed.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	N/A

# MYALEPT

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## Products Affected

- Myalept

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, an endocrinologist or a geneticist physician specialist
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	N/A

# NATPARA

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## Products Affected

- Natpara

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an endocrinologist.
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	Chronic hypoparathyroidism, initial therapy - approve if before starting Natpara, serum calcium concentration is greater than 7.5 mg/dL and 25-hydroxyvitamin D stores are sufficient per the prescribing physician. Chronic hypoparathyroidism, continuing therapy - approve if during Natpara therapy, the patient's 25-hydroxyvitamin D stores are sufficient per the prescribing physician, AND the patient is responding to Natpara therapy, as determined by the prescriber.

# NEULASTA

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## Products Affected

- Neulasta subcutaneous syringe

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus patients undergoing PBPC collection and therapy
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Cancer patients receiving chemotherapy, if prescribed by or in consultation with an oncologist or hematologist. PBPC - prescribed by or in consultation with an oncologist, hematologist, or physician that specializes in transplantation. Radiation syndrome-prescribed by or in consultation with physician with expertise in treating acute radiation syndrome.
<b>Coverage Duration</b>	Cancer pts receiving chemo-6 mo. PBPC/Radiation Syndrome-1 mo
<b>Other Criteria</b>	Cancer patients receiving chemotherapy, approve if the patient is receiving myelosuppressive anti-cancer medications that are associated with a high risk of febrile neutropenia (the risk is at least 20% based on the chemotherapy regimen), OR the patient is receiving myelosuppressive anti-cancer medications that are associated with a risk of febrile neutropenia but the risk is less than 20% based on the chemotherapy regimen and the patient has one or more risk factors for febrile neutropenia (eg, aged greater than or equal to 65 years, prior chemotherapy or radiation therapy, persistent neutropenia, bone marrow involvement by tumor, recent surgery and/or open wounds, liver and/or renal dysfunction, poor performance status or HIV infection, OR the patient has had a neutropenic complication from prior chemotherapy and did not receive prophylaxis with a colony stimulating factor and a reduced dose or frequency of chemotherapy may compromise treatment.

# NEUPOGEN

## Products Affected

- Neupogen

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D worded more broadly as cancer patients receiving myelosuppressive chemotherapy, patients with acute myeloid leukemia (AML) receiving chemotherapy, cancer patients receiving bone marrow transplantation (BMT), patients undergoing peripheral blood progenitor cell (PBPC) collection and therapy, and patients with severe chronic neutropenia [SCN] (e.g., congenital neutropenia, cyclic neutropenia, idiopathic neutropenia). Neutropenia associated with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS). Treatment of myelodysplastic syndromes (MDS). Drug induced agranulocytosis or neutropenia. Aplastic anemia (AA). Acute lymphocytic leukemia (ALL).
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	AML, HIV/AIDS, MDS - adults
<b>Prescriber Restrictions</b>	Cancer/AML, MDS, ALL, oncologist or a hematologist. Cancer patients receiving BMT and PBPC, prescribed by or in consultation with an oncologist, hematologist, or a physician who specializes in transplantation. SCN, AA - hematologist. HIV/AIDS neutropenia, infectious disease (ID) physician (MD), hematologist, or MD specializing in HIV/AIDS.
<b>Coverage Duration</b>	chemo/SCN/AML-6 mo.HIV/AIDS-4 months.MDS-3 mo.PBPC,Drug induce A/N,AA,ALL,BMT-1 mo.All others=12mo.
<b>Other Criteria</b>	Cancer patients receiving chemotherapy, approve if the patient meets one of the following conditions: patient is receiving myelosuppressive anti-cancer medications that are associated with a high risk of febrile neutropenia (the risk is at least 20% based on the chemotherapy regimen), patient is receiving myelosuppressive anti-cancer medications that are associated with a risk of febrile neutropenia but the risk is less than 20% based on the chemotherapy regimen and the patient has one or more risk

<b>PA Criteria</b>	<b>Criteria Details</b>
	<p>factors for febrile neutropenia (eg, aged greater than or equal to 65 years, prior chemotherapy or radiation therapy, persistent neutropenia, bone marrow involvement by tumor, recent surgery and/or open wounds, liver or renal dysfunction, poor performance status, HIV infection), patient has had a neutropenic complication from prior chemotherapy and did not receive prophylaxis with a colony stimulating factor (eg, Leukine, Neulasta, Neupogen Granix, or Zarxio) and a reduced dose or frequency of chemotherapy may compromise treatment, patient has received chemotherapy has febrile neutropenia and has at least one risk factor (eg, sepsis syndrome, aged greater than 65 years, severe neutropenia [absolute neutrophil account less than 100 cells/mm<sup>3</sup>], neutropenia expected to be greater than 10 days in duration, invasive fungal infection).</p>

# NEXAVAR

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## Products Affected

- Nexavar

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus , patients already started on Nexavar for a covered use, osteosarcoma, angiosarcoma, advanced or unresectable desmoids tumors, gastrointestinal stromal tumors (GIST), medullary thyroid carcinoma, Acute Myeloid Leukemia, Chordoma with recurrent disease, solitary fibrous tumor and hemangiopericytoma
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	Osteosarcoma, approve if the patient has tried standard chemotherapy and have relapsed/refractory or metastatic disease. GIST, approve if the patient has tried TWO of the following: imatinib mesylate (Gleevec), sunitinib (Sutent), or regorafenib (Stivarga). Differentiated (ie, papillary, follicular, Hurthle) thyroid carcinoma (DTC), approve if the patient is refractory to radioactive iodine treatment. Medullary thyroid carcinoma, approve if the patient has tried vandetanib (Caprelsa) or cabozantinib (Cometriq). AML - Approve

# NINLARO

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## Products Affected

- Ninlaro oral capsule 2.3 mg, 3 mg, 4 mg

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus , patients already started on Ninlaro.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	MM - be used in combination with Revlimid and dexamethasone AND pt had received at least ONE previous therapy for multiple myeloma (e.g., Velcade, Kyprolis, Thalomid, Revlimid, Pomalyst, Alkeran, dexamethasone, prednisone).

# NORTHERA

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## Products Affected

- Northera

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Medication history
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a cardiologist or a neurologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	NOH, approve if the patient meets ALL of the following criteria: a) Patient has been diagnosed with symptomatic NOH due to primary autonomic failure (Parkinsons disease, multiple system atrophy, pure autonomic failure), dopamine beta-hydroxylase deficiency, or non-diabetic autonomic neuropathy, AND b) Patient has tried midodrine

# NUCALA

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## Products Affected

- Nucala

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Concurrent use with Xolair
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	12 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an allergist, immunologist, or pulmonologist
<b>Coverage Duration</b>	Authorization will be for 6 months initial, 12 months continuation.
<b>Other Criteria</b>	Initial - must have peripheral blood eosinophil count of greater than or equal to 150 cells per microliter within the previous 6 weeks (prior to treatment with an IL-5 antagonist monoclonal antibody) AND Patient has received at least 3 consecutive months of combination therapy with an inhaled corticosteroid AND one of the following A. inhaled LABA, B. inhaled long-acting muscarinic antagonist, C. Leukotriene receptor antagonist, or D. Theophylline. Patient's asthma continues to be uncontrolled as defined by ONE of the following - patient experienced two or more asthma exacerbations requiring treatment with systemic corticosteroids in the previous year, patient experienced one or more asthma exacerbation requiring hospitalization or an Emergency Department (ED) visit in the previous year, patient has a FEV1 less than 80 percent predicted, Patient has an FEV1/FVC less than 0.80, or Patient's asthma worsens upon tapering of oral corticosteroid therapy. Continuation - The patient has responded to Nucala therapy as determined by the prescribing physician (e.g., decreased asthma exacerbations, decreased asthma symptoms, decreased hospitalizations, emergency department (ED)/urgent care, or physician visits due to asthma, decreased requirement for oral corticosteroid therapy) AND Patient continues to receive therapy with an inhaled corticosteroid.

# NUVIGIL/PROVIGIL

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## Products Affected

- armodafinil
- modafinil

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.Excessive daytime sleepiness (EDS) due to myotonic dystrophy - modafinil only. Adjunctive/augmentation for treatment of depression in adults - modafinil only.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	Patients must be greater than or equal to 17 years of age.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	Excessive sleepiness due to SWSD if the patient is working at least 5 overnight shifts per month. Adjunctive/augmentation treatment for depression in adults if the patient is concurrently receiving other medication therapy for depression.

# OCALIVA

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## Products Affected

- Ocaliva

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus patients already started on Ocaliva for a covered use.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Prescriber specialty, lab values, prior medications used for diagnosis and length of trials
<b>Age Restrictions</b>	18 years and older (initial and continuation therapy)
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a gastroenterologist, hepatologist, or liver transplant physician (initial and continuation therapy)
<b>Coverage Duration</b>	6 months initial, 3 years cont.
<b>Other Criteria</b>	Initial treatment of PBC-Patient must meet both 1 and 2-1. Patient has a diagnosis of PBC as defined by TWO of the following:a)Alkaline phosphatase (ALP) elevated above the upper limit of normal as defined by normal laboratory reference values b)Positive anti-mitochondrial antibodies (AMAs) c)Histologic evidence of primary biliary cholangitis (PBC) from a liver biopsy 2. Patient meets ONE of the following: a) Patient has been receiving ursodiol therapy for greater than or equal to 1 year and has had an inadequate response. b) Patient is unable to tolerate ursodiol therapy. Cont tx - approve if the patient has responded to Ocaliva therapy as determined by the prescribing physician (e.g., improved biochemical markers of PBC (e.g., alkaline phosphatase [ALP], bilirubin, gamma-glutamyl transpeptidase [GGT], aspartate aminotransferase [AST], alanine aminotransferase [ALT] levels)).

# ODOMZO

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## Products Affected

- Odomzo

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus metastatic BCC.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	BCC - Must not have had disease progression while on Erivedge (vismodegib).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	Locally advanced BCC approve if the BCC has recurred following surgery/radiation therapy or if the patient is not a candidate for surgery AND the patient is not a candidate for radiation therapy, according to the prescribing physician. Metastatic BCC - approve.

# OFEV

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## Products Affected

- Ofev

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Combination use with pirfenidone
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	18 years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	IPF baseline - must have FVC greater than or equal to 50 percent of the predicted value AND IPF must be diagnosed with either findings on high-resolution computed tomography (HRCT) indicating usual interstitial pneumonia (UIP) or surgical lung biopsy demonstrating UIP.

# OPDIVO

## Products Affected

- Opdivo intravenous solution 100 mg/10 mL, 40 mg/4 mL

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus, patients already started on nivolumab for a Covered Use, Small Cell Lung Cancer (SCLC)[non-FDA labeled indication]
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, previous medication therapies (past and/or concomitant), prescriber specialty, disease status, mutation status, transplant history
<b>Age Restrictions</b>	cHL, 18 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist.
<b>Coverage Duration</b>	Initial approval, 6 months. Continuation, approve at 6 month intervals
<b>Other Criteria</b>	Part B versus Part D determination will be made at time of prior authorization review per CMS guidance. Head and Neck Squamous Cell Carcinoma (HNSCC)-approve if the patient meets BOTH of the following conditions: 1) patient has recurrent or metastatic disease, AND 2) patient has disease progression on or after trying platinum containing chemotherapy OR patient has tried chemotherapy for recurrent or metastatic disease OR platinum-containing chemotherapy or other chemotherapy regimen is contraindicated according to the prescribing physician. Classical Hodgkin Lymphoma (cHL)-approve if Opdivo is being used as single agent therapy and if the patient meets ONE of the follow conditions: 1) patient has relapsed after autologous hematopoietic stem-cell transplantation, OR 2) patient has relapsed after receiving brentuximab vedotin intravenous injection, OR 3) Opdivo will be used as palliative therapy. Melanoma-approve if the patient has unresectable, advanced, or metastatic melanoma. Non-Small Cell Lung Cancer (NSCLC)-approve if the patient meets criteria ALL (1, 2, 3 and 4) of the following conditions: 1) patient has metastatic disease, AND 2) patient has tried systemic

PA Criteria	Criteria Details
	<p>chemotherapy, AND 3) patient has not previously been treated with Keytruda, Opdivo, or Tecentriq, AND 4) if the patient has non-squamous cell carcinoma, testing has been completed for EGFR exon 19 deletion or exon 21 (L858R) substitution, ALK fusions or ROS1 rearrangements and the patient meets the ONE of the following conditions (a or b or c): a) if the patient's tumor has EGFR exon 19 deletion or exon 21 (L858R) substitution, prior targeted therapy with Tarceva (erlotinib), Gilotrif (afatinib), or Iressa (gefitinib) has been tried, OR b) if the patient's tumor is positive for ALK fusions, prior targeted therapy with Xalkori (crizotinib) or Zykadia (ceritinib) or Alecensa (alectinib) has been tried, OR c) if the patient's tumor is positive for ROS1 rearrangements, prior targeted therapy with Xalkori (crizotinib) has been tried. Renal Cell Carcinoma (RCC)-approve if the patient meets BOTH of the following conditions: 1) patient has advanced (ie, relapsed or Stage IV and surgically unresectable) disease, AND 2) patient has RCC with predominant clear-cell histology and has tried one of Sutent (sunitinib), Inlyta (axitinib), Votrient (pazopanib), or Nexavar (sorafenib) OR the patient has RCC with non-clear cell histology. Urothelial Carcinoma-approve if the patient has recurrent, locally advanced, or metastatic urothelial carcinoma and meets ONE of the following conditions: 1) patient has disease progression after trying platinum containing chemotherapy, OR 2) patient has tried chemotherapy, OR 3) a platinum containing chemotherapy regimen or other chemotherapy is contraindicated according to the prescribing physician. SCLC-approve if the patient has relapsed or progressed after receiving a platinum containing chemotherapy.</p>

# OPSUMIT

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## Products Affected

- Opsumit

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	PAH WHO group, right heart catheterization results, WHO functional status, previous drugs tried
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	PAH - must be prescribed by or in consultation with a cardiologist or a pulmonologist.
<b>Coverage Duration</b>	Authorization will be for 3 years
<b>Other Criteria</b>	Pulmonary arterial hypertension (PAH) WHO Group 1 patients not currently on Opsumit or another agent indicated for WHO Group 1 PAH are required to have had a right-heart catheterization to confirm the diagnosis of PAH to ensure appropriate medical assessment. PAH WHO Group 1 patients currently on Opsumit or another agent indicated for WHO Group 1 PAH may continue therapy without confirmation of a right-heart catheterization.

# ORENCIA

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## Products Affected

- Orenzia
- Orenzia (with maltose)
- Orenzia ClickJect

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus patients who have already been started on abatacept (IV or SC) for a covered use.
<b>Exclusion Criteria</b>	Concurrent use with a Biologic DMARD or Targeted Synthetic DMARD.
<b>Required Medical Information</b>	Diagnosis, concurrent medications, previous drugs tried.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	RA and JIA/JRA prescribed by or in consultation with a rheumatologist.
<b>Coverage Duration</b>	3 mos initial, 3 years cont
<b>Other Criteria</b>	RA initial, patient has tried one conventional synthetic DMARD for at least 3 months (note: patients who have already had a 3-month trial of a biologic for RA are not required to 'step back' and try a conventional synthetic DMARD). Juvenile idiopathic arthritis (JIA) [or Juvenile Rheumatoid Arthritis (JRA)], approve. Cont tx - responded to therapy as per the prescriber.

# ORKAMBI

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## Products Affected

- Orkambi oral tablet

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Combination use with Kalydeco
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	6 years of age and older
<b>Prescriber Restrictions</b>	prescribed by or in consultation with a pulmonologist or a physician who specializes in CF
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	CF - homozygous for the Phe508del (F508del) mutation in the CFTR gene (meaning the patient has two copies of the Phe508del mutation)

# OTEZLA

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## Products Affected

- Otezla
- Otezla Starter oral tablets, dose pack 10 mg (4)-20 mg (4)-30 mg (47)

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus patients currently taking Otezla for a Covered Use.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, previous drugs tried
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	PsA - Prescribed by or in consultation with a dermatologist or rheumatologist. PP - prescribed by or in consultation with a dermatologist.
<b>Coverage Duration</b>	4 months initial, 3 years cont
<b>Other Criteria</b>	PP initial-approve if the patient meets one of the following criteria: 1) pt has tried at least one traditional systemic agent (eg, MTX, cyclosporine, acitretin, PUVA) for at least 3 months, unless intolerant (note: pts who have already tried a biologic for psoriasis are not required to step back and try a traditional agent first) OR 2) pt has a contraindication to MTX as determined by the prescribing physician. PsA initial-approve if the patient has tried at least one conventional synthetic DMARD (eg, MTX, leflunomide, sulfasalazine) for at least 3 months, unless intolerant (note: pts who have already tried a biologic DMARD are not required to step back and try a conventional DMARD first). PsA/PP cont - pt has received 4 months of therapy and had a response, as determined by the prescribing physician.

# PALYNZIQ

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## Products Affected

- Palynziq

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, phenylalanine concentrations
<b>Age Restrictions</b>	18 years and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a specialist who focuses in the treatment of metabolic diseases
<b>Coverage Duration</b>	1 year (initial and continuation)
<b>Other Criteria</b>	Initial therapy - approve if the patient has uncontrolled blood phenylalanine concentrations greater than 600 micromol/L on at least one existing treatment modality (e.g., restriction of dietary phenylalanine and protein intake, prior treatment with Kuvan). Maintenance therapy - approve if the patient's blood phenylalanine concentration is less than or equal to 600 micromol/L OR the patient has achieved at least a 20% reduction in blood phenylalanine concentration from pre-treatment baseline.

# PHOSPHODIESTERASE-5 INHIBITORS FOR PAH

## Products Affected

- Adcirca
- sildenafil (Pulmonary Arterial Hypertension) intravenous solution 10 mg/12.5 mL
- sildenafil (Pulmonary Arterial Hypertension) oral tablet 20 mg

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Pulmonary arterial hypertension (PAH) WHO Group 1, patients not currently taking an agent indication for WHO Group 1 PAH are required to have had a right-heart catheterization to confirm diagnosis of PAH to ensure appropriate medical assessment. PAH WHO Group 1 patients currently receiving an agent indicated for WHO Group 1 PAH may continue therapy without confirmation of a right-heart catheterization.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	For PAH, if prescribed by, or in consultation with, a cardiologist or a pulmonologist.
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	For approval of sildenafil injection, patient must be unable to take an oral PDE-5 inhibitor. Clinical criteria incorporated into the quantity limit edits for sildenafil 20 mg tablets and suspension (Revatio, generics) require confirmation that the indication is PAH (ie, FDA labeled use) prior to reviewing for quantity exception.

# PLEGRIDY

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## Products Affected

- Plegridy subcutaneous pen injector 125 mcg/0.5 mL, 63 mcg/0.5 mL- 94 mcg/0.5 mL
- Plegridy subcutaneous syringe 125 mcg/0.5 mL, 63 mcg/0.5 mL- 94 mcg/0.5 mL

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Concurrent use of with other disease-modifying agents used for multiple sclerosis (MS).
<b>Required Medical Information</b>	For use in MS, patient has a relapsing form of MS.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, a neurologist or an MS specialist.
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	N/A

# PRALUENT

## Products Affected

- Praluent Pen subcutaneous pen injector  
150 mg/mL, 75 mg/mL

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Concurrent use of Juxtapid or Kynamro.
<b>Required Medical Information</b>	LDL-C and response to other agents, prior therapies tried, medication adverse event history, medical history
<b>Age Restrictions</b>	18 years of age and older.
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, a cardiologist, endocrinologist, or a physician who focuses in the treatment of CV risk management and/or lipid disorders
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	Hyperlipidemia in patients with HeFH without ASCVD -approve if meets all of the following 1. Pt has been diagnosed with HeFH AND 2. tried ONE high intensity statin (i.e. atorvastatin greater than or equal to 40 mg daily or Crestor greater than or equal to 20 mg daily) AND 3. LDL-C remains greater than or equal to 70 mg/dL unless is determined to be statin intolerant defined by experiencing statin related rhabdomyolysis or experienced skeletal-related muscle symptoms while receiving separate trials of atorvastatin and Crestor and during both trials the skeletal-related symptoms resolved during d/c. Hyperlipidemia Pt with Clinical ASCVD with or without HeFH -approve if meets all of the following has an LDL-C greater than or equal to 70 mg/dL (after treatment with antihyperlipidemic agents but prior to PCSK9 therapy), AND has one of the following conditions prior MI, h/o ACS, diagnosis of angina, h/o CVA or TIA, PAD, undergone a coronary or other arterial revascularization procedure, AND tried ONE high intensity statin (as defined above) AND LDL-C remains greater than or equal to 70 mg/dL unless the pt is determined to be statin intolerant defined by experiencing statin related rhabdomyolysis or pt experienced skeletal-related muscle symptoms while

<b>PA Criteria</b>	<b>Criteria Details</b>
	receiving separate trials of atorvastatin and Crestor and during both trials the skeletal-related symptoms resolved during d/c.

# PROLIA

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## Products Affected

- Prolia

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Concomitant use with other medications for osteoporosis (eg, denosumab [Prolia], bisphosphonates, raloxifene, calcitonin nasal spray [Miacalcin, Fortical]), except calcium and Vitamin D.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	Treatment of postmenopausal osteoporosis/Treatment of osteoporosis in men (to increase bone mass) [a man is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression], approve if the patient meets one of the following: 1. has had inadequate response after 12 months of therapy with an oral bisphosphonate, had osteoporotic fracture while receiving an oral bisphosphonate, or intolerability to an oral bisphosphonate, OR 2. the patient cannot take an oral bisphosphonate because they cannot swallow or have difficulty swallowing, they cannot remain in an upright position, or they have a pre-existing GI medical condition, OR 3. pt has tried an IV bisphosphonate (ibandronate or zoledronic acid), OR 4. the patient has severe renal impairment (eg, creatinine clearance less than 35 mL/min) or chronic kidney disease, or if the patient has multiple osteoporotic fractures. Treatment of bone loss in patient at high risk for fracture receiving ADT for nonmetastatic prostate cancer, approve if the patient has prostate cancer that is not metastatic to the bone and the patient is receiving ADT (eg, leuprolide, triptorelin, goserelin) or the patient has undergone a bilateral orchiectomy. Treatment of bone loss (to increase bone mass) in patients at high risk for fracture receiving adjuvant AI therapy for breast cancer,

<b>PA Criteria</b>	<b>Criteria Details</b>
	<p>approve if the patient has breast cancer that is not metastatic to the bone and in receiving concurrent AI therapy (eg, anastrozole, letrozole, exemestane). Treatment of GIO, approve if pt tried one oral bisphosphonate OR pt cannot take an oral bisphosphonate because the patient cannot swallow or has difficulty swallowing or the patient cannot remain in an upright position post oral bisphosphonate administration or has a pre-existing GI medical condition (eg, patient with esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]), OR pt has tried zoledronic acid (Reclast), OR pt has severe renal impairment (CrCL less than 35 mL/min) or has CKD or has had an osteoporotic fracture or fragility fracture.</p>

# PROMACTA

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## Products Affected

- Promacta

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Thrombocytopenia due to hepatitis C virus (HCV)-related cirrhosis.
<b>Exclusion Criteria</b>	Use in the management of thrombocytopenia in myelodysplastic syndrome (MDS).
<b>Required Medical Information</b>	Cause of thrombocytopenia. Thrombocytopenia due to HCV-related cirrhosis, platelet counts. Severe aplastic anemia, platelet counts and prior therapy.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Thrombocytopenia due to chronic ITP or Aplastic Anemia, approve if prescribed by, or after consultation with, a hematologist. Thrombocytopenia due to HCV-related cirrhosis, approve if prescribed by, or after consultation with, a gastroenterologist, hematologist, hepatologist, or a physician who specializes in infectious disease.
<b>Coverage Duration</b>	Chronic ITP - 3 years, others 12 months.
<b>Other Criteria</b>	Thrombocytopenia in patients with chronic immune (idiopathic) thrombocytopenia purpura, approve if the patient has tried ONE other therapy or has undergone a splenectomy. Treatment of thrombocytopenia due to HCV-related cirrhosis, approve to allow for initiation of antiviral therapy if the patient has low platelet counts (eg, less than 75,000 mm <sup>3</sup> ) and the patient has chronic HCV infection and is a candidate for hepatitis C therapy. Aplastic anemia - has low platelet counts at baseline/pretreatment (e.g., less than 30,000 mm <sup>3</sup> ) AND tried one immunosuppressant therapy (e.g., cyclosporine, mycophenolate mofetil, sirolimus, Atgam)

# REBIF

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## Products Affected

- Rebif (with albumin)
- Rebif Titration Pack
- Rebif Rebidose subcutaneous pen injector  
22 mcg/0.5 mL, 44 mcg/0.5 mL,  
8.8mcg/0.2mL-22 mcg/0.5mL (6)

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus patients who experienced an attack and are at risk for multiple sclerosis.
<b>Exclusion Criteria</b>	Concurrent use with other disease-modifying agent used for multiple sclerosis
<b>Required Medical Information</b>	Diagnosis of MS includes the following patient types: patients with actual diagnosis of MS, patients who have experienced an MS attack, and patients who are at risk for developing MS.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or after consultation with a neurologist or an MS specialist.
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	N/A

# RECLAST

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## Products Affected

- zoledronic acid-mannitol-water

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Concurrent Use with Other Medications for Osteoporosis (e.g., other bisphosphonates, Prolia, Forteo, Evista, calcitonin nasal spray), except calcium and Vitamin D.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Paget's 1 month. Others 12 months.
<b>Other Criteria</b>	Tx of osteoporosis in post menopausal patient or osteoporosis in men (a man is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression), must meet ONE of the following: pt had an inadequate response after 12 months (eg, ongoing and significant loss of BMD, lack of BMD increase) or pt had an osteoporotic fracture while receiving therapy or pt experienced intolerability (eg, severe GI-related adverse effects, severe musculoskeletal-related side effects, a femoral fracture), OR pt cannot take oral bisphosphonate because pt cannot swallow or has difficulty swallowing or pt cannot remain in upright position post oral bisphos admin or pt has pre-existing GI medical condition (eg, pt with esophageal lesions/ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]), OR pt has tried IV Reclast. Tx of PMO may have also tried IV Boniva for approval. Prevention or treatment of glucocorticoid induced osteoporosis (GIO), approve if: pt is initiating or continuing therapy with systemic glucocorticoids, AND has had an inadequate response after 12 months (eg, ongoing and significant loss of BMD, lack of BMD increase) or pt had an osteoporotic fracture while on therapy or pt experienced intolerability (eg, severe GI-related adverse

PA Criteria	Criteria Details
	<p>effects, severe musculoskeletal-related side effects, a femoral fracture), OR pt cannot take oral bisphosphonate because pt cannot swallow or has difficulty swallowing or pt cannot remain in an upright position post oral bisphosphonate administration or pt has a pre-existing GI medical condition (eg, patient with esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]), or has tried Reclast. Tx of Paget's disease, approve if pt has elevations in serum alkaline phosphatase of two times higher than the upper limit of the age-specific normal reference range, OR pt is symptomatic (eg, bone pain, hearing loss, osteoarthritis), OR pt is at risk for complications from their disease (eg, immobilization, bone deformity, fractures, nerve compression syndrome). Preventions of PMO - meets one of the following had an inadequate response after a trial duration of 12 months (eg, ongoing and significant loss of BMD, lack of BMD increase) or patient had an osteoporotic fracture while receiving therapy or patient experienced intolerability (eg, severe GI-related adverse effects, severe musculoskeletal-related side effects, a femoral fracture), OR pt cannot take an oral bisphosphonate because the pt cannot swallow or has difficulty swallowing or the pt cannot remain in an upright position post oral bisphosphonate administration or pt has a pre-existing GI medical condition (eg, patient with esophageal lesions/ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]), OR pt has tried Reclast.</p>

# REMICADE

## Products Affected

- Remicade

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D plus patients already started on infliximab (Remicade or Inflectra) for non-Crohn's disease covered uses. Behcet's disease (BD). Still's disease (SD). Uveitis (UV). Pyoderma gangrenosum (PG). Hidradenitis suppurativa (HS). Graft-versus-host disease (GVHD). Juvenile Idiopathic Arthritis (JIA). Sarcoidosis
<b>Exclusion Criteria</b>	Concurrent use with Biologic DMARD or Targeted Synthetic DMARD
<b>Required Medical Information</b>	Diagnosis, concurrent medication, previous medications tried
<b>Age Restrictions</b>	CD and UC, Pts aged 6 years or more.
<b>Prescriber Restrictions</b>	Prescribed by or in consult w/:RA/AS/Still's/JIA-rheumatol.Plaque Psor/Pyoderma gangrenosum/HS-dermatol.Psoriatic Arthritis-rheumatol or dermatol.CD/UC-gastroenterol.Uveitis-ophthalmol.GVHD-transplant center, oncol, or hematol.Behcet's- rheumatol, dermatol,ophthalmol, gastroenterol, or neurol.Sarcoidosis-pulmonol, ophthalmol, or dermatol.
<b>Coverage Duration</b>	FDA ind/JIA initial - 3 mos, cont 3 years, others 12 mo
<b>Other Criteria</b>	Approve for RA if pt has tried Enbrel or Humira. [Note: the patient does not have to have a trial with one of the drugs listed if they have had a trial with Cimzia or Simponi SC in the past.] Approve for Ankylosing Spondylitis and PsA if the patient has tried Enbrel or Humira. [Note: the patient does not have to have a trial with etanercept or adalimumab if they have had a trial with Cimzia or Simponi SC in the past.] CD in patients aged greater than 6 years but less than 18 years, approve if the pt has tried corticosteroid (CS) or if CSs contraindicated or if currently on CS or if the patient has tried one other agent for CD (eg, azathioprine, 6-MP, MTX, certolizumab, adalimumab, Entyvio) OR the patient has enterocutaneous (perianal or abdominal) or rectovaginal fistulas OR the patient has had ileocolonic resection. CD in patients 18 years or more, approve if the

PA Criteria	Criteria Details
	<p>patient has tried adalimumab. [Note: the patient does not have to try adalimumab if they have tried Cimzia in the past.] Plaque psoriasis (PP).Pt tried etanercept, adalimumab, or ustekinumab.Ulcerative colitis (UC).Tried 2-mo trial of systemic CS, 6-MP, AZA, CSA or tacrolimus or was intolerant to one of these agents OR the patient has pouchitis AND has tried therapy with an antibiotic, probiotic, corticosteroid enema, or mesalamine enema. Behcet's.Pt has tried at least one conventional tx (eg, systemic CSs, immunosuppressants [e.g., AZA, MTX, MM, CSA, tacrolimus, chlorambucil, cyclophosphamide] or interferon alfa), Enbrel or Humira OR has ophthalmic manifestations. SD.Tried CS AND 1 conventional synthetic DMARD (eg, MTX) for 2 mos, or was intolerant.UV.Tried periocular/intraocular CS, systemic CS, immunosuppressant (eg, MTX, MM, CSA, AZA, CPM), etanercept, adalimumab.Sarcoidosis.Tried CS and immunosuppressant (eg, MTX, AZA, CSA, chlorambucil), or chloroquine, or thalidomide.Pyoderma gangrenosum (PG).Tried one systemic CS or immunosuppressant (eg, mycophenolate, CSA) for 2 mos. Hidradenitis suppurativa (HS).Tried 1 tx (eg, intralesional/oral CS, systemic antibiotic, isotretinoin).GVHD.Tried 1 tx (eg, high-dose CS, antithymocyte globulin, CSA, thalidomide, tacrolimus, MM, etc.) or receiving IFX concurrently. JIA (regardless of type of onset) approve if Remicade started in combination with MTX or one other traditional DMARD (eg, leflunomide, sulfasalazine) AND the pt has tried 1 other agent for this condition (eg, MTX, sulfasalazine, or leflunomide, an NSAID, or one biologic DMARD [eg, Humira, Orencia, Enbrel, Kineret, Actemra]) or the pt has aggressive disease. FDA approved indications cont tx - approve if patient has had a response, as determined by the prescriber.</p>

# REMODULIN

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## Products Affected

- Remodulin

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	PAH WHO group, right heart catheterization results, WHO functional status, previous drugs tried
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	PAH WHO Group 1, prescribed by or in consultation with a cardiologist or a pulmonologist.
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	Part B versus Part D determination will be made at time of prior authorization review per CMS guidance. PAH WHO Group 1, patients not currently on Remodulin pt required to have had a right-heart catheterization to confirm the diagnosis of PAH (mPAP greater than or equal to 25 mm Hg at rest, PCWP equal to or less than 15 mm Hg, and PVR greater than 3 Wood units) AND have Class II, III, or IV WHO functional status AND if the pt has idiopathic PAH, they must have one of the following: 1. had an acute response to vasodilator testing that occurred during the right heart cath (defined as decrease in mPAP of at least 10 mm Hg to an absolute mPAP of less than 40 mm Hg without a decrease in cardiac output) AND has tried an oral CCB or 2. pt did not have an acute response to vasodilator testing or 3. cannot undergo vasodilator test or cannot take CCB due to extreme right HF (e.g. hypotension, cardiac index less than 1.5, or right atrial pressure greater than 20, or 4. has tried a CCB without vasodilator testing. PAH WHO Group1, patients currently on Remodulin- pt must have had a right heart catheterization to confirm the diagnosis of PAH.

# REPATHA

## Products Affected

- Repatha
- Repatha Pushtronex
- Repatha SureClick

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Concurrent use of Juxtapid, Kynamro, or Praluent.
<b>Required Medical Information</b>	LDL-C and response to other agents, prior therapies tried, medication adverse event history, medical history
<b>Age Restrictions</b>	ASCVD/HeFH/Primary Hyperlipidemia - 18 yo and older, HoFH 13 yo and older.
<b>Prescriber Restrictions</b>	Prescribed by, or in consultation with, a cardiologist, endocrinologist, or a physician who focuses in the treatment of CV risk management and/or lipid disorders
<b>Coverage Duration</b>	Approve for 3 years for ASCVD/HeFH/HoFH. Approve for 1 year for primary hyperlipidemia.
<b>Other Criteria</b>	Hyperlipidemia in patients with HeFH without ASCVD - approve if meets all of the following 1. Pt has been diagnosed with HeFH AND 2. tried ONE high intensity statin (i.e. atorvastatin greater than or equal to 40 mg daily or Crestor greater than or equal to 20 mg daily) AND 3. LDL-C remains greater than or equal to 70 mg/dL unless is determined to be statin intolerant defined by experiencing statin related rhabdomyolysis or experienced skeletal-related muscle symptoms while receiving separate trials of atorvastatin and Crestor and during both trials the skeletal-related symptoms resolved during d/c. Hyperlipidemia Pt with Clinical ASCVD with or without HeFH - approve if meets all of the following has an LDL-C greater than or equal to 70 mg/dL (after treatment with antihyperlipidemic agents but prior to PCSK9 therapy), AND has one of the following conditions prior MI, h/o ACS, diagnosis of angina, h/o CVA or TIA, PAD, undergone a coronary or other arterial revascularization procedure, AND tried ONE high intensity statin (as defined above) AND LDL-C remains greater than or equal to 70 mg/dL unless the pt is determined to be statin intolerant defined by experiencing statin related rhabdomyolysis or pt experienced skeletal-related muscle symptoms while

PA Criteria	Criteria Details
	<p>receiving separate trials of atorvastatin and Crestor and during both trials the skeletal-related symptoms resolved during d/c. HoFH - approve if meets all of the following has one of the following genetic confirmation of two mutant alleles at the LDLR, APOB, PCSK9, or LDLRAP1 gene locus, OR untreated LDL-C greater than 500 mg/dL (prior to treatment with antihyperlipidemic agents), OR treated LDL-C greater than or equal to 300 mg/dL (after treatment with antihyperlipidemic agents but prior to agents such as Repatha, Kynamro or Juxtapid), OR have clinical manifestations of HoFH (e.g., cutaneous xanthomas, tendon xanthomas, arcus cornea, tuberous xanthomas or xanthelasma), AND tried ONE high intensity statin (as defined above) for greater than or equal to 8 weeks and LDL-C remains greater than or equal to 70 mg/dL unless is determined to be statin intolerant defined by experiencing statin related rhabdomyolysis or experienced skeletal-related muscle symptoms while receiving separate trials of atorvastatin and Crestor and during both trials the skeletal-related symptoms resolved during d/c.</p>

# REVLIMID

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## Products Affected

- Revlimid

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D. Plus patients already started on Revlimid for a Covered Use. Systemic Amyloidosis Light Chain, Diffuse Large B Cell Lymphoma (Non-Hodgkin's Lymphoma), Follicular Lymphoma (Non-Hodgkin's Lymphoma), Myelofibrosis, Castleman's Disease, Hodgkin lymphoma (Classical).
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis and previous therapies or drug regimens tried.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	MCL-approve if the patient meets one of the following 1) Pt has tried two prior therapies or therapeutic regimens (eg, Velcade, HyperCVAD [cyclophosphamide, vincristine, doxorubicin, and dexamethasone alternating with high-dose methotrexate and cytarabine] + Rituxan [rituximab injection], the NORDIC regimen [dose-intensified induction immunochemotherapy with Rituxan + cyclophosphamide, vincristine, doxorubicin, prednisone alternating with Rituxan and high-dose cytarabine], RCHOP/RICE [Rituxan, cyclophosphamide, doxorubicin, vincristine, prednisone]/[Rituxan, Ifex (ifosafamide injection), carboplatin, etoposide], Treanda (bendamustine injection) plus Rituxan, Velcade (bortezomib injection) +/- Rituxan, cladribine + Rituxan, FC (fludarabine, cyclophosphamide) +/- Rituxan, PCR [pentostatin, cyclophosphamide, Rituxan]), or Imbruvica (ibrutinib capsules), OR 2) Pt has tried one prior therapy or therapeutic regimen (examples listed above) and cannot take Velcade according to the prescribing physician. MDS-approve if the patient

PA Criteria	Criteria Details
	<p>meets one of the following: 1) Pt has symptomatic anemia, OR 2) Pt has transfusion-dependent anemia, OR 3) Pt has anemia that is not controlled with an erythroid stimulating agent (eg, Epogen, Procrit [epoetin alfa injection], Aranesp [darbepoetin alfa injection]). Diffuse, Large B Cell Lymphoma (Non-Hodgkin's Lymphoma)-approve if the pt has tried one other medication treatment regimen (eg, RCHOP, dose-adjusted EPOCH [etoposide, prednisone, vincristine, cyclophosphamide, doxorubicin] + Rituxan, RCEPP [Rituxan, cyclophosphamide, etoposide, prednisone, procarbazine], DHAP [dexamethasone, cisplatin, cytarabine] +/- Rituxan, ICE [Ifex, carboplatin, etoposide] +/- Rituxan, and Treanda +/- Rituxan). Myelofibrosis-approve if the pt has tried one other therapy (eg, Jakafi [ruxolitinib tablets], androgens [eg, nandrolone, oxymetholone], Epogen, Procrit, Aranesp, prednisone, danazol, Thalomid [thalidomide capsules], melphalan, Myleran [busulfan tablets], alpha interferons, and hydroxyurea).</p>

# RITUXAN

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## Products Affected

- Rituxan

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically-accepted indications not otherwise excluded from Part D. Patients already started on Rituxan for a Covered Use.
<b>Exclusion Criteria</b>	Concurrent use with a Biologic DMARD or Targeted Synthetic DMARD
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	RA (initial course). Prescribed by a rheumatologist or in consultation with a rheumatologist.
<b>Coverage Duration</b>	RA,3mo. Othr=12 mo.
<b>Other Criteria</b>	Part B versus Part D determination will be made at time of prior authorization review per CMS guidance. RA (initial course), approve if patient has tried one DMARD (brand or generic, oral or injectable, traditional or biologic) for at least 3 months.

# RUBRACA

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## Products Affected

- Rubraca oral tablet 200 mg, 250 mg, 300 mg

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D. Plus patients already started on Rubraca for a Covered Use.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis for which Rubraca is being used. For Ovarian Cancer must have documentation of BRCA-mutation (germline or somatic). Other medications tried for the diagnosis provided
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 3years
<b>Other Criteria</b>	Initial Therapy. Approve for 3 years if the patient meets the following criteria (i and ii): i.The patient has a BRCA-mutation (germline or somatic) as confirmed by an approved test, AND ii.The patient has progressed on two or more prior lines of chemotherapy.

# RYDAPT

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## Products Affected

- Rydapt

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus patients already started on midostaurin for a Covered Use.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For AML, FLT3 status
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	AML-approve if the patient is FLT3-mutation positive as detected by an approved test.

# SAMSCA

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## Products Affected

- Samsca

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Serum sodium less than 125 mEq/L at baseline or less marked hyponatremia, defined as serum sodium less than 135 mEq/L at baseline, that is symptomatic (eg, nausea, vomiting, headache, lethargy, confusion).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 30 days
<b>Other Criteria</b>	Hyponatremia - Pt must meet ONE of the following: 1. serum sodium less than 125 mEq/L at baseline, OR 2. marked hyponatremia, defined as less than 135 mEq/L at baseline, that is symptomatic (eg, nausea, vomiting, headache, lethargy, confusion), OR 3. patient has already been started on Samsca and has received less than 30 days of therapy.

# SIMPONI

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## Products Affected

- Simponi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D. Plus patients already started on golimumab (IV or SC) for a covered use.
<b>Exclusion Criteria</b>	Concurrent use with a Biologic DMARD or Targeted Synthetic DMARD
<b>Required Medical Information</b>	Diagnosis, concurrent medications, previous therapies tried.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	RA/Ankylosing spondylitis, prescribed by or in consultation with a rheumatologist. Psoriatic arthritis, prescribed by or in consultation with a rheumatologist or dermatologist. UC-prescribed by or in consultation with a gastroenterologist
<b>Coverage Duration</b>	3 mos initial, 3 years cont
<b>Other Criteria</b>	AS approve if the patient has tried TWO of the following: Enbrel, Humira, Cosentyx. PsA-approve if the patient has tried TWO of the following: Enbrel, Humira, Cosentyx, Stelara, Otezla. RA, approve if the patient has tried two of the following: Enbrel, Humira, Orencia, or Xeljanz/XR. Ulcerative colitis - approve if the patient has had a trial with Humira. Cont tx - must have a response to therapy as according to prescriber

# SIMPONI ARIA

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## Products Affected

- Simponi ARIA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus patients already started on golimumab (IV or SC) for a covered use.
<b>Exclusion Criteria</b>	Concurrent use with a Biologic DMARD or Targeted Synthetic DMARD
<b>Required Medical Information</b>	Diagnosis, concurrent medications, previous therapies tried.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	RA - Prescribed by or in consultation with a rheumatologist
<b>Coverage Duration</b>	3 mos initial, 3 years cont
<b>Other Criteria</b>	RA - approve if the patient has tried etanercept or adalimumab. [Note: the patient does not have to have a trial with etanercept or adalimumab if they have had a trial with Cimzia or Simponi SC in the past.] Cont tx - must have a response to therapy as according to prescriber

# SOLARAZE

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## Products Affected

- diclofenac sodium topical gel 3 %

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 6 months.
<b>Other Criteria</b>	N/A

# SPRYCEL

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## Products Affected

- Sprycel oral tablet 100 mg, 140 mg, 20 mg, 50 mg, 70 mg, 80 mg

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D. Plus GIST and patients already started on Sprycel for a Covered Use.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis for which Sprycel is being used. For indications of CML and ALL, the Philadelphia chromosome (Ph) status of the leukemia must be reported.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	For CML, new patient must have Ph-positive CML for approval of Sprycel. For ALL, new patient must have Ph-positive ALL for approval of Sprycel. GIST - has D842V mutation AND previously tried Sutent and Gleevec.

# STELARA

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## Products Affected

- Stelara subcutaneous

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus approve Stelara SC in patients already started on Stelara (IV/SC) for a Covered Use.
<b>Exclusion Criteria</b>	Ustekinumab should not be given in combination with a Biologic DMARD or Targeted Synthetic DMARD
<b>Required Medical Information</b>	Diagnosis, concurrent medications, previous drugs tried.
<b>Age Restrictions</b>	Adults-PsA and CD. PP-12 years and older.
<b>Prescriber Restrictions</b>	Plaque psoriasis.Prescribed by or in consultation with a dermatologist. PsA-prescribed by or in consultation with a rheumatologist or dermatologist. CD-prescribed by or in consultation with a gastroenterologist.
<b>Coverage Duration</b>	PP/PsA Init-3mo,CD load-approve 1 dose IV,CD post IV load-approve SC 3 mo,cont tx-approve SC 3 yr
<b>Other Criteria</b>	PP initial - approve Stelara SC. CD, induction therapy - approve single dose of IV formulation if the patient meets ONE of the following criteria: 1) patient has tried or is currently taking corticosteroids, or corticosteroids are contraindicated, OR 2) patient has tried one other agent for CD (eg, azathioprine, 6-MP, MTX, certolizumab, vedolizumab, adalimumab, infliximab). CD, initial therapy (only after receiving single IV loading dose) - approve 3 months of the SC formulation if the patient meets ONE of the following criteria: 1) patient has tried or is currently taking corticosteroids, or corticosteroids are contraindicated, OR 2) patient has tried one other agent for CD. PP/PsA/CD cont - approve Stelara SC if according to the prescribing physician, the patient has responded to therapy.

# STIVARGA

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## Products Affected

- Stivarga

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D. Plus patients already started on Stivarga for a Covered Use.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis for which Stivarga is being used. Prior therapies tried. For metastatic CRC, KRAS/NRAS mutation status.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	Metastatic CRC, patient must have previously been treated with each of the following for approval: a fluoropyrimidine (eg, Xeloda, 5-FU), oxaliplatin, and irinotecan. If patient's tumor or metastases are wild-type KRAS and/or NRAS (that is, the tumors or metastases are KRAS and/or NRAS mutation negative), approve if Erbitux or Vectibix has been tried. For GIST, patient must have previously been treated with imatinib (Gleevec) and sunitinib (Sutent). For HCC, patient must have previously been treated with Nexavar (sorafenib).

# SUTENT

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## Products Affected

- Sutent oral capsule 12.5 mg, 25 mg, 37.5 mg, 50 mg

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus patients already started on Sutent for a Covered Use. Advanced, unresectable neuroendocrine tumors, chordoma, angiosarcoma, solitary fibrous tumor/hemangiopericytoma, alveolar soft part sarcoma (ASPS), differentiated (ie, papillary, follicular, and Hurthle) thyroid carcinoma, medullary thyroid carcinoma, thymic carcinoma.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	Gastrointestinal stromal tumors (GIST), approve if the patient has previously tried imatinib (Gleevec). Chordoma, approve if the patient has recurrent disease. Differentiated thyroid carcinoma, approve if the patient is refractory to radioactive iodine therapy. Medullary thyroid carcinoma, approve if the patient has tried vandetanib (Caprelsa) or cabozantinib (Cometriq). Meningioma, approve if the patient has recurrent or progressive disease. Thymic carcinoma - has tried chemotherapy (e.g., carboplatin/paclitaxel) or radiation therapy.

# SYMDEKO

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## Products Affected

- Symdeko

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Patients with unknown CFTR gene mutations
<b>Required Medical Information</b>	Diagnosis, specific CFTR gene mutations
<b>Age Restrictions</b>	Twelve years of age and older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist or a physician who specializes in CF
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	CF - must have at least one of the following mutations in the cystic fibrosis transmembrane conductance regulator (CFTR) gene: E56K, P67L, R74W, D110E, D110H, R117C, E193K, L206W, R347H, R352Q, A455E, D579G, 711+3A G, S945L, S977F, F1052V, E831X, K1060T, A1067T, R1070W, F1074L, D1152H, D1270N, 2789+5G A, 3272-26A G, or 3849 + 10kbC T OR the patient has two copies of the F508del mutation

# SYMLIN

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## Products Affected

- SymlinPen 120
- SymlinPen 60

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D worded as patient has type 1 or 2 diabetes mellitus.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	N/A

# SYPRINE

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## Products Affected

- Syprine
- trientine

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus patients already started on Syprine for a Covered Use.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, medication history, pregnancy status, disease manifestations
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a gastroenterologist, hepatologist, or liver transplant physician.
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	For Wilson's Disease, approve if the patient meets ONE of the following: 1) Patient has tried a penicillamine product and per the prescribing physician the patient is intolerant to penicillamine therapy, OR 2) Per the prescribing physician, the patient has clinical features indicating the potential for intolerance to penicillamine therapy (ie, history of any renal disease, congestive splenomegaly causing severe thrombocytopenia, autoimmune tendency), OR 3) Per the prescribing physician, the patient has a contraindication to penicillamine therapy, OR 4) The patient has neurologic manifestations of Wilson's disease, OR 5) The patient is pregnant.

# TAFINLAR

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## Products Affected

- Tafinlar oral capsule 50 mg, 75 mg

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus NSCLC in patients with BRAF V600 E mutation. Plus patients already started on Tafinlar for a Covered Use.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis for which Tafinlar is being used. BRAF V600 mutations
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	For unresectable or metastatic melanoma with BRAF V600 mutation. For NSCLC, must have BRAF V600E mutation

# TAGRISSEO

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## Products Affected

- Tagrisso oral tablet 40 mg, 80 mg

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus patients with advanced or metastatic Non-Small Cell Lung Cancer (NSCLC) who have EGFR exon 19 deletion or exon 21 (L858R) substitution as detected by an approved test.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	NSCLC - prior therapies and EGFR T790M mutation or EGFR exon 19 deletion or exon 21 (L858R) substitution
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	NSCLC - Must have metastatic epidermal growth factor receptor (EGFR) T790M mutation-positive NSCLC as detected by an approved test AND has progressed on or after one of Tarceva, Iressa, or Gilotrif therapy OR Advanced or metastatic Non-Small Cell Lung Cancer (NSCLC) who have EGFR exon 19 deletion or exon 21 (L858R) substitution as detected by an approved test.

# TARCEVA

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## Products Affected

- Tarceva oral tablet 100 mg, 150 mg, 25 mg

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus patients already started on Tarceva for a Covered Use, renal cell carcinoma (RCC).
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Advanced, recurrent, or metastatic non small cell lung cancer (NSCLC), EGFR mutation or gene amplification status.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	Metastatic NSCLC, approve if the patient meets both of the following: 1. patient is EGFR mutation positive, AND 2. patient has EGFR exon 19 deletions OR exon 21 (L858R) substitution mutations as detected by an FDA-approved test. Pancreatic locally advanced, unresectable, or metastatic cancer, approve if Tarceva is being prescribed in combination with gemcitabine. Advanced RCC, approve if the patient has non-clear cell histology.

# TASIGNA

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## Products Affected

- Tasigna oral capsule 150 mg, 200 mg, 50 mg

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D. Plus patients already started on Tasigna for a Covered Use. Plus Philadelphia positive Acute Lymphoblastic Leukemia (ALL) and Gastrointestinal Stromal Tumor (GIST).
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis for which Tasigna is being used. For indication of CML and ALL, the Philadelphia chromosome (Ph) status of the leukemia must be reported. For indication of gastrointestinal stromal tumor (GIST) and ALL, prior therapies tried.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	For CML, new patient must have Ph-positive CML for approval of Tasigna. For GIST, patient must have tried TWO of the following - sunitinib (Sutent), imatinib (Gleevec), or regorafenib (Stivarga). For ALL, Approve if the patient has tried one other tyrosine kinase inhibitors that is used for Philadelphia chromosome positive ALL (e.g., Gleevec, Sprycel, etc).

# TAZORAC

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## Products Affected

- tazarotene
- Tazorac topical cream 0.05 %
- Tazorac topical gel

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Cosmetic uses
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	PP/acne vulgaris - 3 years, other - 12 months.
<b>Other Criteria</b>	Acne vulgaris after a trial with at least 1 other topical retinoid product (eg, tretinoin cream/gel/solution/microgel, adapalene).

# TECFIDERA

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## Products Affected

- Tecfidera

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Concurrent use with other disease-modifying agents used for multiple sclerosis (MS).
<b>Required Medical Information</b>	MS, patient must have a relapsing form of MS (RRMS, SPMS with relapses, or PRMS). MS, previous MS therapies tried.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist or MS specialist.
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	N/A

# THALOMID

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## Products Affected

- Thalomid

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus patients already started on Thalomid for a Covered Use, Discoid lupus erythematosus or cutaneous lupus erythematosus, Myelofibrosis, Prurigo nodularis, Recurrent aphthous ulcers or aphthous stomatitis, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, Systemic Light Chain Amyloidosis.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	Discoid lupus erythematosus or cutaneous lupus erythematosus, approve if the patient has tried two other therapies (eg, corticosteroids [oral, topical, intralesional], hydroxychloroquine, tacrolimus [Protopic], methotrexate, dapsone, acitretin [Soriatane]). Myelofibrosis, approve if the patient has tried one other therapy (eg, ruxolitinib [Jakafi], danazol, epoetin alfa [Epogen/Procrit], prednisone, lenalidomide [Revlimid], hydroxyurea). Prurigo nodularis, approve if the patient has tried two other therapies (eg, azathioprine, capsaicin, psoralen plus ultraviolet A [PUVA] therapy, ultraviolet B [UVB] therapy). Recurrent aphthous ulcers or aphthous stomatitis, approve if the patient has tried two other therapies (eg, topical or intralesional corticosteroids, systemic corticosteroids, topical anesthetics/analgesics [eg, benzocaine lozenges], antimicrobial mouthwashes [eg, tetracycline], acyclovir, colchicine).

# TOPICAL AGENTS FOR ATOPIC DERMATITIS

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## Products Affected

- tacrolimus topical

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	Authorize use in patients who have tried a prescription strength topical corticosteroid (brand or generic) for the current condition. Dermatologic condition on or around the eyes, eyelids, axilla, or genitalia, authorize use without a trial of a prescription strength topical corticosteroid.

# TOPICAL RETINOID PRODUCTS

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## Products Affected

- adapalene topical cream
- adapalene topical gel
- adapalene-benzoyl peroxide
- Avita topical cream
- clindamycin-tretinoin
- tretinoin microspheres topical gel
- tretinoin topical

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Coverage is not provided for cosmetic use.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months
<b>Other Criteria</b>	N/A

# TOPICAL TESTOSTERONE PRODUCTS

## Products Affected

- Androderm
- 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)
- Fortesta
- Testim
- testosterone transdermal gel in metered-dose pump 12.5 mg/ 1.25 gram (1 %)
- testosterone transdermal gel in packet
- testosterone transdermal solution in metered pump w/app

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis of primary hypogonadism (congenital or acquired) in males. Diagnosis of secondary (hypogonadotropic) hypogonadism (congenital or acquired) in males. Hypogonadism (primary or secondary) in males, serum testosterone level. [Man is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression.]
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	Hypogonadism (primary or secondary) in males - initial therapy, approve if all of the following criteria are met: 1) patient has persistent signs and symptoms of androgen deficiency (pre-treatment) [eg, depressed mood, decreased energy, progressive decrease in muscle mass, osteoporosis, loss of libido, AND 2) patient has had two pre-treatment serum testosterone (total or available) measurements, each taken in the morning on two separate days, AND 3) the two serum testosterone levels are both low, as defined by the normal laboratory reference values. hypogonadism has been confirmed by a low for age serum testosterone (total or free) level defined by the normal laboratory reference values. Hypogonadism (primary or secondary) in males - continuing therapy, approve if the patient meets all of the following criteria: 1) patient has persistent signs and symptoms of

<b>PA Criteria</b>	<b>Criteria Details</b>
	androgen deficiency (pre-treatment) AND 2) patient had at least one pre-treatment serum testosterone level that was low. For patients requesting Fortesta, or Testim, approve if the patient has previously tried Androgel 1.62%. Patients who have tried generic Androgel in the past do not need to try brand Androgel prior to approval of the requested drug. [Note: male is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression.]

# TOPIRAMATE/ZONISAMIDE

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## Products Affected

- topiramate oral capsule, sprinkle
- topiramate oral tablet
- zonisamide

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All medically accepted indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Coverage is not provided for weight loss or smoking cessation.
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	N/A

# TRANSDERMAL FENTANYL

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## Products Affected

- fentanyl

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	Acute (i.e., non-chronic) pain.
<b>Required Medical Information</b>	Pain type (chronic vs acute), prior pain medications/therapies tried, concurrent pain medications/therapies
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	For pain severe enough to require daily, around-the-clock, long-term opioid treatment (with no cancer diagnosis and not in hospice), approve if all of the following criteria are met: 1) patient is not opioid naive, AND 2) non-opioid therapies have been optimized and are being used in conjunction with opioid therapy according to the prescribing physician, AND 3) the prescribing physician has checked the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP), unless unavailable in the state, AND 4) the prescribing physician has discussed risks (eg, addiction, overdose) and realistic benefits of opioid therapy with the patient, AND 5) according to the prescriber physician there is a treatment plan (including goals for pain and function) in place and reassessments are scheduled at regular intervals. Clinical criteria incorporated into the quantity limit edits for all oral long-acting opioids (including transdermal fentanyl products) require confirmation that the indication is intractable pain (ie, FDA labeled use) prior to reviewing for quantity exception.

# TRANSMUCOSAL FENTANYL DRUGS

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## Products Affected

- fentanyl citrate

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 12 months.
<b>Other Criteria</b>	For breakthrough pain in patients with cancer if patient is unable to swallow, has dysphagia, esophagitis, mucositis, or uncontrollable nausea/vomiting OR patient is unable to take 2 other short-acting narcotics (eg, oxycodone, morphine sulfate, hydromorphone, etc) secondary to allergy or severe adverse events AND patient is on or will be on a long-acting narcotic (eg, Duragesic), or the patient is on intravenous, subcutaneous, or spinal (intrathecal, epidural) narcotics (eg, morphine sulfate, hydromorphone, fentanyl citrate). Clinical criteria incorporated into the quantity limit edits for all transmucosal fentanyl drugs require confirmation that the indication is breakthrough cancer pain (ie, FDA labeled use) prior to reviewing for quantity exception.

# TYKERB

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## Products Affected

- Tykerb

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D. Plus patients already started on Tykerb for a Covered Use.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis for which Tykerb is being used. Metastatic breast cancer, HER2 status or hormone receptor (HR) status.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	HER2-positive advanced or metastatic breast cancer, approve if Tykerb will be used in combination with Xeloda or Herceptin and the patient has received prior therapy with Herceptin. HER2-positive HR positive metastatic breast cancer, approve if the patient is a man receiving a LHRH agonist, a premenopausal or perimenopausal woman receiving ovarian suppression/ablation with a LHRH agonist, or a postmenopausal woman and Tykerb will be used in combination with an aromatase inhibitor, that is letrozole (Femara), anastrozole, or exemestane. In this criteria, man/woman is defined as an individual with the biological traits of a man/woman, regardless of the individual's gender identity or expression.

# TYMLOS

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## Products Affected

- Tymlos

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	Concomitant use with other medications for osteoporosis (eg, denosumab [Prolia], bisphosphonates, calcitonin nasal spray [Miacalcin, Fortical, Forteo), except calcium and Vitamin D. Previous use of Tymlos and/or Forteo for a combined total no greater than 2 years duration during a patient's lifetime.
<b>Required Medical Information</b>	Previous medications tried, renal function
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 2 years of therapy over a patient's lifetime
<b>Other Criteria</b>	Treatment of PMO, approve if the patient meets ONE of the following criteria: patient has tried one oral bisphosphonate or cannot take an oral bisphosphonate because the patient cannot swallow or has difficulty swallowing or patient cannot remain in an upright position post oral bisphosphonate administration or patient has a pre-existing GI medical condition (eg, patient with esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]), OR patient has tried an IV bisphosphonate (ibandronate or zoledronic acid), OR patient has severe renal impairment or CKD, OR patient has had an osteoporotic fracture or fragility fracture

# TYSABRI

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## Products Affected

- Tysabri

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D. Plus patients already started on Tysabri for a Covered Use.
<b>Exclusion Criteria</b>	CD - Concurrent Use of Tysabri with an Immunosuppressant Agent in Patients with Crohn's Disease. MS - Current Use of Tysabri with Other Disease-Modifying Agents or immunosuppressants used for MS. Per warning and precautions, coverage is not provided for immune compromised patients with MS or CD.
<b>Required Medical Information</b>	Adults with MS. Patient has a relapsing form of MS (relapsing forms of MS are relapsing remitting [RRMS], secondary progressive [SPMS] with relapses, and progressive relapsing [PRMS]). Adults with CD. Patient has moderately to severely active CD with evidence of inflammation (eg, elevated C-reactive protein).
<b>Age Restrictions</b>	Adults
<b>Prescriber Restrictions</b>	MS. Prescribed by, or in consultation with, a neurologist or physician who specializes in the treatment of MS. CD. Prescribed by or in consultation with a gastroenterologist.
<b>Coverage Duration</b>	MS-Authorization will be for 3 years. CD, initial-3 mo. CD, cont therapy-3 years.
<b>Other Criteria</b>	Adults with a relapsing form of MS. Patient has had an inadequate response to, or is unable to tolerate, one disease modifying agent used for MS (eg, interferon beta-1a (Avonex, Rebif), interferon beta-1b (Betaseron, Extavia), glatiramer acetate (Copaxone/Glatopa), Plegridy, fingolimod (Gilenya), Tecfidera, Lemtrada, daclizumab (Zinbryta), Aubagio) OR the patient has highly active or aggressive disease according to the prescribing physician. Adults with CD, initial. Patient has moderately to severely active CD with evidence of inflammation (eg, elevated C-reactive protein) and patient has tried two of the following agents for CD for at least 2 months each: adalimumab, certolizumab pegol, infliximab, vedolizumab, ustekinumab, OR pt has had an inadequate response or was intolerant to these agents. CD, continuation therapy. Patient has had a response to Tysabri, as determined by the prescribing physician.

# UPTRAVI

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## Products Affected

- Uptravi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus patients currently taking Uptravi.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Confirmation of right heart catheterization (select populations), medication history.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	PAH must be prescribed by, or in consultation with, a cardiologist or a pulmonologist.
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	Must have PAH (WHO Group 1) and had a right heart catheterization to confirm the diagnosis of PAH (WHO Group 1). Right heart catheterization is NOT required in pts who are currently receiving Uptravi or another agent indicated for PAH (WHO group 1). Patient must meet a) OR b): a) tried TWO or is currently taking TWO oral therapies for PAH (either alone or in combination) each for 30 days, unless patient has experienced treatment failure, intolerance, or oral therapy is contraindicated: PDE5 inhibitor (eg, sildenafil, Adcirca, Revatio), endothelin receptor antagonist (ERA) [eg, Tracleer, Letairis or Opsumit], or Adempas, OR b) receiving or has received in the past one prostacyclin therapy for PAH (eg, Orenitram, Ventavis, Remodulin, or epoprostenol injection).

# VENCLEXTA

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## Products Affected

- Venclexta
- Venclexta Starting Pack

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus patients currently taking Venclexta for a Covered Use.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, prior therapy
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	CLL with or without 17p deletion - approve if the patient has tried one prior therapy.

# VERZENIO

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## Products Affected

- Verzenio oral tablet 100 mg, 150 mg, 200 mg, 50 mg

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	HR status, HER2 status, previous medications/therapies tried, concomitant therapy, menopausal status
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	Breast cancer in a woman - approve if the patient has advanced or metastatic HR+ [i.e., (ER+) and/or (PR+)], HER2-negative breast cancer and meets all of the following criteria: 1) cancer has progressed during or after endocrine therapy (e.g., anastrozole, exemestane, letrozole, tamoxifen, Fareston [toremifene], exemestane plus Afinitor [everolimus], Faslodex [fulvestrant intramuscular injection], megestrol acetate, fluoxymesterone, high-dose ethinyl estradiol), AND 2) patient is postmenopausal and Verzenio will be used in combination with Faslodex (fulvestrant IM injection) OR patient is premenopausal or perimenopausal and is receiving ovarian suppression with a gonadotropin-releasing hormone agonist (eg, leuprolide, triptorelin, goserelin) and Verzenio will be used in combination with Faslodex (fulvestrant IM injection) OR Verzenio will be used as monotherapy and the patient has had prior chemotherapy for metastatic breast cancer. Note: a woman is defined as an individual with the biological traits of a woman, regardless of the individual's gender identity or gender expression.

# VOTRIENT

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## Products Affected

- Votrient

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus, patients already taking Votrient for a Covered Use. Differentiated (ie, papillary, follicular, Hurthle cell) thyroid carcinoma. Uterine sarcoma, Dermatofibrosarcoma Protuberans (DFSP), Epithelial Ovarian, Fallopian Tube, or Primary Peritoneal Cancer, Gastrointestinal Stromal Tumor (GIST).
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	Soft tissue sarcoma other than GIST [angiosarcoma, Pleomorphic rhabdomyosarcoma, retroperitoneal/intra-abdominal soft tissue sarcoma that is unresectable or progressive, soft tissue sarcoma of the extremity/superficial trunk or head/neck, including synovial sarcoma, or other non-lipogenic (non-adipocytic) soft tissue sarcoma], approve. Differentiated (ie, papillary, follicular, Hurthle) thyroid carcinoma, approve if the patient is refractory to radioactive iodine therapy. Uterine sarcoma, approve if the patient has advanced or metastatic disease. Advanced RCC - approve. DFSP - approve if the patient has metastasis. Ovarian Cancer (ie, Epithelial Ovarian, Fallopian Tube, or Primary Peritoneal Cancer) - approve if the patient has persistent or recurrent disease OR the patient has complete clinical remission after receiving primary treatment with chemotherapy (e.g., carboplatin with paclitaxel) and/or surgery. GIST - approve if the patient has tried TWO of the following: Gleevec, Sutent, or Stivarga. Medullary Thyroid Carcinoma, approve if the patient has tried

<b>PA Criteria</b>	<b>Criteria Details</b>
	vandetanib (Caprelsa) or cabozantinib (Cometriq).

# XALKORI

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## Products Affected

- Xalkori oral capsule 200 mg, 250 mg

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus soft tissue sarcoma Inflammatory Myofibroblastic Tumor (IMT) with ALK translocation, Plus peripheral T-Cell Lymphoma - Anaplastic Large Cell Lymphoma (ALCL), Plus NSCLC with high level MET amplification or MET Exon 14 skipping mutation. Plus patients already started on crizotinib for a Covered Use.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For the FDA-approved indication of NSCLC for patients new to therapy, ALK status, high level MET amplification status, MET Exon 14 skipping mutation, and ROS1 rearrangement required. For soft tissue sarcoma IMT, ALK translocation.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	NSCLC, patient new to therapy must be ALK-positive, have high level MET amplification, have MET Exon 14 skipping mutation, or have ROS1 rearrangement for approval. For IMT, patient new to therapy must have ALK translocation for approval.

# XELJANZ

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## Products Affected

- Xeljanz
- Xeljanz XR

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus patients already started on Xeljanz/XR for a Covered Use.
<b>Exclusion Criteria</b>	Concurrent use with a biologic for an inflammatory condition (eg, tocilizumab, anakinra, abatacept, rituximab, certolizumab pegol, etanercept, adalimumab, infliximab, golimumab). Concurrent use with potent immunosuppressants that are not methotrexate (MTX) [eg, azathioprine, tacrolimus, cyclosporine, mycophenolate mofetil].
<b>Required Medical Information</b>	Diagnosis, concurrent medications, previous drugs tried.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	RA, prescribed by or in consultation with a rheumatologist.
<b>Coverage Duration</b>	Authorization will be for 3 months initial, 3 years cont.
<b>Other Criteria</b>	RA initial, patient has tried one conventional synthetic DMARD for at least 3 months (note: patients who have already had a 3-month trial of a biologic for RA are not required to step back and try a conventional synthetic DMARD). Continuation Therapy - Patient must have responded, as determined by the prescriber

# XENAZINE

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## Products Affected

- tetrabenazine oral tablet 12.5 mg, 25 mg

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Tardive dyskinesia (TD). Tourette syndrome and related tic disorders. Hyperkinetic dystonia. Hemiballism.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	For treatment of chorea associated with Huntington's disease, Tourette syndrome or related tic disorders, hyperkinetic dystonia, or hemiballism, must be prescribed by or after consultation with a neurologist. For TD, must be prescribed by or after consultation with a neurologist or psychiatrist.
<b>Coverage Duration</b>	Authorization will be for 1 year.
<b>Other Criteria</b>	N/A

# XERMELO

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## Products Affected

- Xermelo

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, previous therapy, concomitant therapy
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	Initial therapy - approve if the patient meets ALL of the following criteria: 1) patient has been on long-acting somatostatin analog (SSA) therapy (eg, Somatuline Depot [lanreotide for injection], Sandostatin LAR Depot [octreotide for injection]) for at least 3 consecutive months, AND 2) while on long-acting SSA therapy (prior to starting Xermelo), the patient continues to have at least four bowel movements per day, AND 3) Xermelo will be used concomitantly with a long-acting SSA therapy. Continuation therapy - approve if the patient is continuing to take Xermelo concomitantly with a long-acting SSA therapy for carcinoid syndrome diarrhea.

# XOLAIR

## Products Affected

- Xolair

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Seasonal or perennial allergic rhinitis (SAR or PAR).
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Moderate to severe persistent asthma and SAR/PAR, baseline IgE level of at least 30 IU/mL. For asthma, patient has a positive skin test or in vitro testing (ie, a blood test for allergen-specific IgE antibodies such as an enzyme-linked immunoabsorbant assay (eg, immunoCAP, ELISA) or the RAST) for 1 or more perennial aeroallergens (eg, house dust mite, animal dander [dog, cat], cockroach, feathers, mold spores) and/or for 1 or more seasonal aeroallergens (grass, pollen, weeds). For SAR/PAR, patient has positive skin testing (eg, grass, tree, or weed pollen, mold spores, house dust mite, animal dander, cockroach) and/or positive in vitro testing (ie, a blood test for allergen-specific IgE antibodies) for one or more relevant allergens (eg, grass, tree, or weed pollen, mold spores, house dust mite, animal dander, cockroach). CIU - must have urticaria for more than 6 weeks, with symptoms present more than 3 days/wk despite daily non-sedating H1-antihistamine therapy (e.g., cetirizine, desloratadine, fexofenadine, levocetirizine, loratadine) AND must have tried therapy with a leukotriene modifier (e.g., montelukast) with a daily non-sedating H1 antihistamine
<b>Age Restrictions</b>	Moderate to severe persistent asthma-6 years and older. All other diagnoses-12 years and older
<b>Prescriber Restrictions</b>	Moderate to severe persistent asthma/SAR/PAR if prescribed by, or in consultation with an allergist, immunologist, or pulmonologist. CIU if prescribed by or in consultation with an allergist, immunologist, or dermatologist.
<b>Coverage Duration</b>	Initial tx 4 months, continued tx 12 months
<b>Other Criteria</b>	Moderate to severe persistent asthma approve if pt meets criteria 1 and 2: 1)pt has received at least 3 months of combination therapy with an inhaled

PA Criteria	Criteria Details
	<p>corticosteroid and at least one the following: long-acting beta-agonist (LABA), long-acting muscarinic antagonist (LAMA), leukotriene receptor antagonist, or theophylline, and 2) inadequate control demonstrated by hospitalization for asthma or requirement for systemic corticosteroids to control asthma exacerbation(s). For continued Tx for asthma - patient has responded to therapy as determined by the prescribing physician.</p> <p>SAR/PAR - approve if pt meets all of the following criteria: 1) pt has tried concurrent therapy with at least one drug from 2 of the following classes: an oral non-sedating or low-sedating antihistamine, a nasal antihistamine, a nasal corticosteroid, or montelukast, AND 2) pt has had immunotherapy, is receiving immunotherapy, or will be receiving immunotherapy or has contraindications to immunotherapy. For continued tx SAR/PAR - pt must have responded to therapy as determined by the prescribing physician. For CIU cont tx - have responded to therapy as determined by the prescribing physician.</p>

# XTANDI

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## Products Affected

- Xtandi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus non-metastatic, castration-resistant prostate cancer, Plus patients already started on Xtandi for a Covered Use.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis for which Xtandi is being used.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	N/A

# XYREM

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## Products Affected

- Xyrem

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Medication history
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by a sleep specialist physician or a Neurologist
<b>Coverage Duration</b>	12 months.
<b>Other Criteria</b>	For Excessive daytime sleepiness (EDS) in patients with narcolepsy - approve if the patient has tried one CNS stimulant (e.g., methylphenidate, dexamethylphenidate, dextroamphetamine), modafinil, or Nuvigil.

# YONSA

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## Products Affected

- Yonsa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus patients already started on Yonsa for a covered use.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis, concomitant medications
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	Metastatic castration-resistant prostate cancer (mCRPC) - approve if the patient will be using Yonsa in combination with methylprednisolone.

# ZARXIO

## Products Affected

- Zarxio

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D worded more broadly as cancer patients receiving myelosuppressive chemotherapy, patients with acute myeloid leukemia (AML) receiving chemotherapy, cancer patients receiving bone marrow transplantation (BMT), patients undergoing peripheral blood progenitor cell (PBPC) collection and therapy, and patients with severe chronic neutropenia [SCN] (e.g., congenital neutropenia, cyclic neutropenia, idiopathic neutropenia). Neutropenia associated with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS). Treatment of myelodysplastic syndromes (MDS). Drug induced agranulocytosis or neutropenia. Aplastic anemia (AA). Acute lymphocytic leukemia (ALL).
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	AML, HIV/AIDS, MDS - adults
<b>Prescriber Restrictions</b>	Cancer/AML, MDS, ALL, oncologist or a hematologist. Cancer patients receiving BMT and PBPC, prescribed by or in consultation with an oncologist, hematologist, or a physician who specializes in transplantation. SCN, AA - hematologist. HIV/AIDS neutropenia, infectious disease (ID) physician (MD), hematologist, or MD specializing in HIV/AIDS.
<b>Coverage Duration</b>	chemo/SCN/AML-6 mo.HIV/AIDS-4 mo.MDS-3 mo.PBPC,Drug induce A/N,AA,ALL,BMT-1 mo.All other=12mo.
<b>Other Criteria</b>	Cancer patients receiving chemotherapy, approve if the patient meets one of the following conditions: patient is receiving myelosuppressive anti-cancer medications that are associated with a high risk of febrile neutropenia (the risk is at least 20% based on the chemotherapy regimen), patient is receiving myelosuppressive anti-cancer medications that are associated with a risk of febrile neutropenia but the risk is less than 20% based on the chemotherapy regimen and the patient has one or more risk

<b>PA Criteria</b>	<b>Criteria Details</b>
	<p>factors for febrile neutropenia (eg, aged greater than or equal to 65 years, prior chemotherapy or radiation therapy, persistent neutropenia, bone marrow involvement by tumor, recent surgery and/or open wounds, liver and/or renal dysfunction, poor performance status, or HIV infection), patient has had a neutropenic complication from prior chemotherapy and did not receive prophylaxis with a colony stimulating factor (eg, Leukine, Neulasta, Neupogen) and a reduced dose or frequency of chemotherapy may compromise treatment, patient has received chemotherapy has febrile neutropenia and has at least one risk factor (eg, sepsis syndrome, aged greater than 65 years, severe neutropenia [absolute neutrophil count less than 100 cells/mm<sup>3</sup>], neutropenia expected to be greater than 10 days in duration, invasive fungal infection).</p>

# ZEJULA

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## Products Affected

- Zejula

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus patients already started on Zejula for a Covered Use.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	3 years
<b>Other Criteria</b>	Recurrent ovarian, fallopian tube, or primary peritoneal cancer - approve if the patient has had a complete or partial response after platinum-based chemotherapy regimen AND Zejula is requested for maintenance treatment.

# ZELBORAF

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## Products Affected

- Zelboraf

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus, patients with Hairy Cell Leukemia, Non-Small Cell Lung Cancer (NSCLC) with BRAF V600E Mutation, Differentiated thyroid carcinoma (i.e., papillary, follicular, or Hurthle cell) with BRAF-positive disease and patients already started on vemurafenib for a Covered Use.
<b>Exclusion Criteria</b>	Concurrent use with Mekinist.
<b>Required Medical Information</b>	BRAFV600 mutation status required.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	Melanoma, patient new to therapy must have BRAFV600 mutation for approval. HCL - must have relapsed or refractory disease AND tried at least two therapies for hairy cell leukemia (e.g., cladribine, Nipent, cladribine or Nipent with or without Rituxan).

# ZEPATIER

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## Products Affected

- Zepatier

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus patients started on Zepatier for a Covered Use.
<b>Exclusion Criteria</b>	Combination use with other direct acting antivirals, excluding ribavirin or Sovaldi.
<b>Required Medical Information</b>	Genotype, prior medication therapy, concurrent medications, NS5A polymorphism status, prescriber specialty
<b>Age Restrictions</b>	18 years or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation w/ GI, hepatologist, ID, or liver transplant MD.
<b>Coverage Duration</b>	Will be c/w AASLD guidance and inclusive of treatment already received for the requested drug
<b>Other Criteria</b>	Criteria will be applied consistent with current AASLD/IDSA guidance.

# ZYDELIG

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## Products Affected

- Zydelig

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	CLL/Follicular B-Cell Non-Hodgkin Lymphoma/SLL - approve if the patient has tried one prior therapy.

# ZYKADIA

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## Products Affected

- Zykadia

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus Soft Tissue Sarcoma Inflammatory Myofibroblastic Tumor (IMT) with ALK Translocation. Plus patients with metastatic NSCLC that is anaplastic lymphoma kinase (ALK)-positive. Plus patients with NSCLC with ROS1 Rearrangement-First-line therapy.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Must have metastatic NSCLC that is anaplastic lymphoma kinase (ALK)-positive or ROS1 Rearrangement. IMT - ALK Translocation status.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	N/A

# ZYTIGA

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## Products Affected

- Zytiga oral tablet 250 mg, 500 mg

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	All FDA-approved indications not otherwise excluded from Part D. Plus hormone sensitive prostate cancer. Plus, patients already started on Zytiga for a Covered Use.
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	N/A
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Authorization will be for 3 years.
<b>Other Criteria</b>	Approve if Zytiga is being used in combination with prednisone.

## PART B VERSUS PART D

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### Products Affected

- Abelcet
- Abraxane
- acetylcysteine
- Actimmune
- acyclovir sodium intravenous solution
- 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
- Alimta
- Aliqopa
- AmBisome
- Aminosyn 7 % with electrolytes
- Aminosyn 8.5 %-electrolytes
- Aminosyn II 10 %
- Aminosyn II 15 %
- 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
- Arranon
- Avastin
- azacitidine
- azathioprine
- azathioprine sodium
- Bavencio
- Beleodaq
- Bethkis
- BiCNU
- bleomycin injection recon soln 30 unit
- bortezomib
- budesonide inhalation
- busulfan
- Busulfex
- Cancidas
- carboplatin intravenous solution
- caspofungin
- CellCept Intravenous
- cidofovir
- 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)
- clofarabine
- Clolar
- Cosmegen
- cromolyn inhalation
- cyclophosphamide oral capsule
- cyclosporine intravenous
- cyclosporine modified
- cyclosporine oral capsule
- Cyramza
- cytarabine
- cytarabine (PF) injection solution 2 gram/20 mL (100 mg/mL)
- dacarbazine intravenous recon soln 200 mg
- dactinomycin
- Darzalex
- daunorubicin intravenous solution
- decitabine
- docetaxel intravenous solution 160 mg/16 mL (10 mg/mL), 80 mg/4 mL (20 mg/mL)
- doxorubicin intravenous solution 50 mg/25 mL
- doxorubicin, peg-liposomal
- dronabinol
- Emend oral suspension for reconstitution
- Empliciti
- Engerix-B (PF) intramuscular syringe
- Engerix-B Pediatric (PF) intramuscular syringe

- epirubicin intravenous solution 200 mg/100 mL
- Erbitux intravenous solution 100 mg/50 mL
- Erwinaze
- Etopophos
- etoposide intravenous
- Faslodex
- Firmagon kit w diluent syringe
- fludarabine intravenous recon soln
- fluorouracil intravenous solution 5 gram/100 mL
- Folutyn intravenous solution 40 mg/2 mL (20 mg/mL)
- ganciclovir sodium intravenous recon soln
- gemcitabine intravenous recon soln 1 gram
- Gengraf oral capsule 100 mg, 25 mg
- Gengraf oral solution
- granisetron HCl oral
- Halaven
- Hepatamine 8%
- Herceptin
- idarubicin
- ifosfamide intravenous recon soln 1 gram
- Imfinzi
- Intralipid intravenous emulsion 20 %
- Intron A injection
- ipratropium bromide inhalation
- ipratropium-albuterol
- irinotecan intravenous solution 100 mg/5 mL
- Istodax
- Jevtana
- Kyprolis intravenous recon soln 30 mg, 60 mg
- Lartruvo
- levalbuterol HCl
- Lioresal intrathecal solution 2,000 mcg/mL, 500 mcg/mL
- melphalan HCl
- methotrexate sodium
- methotrexate sodium (PF)
- methylprednisolone oral tablet
- Millipred oral tablet
- mitomycin intravenous
- mitoxantrone
- Mustargen
- mycophenolate mofetil
- mycophenolate mofetil HCl
- mycophenolate sodium
- Mylotarg
- Nebupent
- Nephramine 5.4 %
- nitroglycerin intravenous
- Nulojix
- ondansetron
- ondansetron HCl oral
- oxaliplatin intravenous recon soln 100 mg
- oxaliplatin intravenous solution 100 mg/20 mL
- paclitaxel
- Perforomist
- Perjeta
- Plenamine
- prednisolone sodium phosphate oral tablet, disintegrating
- Prednisone Intensol
- prednisone oral tablet
- Premasol 10 %
- Premasol 6 %
- Prograf intravenous
- Proleukin
- Pulmozyme
- Rapamune oral solution
- Recombivax HB (PF) intramuscular suspension 10 mcg/mL, 40 mcg/mL
- Recombivax HB (PF) intramuscular syringe
- Sandimmune oral solution
- Simulect intravenous recon soln 20 mg
- sirolimus
- Sylvant
- Synribo
- tacrolimus oral
- Tecentriq
- thiotepa
- tobramycin in 0.225 % NaCl
- Toposar
- topotecan intravenous recon soln
- Torisel
- Travasol 10 %

- Treanda intravenous recon soln
- Trelstar intramuscular syringe
- Trisenox intravenous solution 2 mg/mL
- TrophAmine 10 %
- Trophamine 6%
- Varubi oral
- Vectibix intravenous solution 100 mg/5 mL (20 mg/mL)
- Velcade
- vinblastine intravenous solution
- Vincasar PFS intravenous solution 1 mg/mL
- vincristine intravenous solution 1 mg/mL
- vinorelbine intravenous solution 50 mg/5 mL
- Vyxeos
- Xatmep
- Xgeva
- Yervoy intravenous solution 50 mg/10 mL (5 mg/mL)
- Yondelis
- Zaltrap intravenous solution 100 mg/4 mL (25 mg/mL)
- Zanosar
- zoledronic acid intravenous solution
- 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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