# ACITRETIN

## Products Affected

- *acitretin*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Severely impaired liver or kidney function. Chronic abnormally elevated blood lipid values. Concomitant use of methotrexate or tetracyclines. Pregnancy. Females of child-bearing potential who intend to become pregnant during therapy or at any time for at least 3 years after discontinuing therapy. Females of child-bearing potential who will not use reliable contraception while undergoing treatment and for at least 3 years following discontinuation. Females of child-bearing potential who drink alcohol during treatment or for two months after cessation of therapy. |
| **Required Medical Information** | For diagnosis for severe, recalcitrant psoriasis (including plaque, guttate, erythrodermic palmar-plantar and pustular) AND must have contraindication or intolerance to at least 1 formulary first line agents per AAD psorasis guidelines (Topical Corticosteroids,Topical Calcipotriene/Calcitriol, Topical Calcipotriene,Topical Tazarotene) |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | Prescribed by or in consultation with a dermatologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# ACTIMMUNE

## Products Affected

- ACTIMMUNE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of chronic granulomatous disease for use in reducing the frequency and severity of serious infections associated with chronic granulomatous disease OR Diagnosis of atopic dermatitis treatment resistant patients (e.g. failure on topical medications OR phototherapy) OR Diagnosis of severe, malignant osteopetrosis (SMO) |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | This criteria applies to new starts only |

# ADEMPAS

## Products Affected

- ADEMPAS

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Concomitant administration with nitrates or nitric oxide donors (such as amyl nitrate) in any form. Concomitant administration with phosphodiesterase inhibitors, including specific PDE-5 inhibitors (such as sildenafil, tadalafil, or vardenafil) or non-specific PDE inhibitors (such as dipyridamole or theophylline). Pregnancy. |
| **Required Medical Information** | Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH AND PAH is symptomatic AND One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH .Chronic thomboembolic pulmonary hypertension (CTEPH) (Initial): One of the following: A) Both of the following: 1) Diagnosis of inoperable or persistent/recurrent CTEPH and 2) CTEPH is symptomatic OR B) Patient is currently on any therapy for the diagnosis of CTEPH. For all indications female patients are enrolled in the ADEMPAS REMS program. |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 6 months - initial. 12 months - renewal |
| **Other Criteria** | None |

# AFINITOR

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of advanced metastatic renal cell carcinoma and patient has failed therapy (disease progressed) with Sutent or Nexavar OR Diagnosis of pancreatic neuroendocrine tumors (pNET) that are unresectable, locally advanced, or metastatic OR Diagnosis of renal angiomyolipoma with tuberous sclerosis complex (TSC) and patient does not require immediate surgery OR Diagnosis of advanced hormone receptor-positive, HER2-negative breast cancer and patient is a postmenopausal woman and patient has failed treatment with Femara or Arimidex and the medication will be used in combination with Aromasin OR Diagnosis of subependymal giant cell astrocytoma (SEGA) associated with TSC that requires therapeutic intervention but is not a candidate for curative surgical resection OR diagnosis of adult patients with progressive, well-differentiated, non-functional, neuroendocrine tumors (NET) of gastrointestinal (GI) or lung origin with unresectable, locally advanced, or metastatic disease OR diagnosis of tuberous sclerosis complex (TSC) associated partial seizures. |
| **Age Restrictions** | 18 years of age and older for RCC, pNET, and renal angiomyolipoma with TSC. 1 year of age and older for SEGA. 2 years of age and older for TSC associated partial seizures. |
| **Prescriber Restrictions** | Prescribed by or in consultation with an oncologist or neurologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | This criteria applies to new starts only |

# ALECENSA

## Products Affected

- ALECENSA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of metastatic anaplastic lymphoma kinase(ALK) positive non-small cell lung cancer detected with an FDA-approved test or Clinical Laboratory Improvement Amendments-approved facility |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | This criteria applies to new starts only |

# ALPHA-1 PROTEINASE INHIBITOR

## Products Affected

- PROLASTIN-C INTRAVENOUS SOLUTION RECONSTITUTED

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Patient has IgA deficiency with antibodies against IgA. |
| **Required Medical Information** | All of the following: A) Patient has an alpha-1 proteinase inhibitor (alpha-1 antitrypsin) deficiency AND B) Diagnosis of emphysema AND C) One of the following: 1) Patient has a high risk phenotype: PiZZ, PiZ(null), Pi(null)(null) OR 2) Patient has serum alpha-1 antitrypsin concentrations of less than 11 uM/L (80 mg/dL) AND D) One of the following: FEV1 level is between 30% and 65% of predicted OR the patient has experienced a rapid decline in lung function (i.e., reduction of FEV1 more than 120 mL/year) that warrants treatment. |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | Pulmonologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# ALUNBRIG

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of metastatic, ALK positive non-small cell lung cancer and have progressed or are intolerant to Xalkori (crizotinib) |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | Prescribed by or in consultation with an oncologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | This criteria applies to new starts only |

# APOKYN

## Products Affected

- APOKYN SUBCUTANEOUS SOLUTION CARTRIDGE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | PD (Initial, reauth): Patient is using Apokyn with any 5-HT3 antagonist (eg, ondansetron, granisetron, dolasetron, palonosetron, alosetron) |
| **Required Medical Information** | Parkinson's disease (PD) (Initial): Diagnosis of advanced PD. Patient is experiencing acute intermittent hypomobility (defined as on/off episodes characterized by muscle stiffness, slow movements, or difficulty starting movements). Patient is receiving Apokyn in combination with other medications for the treatment of PD (e.g., carbidopa/levodopa, pramipexole, ropinirole, benztropine, etc.). |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# ARCALYST

## Products Affected

- ARCALYST

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of cryopyrin-associated period syndromes (CAPS), including Familial Cold Auto-inflammatory Syndrome (FCAS) and/or Muckle-Wells Syndrome (MWS). The medication will not be used in combination with another biologic. |
| **Age Restrictions** | 12 years of age and older |
| **Prescriber Restrictions** | Prescribed by or in consultation with or recommendation of, an immunologist, allergist, dermatologist, rheumatologist, neurologist, or other medical specialist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Approve doses based on FDA labeling |

# ARIKAYCE

## Products Affected

- ARIKAYCE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of Pulmonary Mycobacterium avium complex infection and used as part of a combination antibacterial drug regimen in patients who do not achieve negative sputum cultures after a minimum of 6 consecutive months of a multidrug background regimen therapy |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | Prescribed by or in consultation with infectious disease specialist or pulmonologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# AUBAGIO

## Products Affected

- AUBAGIO

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Severe hepatic impairment. Current treatment with leflunomide. Patients who are pregnant or women of childbearing potential not using reliable contraception. |
| **Required Medical Information** | Diagnosis of relapsing forms of multiple sclerosis (e.g., relapsing-remitting MS or progressive-relapsing MS) OR patient has experienced a first clinical episode and has MRI features consistent with multiple sclerosis AND Patient has tried and had an insufficient response to at least one other formulary MS disease modifying therapy ( e.g., Avonex, Betaseron, Copaxone, Gilenya, Tecfidera) |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For renewal, patient has experienced an objective response to therapy (i.e. no or slowed progression of disease) |

# AURYXIA

## Products Affected

- AURYXIA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | For the management of hyperphosphatemia in patients with chronic kidney disease on dialysis |
| **Age Restrictions** | 18 years and older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# BENLYSTA

## Products Affected

- BENLYSTA SUBCUTANEOUS

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Systemic lupus erythematosus (SLE) (init): Diagnosis of active SLE. Autoantibody positive (ie, anti-nuclear antibody [ANA] titer greater than or equal to 1:80 or anti-dsDNA level greater than or equal to 30 IU/mL). Currently receiving at least one standard of care treatment for active SLE (eg, antimalarials [eg, Plaquenil (hydroxychloroquine)], corticosteroids [eg, prednisone], or immunosuppressants [eg, methotrexate, Imuran (azathioprine), CellCept (mycophenolate mofetil)]). |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | SLE (init): Prescribed by or in consultation with a rheumatologist |
| **Coverage Duration** | SLE (init, reauth): 6 months |
| **Other Criteria** | SLE (reauth): Documentation of positive clinical response to Benlysta therapy |

# BOSULIF

## Products Affected

- BOSULIF ORAL TABLET 100 MG, 400 MG, 500 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of Philadelphia chromosome-positive (Ph+) CML with resistance, relapse, or inadequate response to prior therapy with one of the following tyrosine kinase inhibitors (TKI): Gleevec [imatinib] OR Tasigna [nilotinib] OR newly diagnosed chronic phase Philadelphia chromosome-positive chronic myelogenous leukemia (Ph + CML) |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | This criteria applies to new starts only |

# BRAFTOVI

## Products Affected

- BRAFTOVI ORAL CAPSULE 50 MG, 75 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of unresectable or metastic malignant melanoma with documented BRAF V600E or V600K mutation as detected by an FDA-approved test used in combination with binimetinib |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | Prescribed by or in consultation with a oncologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# BRIVIACT

## Products Affected

- BRIVIACT ORAL

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of partial-onset seizures, member must have history of inadequate response, contraindication, or intolerance to levetiracetam prior to approval. |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | This criteria applies to new starts only |

# CABOMETYX

## Products Affected

- CABOMETYX

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Patients who have or are at risk for severe hemorrhage and/or patients with a recent history of bleeding or hemoptysis. |
| **Required Medical Information** | Diagnosis of advanced or metastatic renal cell carcinoma OR Diagnosis of hepatocellular carcinoma (HCC) in patients previously treated with sorafenib. |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | This criteria applies to new starts only |

# CALQUENCE

## Products Affected

- CALQUENCE

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

# CAPRELSA

## Products Affected

- CAPRELSA ORAL TABLET 100 MG, 300 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Congenital long QT syndrome |
| **Required Medical Information** | Diagnosis of medullary thyroid cancer (MTC), and disease is one of the following: A) unresectable, locally advanced, or B) metastatic AND one of the following: patient has symptomatic disease or patient has progressive disease. |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | This criteria applies to new starts only |

# CARBAGLU

## Products Affected

- CARBAGLU

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

# CAYSTON

## Products Affected

- CAYSTON

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of cystic fibrosis is confirmed by appropriate diagnostic or genetic testing. Confirmation of P. aeruginosa in cultures of the airways. For continuation of therapy, a clinical reason to continue therapy, such as symptomatic improvement or pulmonary function tests have not deteriorated more than 10% from baseline. |
| **Age Restrictions** | 7 years of age and older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For renewal, Patient is benefiting from treatment (i.e. improvement in lung function [FEV1], decreased number of pulmonary exacerbations) |

# CINRYZE

## Products Affected

- CINRYZE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | History of life-threatening immediate hypersensitivity reactions, including anaphylaxis to the product. |
| **Required Medical Information** | Diagnosis of hereditary angioedema AND Medication will be used for routine prophylaxis against angioedema. |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | Prescribed by or in consultation with a hematologist, immunologist or allergist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# COMETRIQ

## Products Affected

- COMETRIQ (100 MG DAILY DOSE)
- COMETRIQ (140 MG DAILY DOSE)
- COMETRIQ (60 MG DAILY DOSE)

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Gastrointestinal perforation. Fistula. Severe hemorrhage. |
| **Required Medical Information** | Diagnosis of progressive, metastatic medullary thyroid cancer |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | This criteria applies to new starts only |

# COPAXONE

## Products Affected

- COPAXONE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- *glatiramer acetate subcutaneous solution prefilled syringe 20 mg/ml, 40 mg/ml*

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

# COPIKTRA

## Products Affected

- COPIKTRA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of relapsed or refractory chronic lymphocytic leukemia OR small lymphocytic lymphoma in patients with history of at least 2 prior therapies. Diagosis of relapsed or refractory follicular lymphoma in patients with at least 2 prior systemic therapies. |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | Prescribed by or in consultation with a oncologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# COTELLIC

## Products Affected

- COTELLIC

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of unresectable OR metastatic malignant melanoma with BRAF V600E OR V600K mutation. Documentation of combination therapy with vemurafenib (Zelboraf) |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | This criteria applies to new starts only |

# CYSTAGON

## Products Affected

- CYSTAGON

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | not covered with a penicillamine hypersensitivity |
| **Required Medical Information** | Supporting statement of diagnosis from the physician |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# DALFAMPRIDINE

## Products Affected

- *dalfampridine er*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | History of seizure. Moderate or severe renal impairment (creatinine clearance less than or equal to 50 mL/minute). |
| **Required Medical Information** | Diagnosis of multiple sclerosis. Patient must demonstrate sustained walking impairment, but with the ability to walk 25 feet (with or without assistance) prior to starting Ampyra (dalfampridine) and patient is currently on a disease modifying drug (interferon beta 1a, peginterferon beta 1a, intereron beta 1b, or glatiramer) to control disease progression, or has documented treatment failure, intolerance, or contraindication to any one of the following: interferon beta 1a, peginterferon beta 1a, intereron beta 1b, or glatiramer. |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | Prescribed by or in consultation with a neurologist |
| **Coverage Duration** | Initial - 3 months. Renewal - 12 months |
| **Other Criteria** | patient must be able to ambulate at least 25 feet |

# DAURISMO

## Products Affected

- DAURISMO

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of A) newly diagnosed acute myeloid leukemia and used in combination with cytarabine in adults 75 years of age or older or in patients who have comorbidities that preclude use of intensive induction chemotherapy |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | Prescribed by or in consultation with an Oncologist or Hematologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# DICLOFENAC TOPICAL

## Products Affected

- *diclofenac sodium transdermal gel 1 %*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of osteoarthritis |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# ENBREL

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Active serious infection (including tuberculosis). Combined use with a biologic disease-modifying anti-rheumatic drugs or potent immunosuppressant (e.g., azathioprine or cyclosporine) |
| **Required Medical Information** | Diagnosis of moderate to severe rheumatoid arthritis and patient had an inadequate response to, intolerance to, or contraindication to one or more non-biologic disease modifying anti-rheumatic drugs for at least 3 consecutive months OR Diagnosis of moderate to severe polyarticular juvenile idiopathic arthritis and patient had an inadequate response, intolerance or contraindication to one or more non-biologic disease modifying anti-rheumatic drugs (DMARDs) for at least 3 consecutive months OR Diagnosis of psoriatic arthritis and patient had an inadequate response, intolerance, or contraindication to methotrexate OR Diagnosis of ankylosing spondylitis and patient had an inadequate response, intolerance or contraindication to one or more NSAIDs OR Diagnosis of moderate to severe chronic plaque psoriasis (affecting more than 5% of body surface area or affecting crucial body areas such as the hands, feet, face, or genitals) and patient had an inadequate response, intolerance or contraindication to conventional therapy with at least one of the following: phototherapy (including but not limited to Ultraviolet A with a psoralen [PUVA] and/or retinoids [RePUVA] for at least one continuous month or one or more oral systemic treatments (i.e. methotrexate, cyclosporine, acitretin, sulfasalazine) for at least 3 consecutive months. |
| **Age Restrictions** | 2 years of age and older for JIA and JRA. 4 years of age and older for plaque psoriasis. 18 years of age and older for all other indications |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |

| PA Criteria | Criteria Details |
|---|---|
| **Other Criteria** | None |

# ENTRESTO

## Products Affected

- ENTRESTO

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | History of angioedema related to previous ACE inhibitor or ARB therapy, concomitant use or use within 36 hours of ACE inhibitors, concomitant use of aliskiren in patients with diabetes |
| **Required Medical Information** | Statement of diagnosis indicating Heart Failure (NYHA Class II through IV) |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# EPIDIOLEX

## Products Affected

- EPIDIOLEX

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of Lennox-Gastaut syndrome OR severe myoclonic epilepsy in infancy |
| **Age Restrictions** | 2 years of age and older |
| **Prescriber Restrictions** | Presbriber by or consultation with a neurologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# ERIVEDGE

## Products Affected

- ERIVEDGE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of metastatic basal cell carcinoma OR Diagnosis of locally advanced basal cell carcinoma that has recurred following surgery or when the patient is not a candidate for surgery and radiation |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | This criteria applies to new starts only |

# ERLEADA

## Products Affected

- ERLEADA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Pregnancy |
| **Required Medical Information** | Diagnosis of nonmetastatic, castration-resistant prostate cancer |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | Prescribed by or in consultation with an oncologist or urologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | This criteria applies to new starts only |

# ESBRIET

## Products Affected

- ESBRIET ORAL TABLET

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | 1)Diagnosis of Idiopathic pulmonary fibrosis (IPF) as documented by all of the following: a) exclusion of other known causes of interstitial lung disease (ILD) (eg, domestic and occupational environmental exposures, connective tissue disease, drug toxicity), AND b) one of the following: i) in patients not subjected to surgical lung biopsy, the presence of a usual interstitial pneumonia (UIP) pattern on high-resolution computed tomography (HRCT) revealing IPF or probable IPF, OR ii) in patients subjected to a lung biopsy, both HRCT and surgical lung biopsy pattern revealing IPF or probable IPF, AND 2) not used in combination with Ofev (nintedanib). |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | Pulmonologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# ESRD THERAPY

## Products Affected

- PROCRIT INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML
- RETACRIT INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML

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

# EXJADE

## Products Affected

- EXJADE

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

# FARYDAK

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of Multiple Myeloma (MM) Used in combination with both of the following: Velcade (bortezomib) and dexamethasone. Patient has received at least two prior treatment regimens which included both of the following: Velcade (bortezomib) and an immunomodulatory agent [eg, Revlimid (lenalidomide), Thalomid (thalidomide)]. |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | Prescribed by or in consultation with an oncologist/hematologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | This criteria applies to new starts only |

# FENTANYL ORAL

## Products Affected

- *fentanyl citrate buccal*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Management of acute or post-operative pain, including headache/migraine, dental pain, or use in the emergency room. Opioid non-tolerant patients. |
| **Required Medical Information** | Patient meets the following: A) Diagnosis of cancer and use is for breakthrough cancer pain, B) Must have tried and failed at least two of the following alts: HYDROMORPHONE, OXYMORPHONE, APAP/CODEINE, OXYCODODONE/APAP, OXYCODONE, HYDROCODONE/APAPC), C) other formulary short-acting strong narcotic analgesic alternatives (other than fentanyl) have been ineffective, not tolerated, or contraindicated, D) prescriber is registered in the Transmucosal Immediate Release Fentanyl (TIRF) Risk Evaluation and Mitigation Strategy Access program |
| **Age Restrictions** | 16 years of age and older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# FERRIPROX

## Products Affected

- FERRIPROX

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of transfusional iron overload due to thalassemia syndromes AND patient has failed prior chelation therapy with Desferal or Exjade (failure is defined as a serum ferritin level greater than 2,500 mcg/L) or patient has a contraindication or intolerance to Desferal or Exjade AND Patient has an absolute neutrophil count greater than 1.5 x 109/L. |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For renewal, patient has experienced at least a 20% reduction in serum ferritin levels and has an absolute neutrophil count greater than 0.5 x 109/L |

# FIRAZYR

## Products Affected

- FIRAZYR

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

# FORTEO

## Products Affected

- FORTEO SUBCUTANEOUS SOLUTION 600 MCG/2.4ML

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Patient has a diagnosis of one of the following: a) osteoporosis in a postmenopausal female, b) primary or hypogonadal osteoporosis in a male, or c) osteoporosis associated with sustained systemic glucocorticoid therapy AND patient is considered to be at high-risk for fracture by meeting one or more of the following: A) history of osteoporotic fracture, B) Low Bone Density less than 2.5 SD below normal, AND one or more of the following: i) failed one oral bisphosphonate and 1 injectable bisphosphonate, or ii) intolerant to one oral bisphosphonate and one injectable bisphosphonate. Patient has not received more than 2 years of therapy with Forteo. |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Approve doses based on FDA labeling |

# GALAFOLD

## Products Affected

- GALAFOLD

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of Fabry disease with an amenable galactosidase alpha gene (GLA) mutation |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# GATTEX

## Products Affected

- GATTEX

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

# GILENYA

## Products Affected

- GILENYA ORAL CAPSULE 0.5 MG

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

# GILOTRIF

## Products Affected

- GILOTRIF

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Supporting statement of diagnosis from the physician in patients with: 1) metastatic non-small cell lung cancer (NSCLC) whose tumors have non-resistant epidermal growth factor receptor (EGFR) mutations as detected by an FDA-approved test or 2) metastatic squamous NSCLC, progressing after platinum-based chemotherapy. |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | Prescribed by or in consultation with an oncologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | This criteria applies to new starts only |

# GOCOVRI

## Products Affected

- GOCOVRI

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

# GROWTH HORMONE

## Products Affected

- NORDITROPIN FLEXPRO

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

| PA Criteria | Criteria Details |
|---|---|
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# HEPATITIS B

## Products Affected

- *adefovir dipivoxil*
- *entecavir*
- VEMLIDY

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Patients that have immune-tolerant chronic hepatitis B per AASLD guidelines |
| **Required Medical Information** | Must submit documenation of immune-active chronic hepatitis B per AASLD guidelines. |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | Prescriber must be a gastroenterologist, hepatologist, or infectious disease specialist |
| **Coverage Duration** | Duration of approval per AASLD Guidelines |
| **Other Criteria** | None |

# HEPATITIS C

## Products Affected

- MAVYRET
- *sofosbuvir-velpatasvir*
- VOSEVI

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

# HETLIOZ

## Products Affected

- HETLIOZ

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of Non-24-hour-sleep-wake disorder (Non-24) AND patient has documented blindness |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 6 months - initial. 12 months - renewal |
| **Other Criteria** | For renewal, patient experienced an objective improvement (e.g., improvement in timing of nighttime sleep, improvement in duration of nighttime sleep, or reduction in daytime sleep). |

# HRM

## Products Affected

- NATPARA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Verify the medication is being used for an FDA-approved diagnosis |
| **Age Restrictions** | Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older. |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# HRM-ANTI-ARRHYTHMICS

## Products Affected

- DIGITEK ORAL TABLET 250 MCG
- DIGOX ORAL TABLET 250 MCG
- *digoxin oral solution*
- *digoxin oral tablet 250 mcg*
- *disopyramide phosphate oral*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | The drug is being prescribed for an FDA-approved indication AND If formulary non HRM alternatives (DIGOXIN: Digoxin 0.125mg dose, propranolol or sotalol for atrial fibrilation, DISOPYRAMIDE: dofetilide, amiodarone, propafenone, mexiletine, multaq ) considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 2 of the alternative(s) AND the prescribing physician attests to the medical necessity for using this high risk medication, AND Monitoring plan for adverse side effects, AND anticipated treatment course/duration. |
| **Age Restrictions** | Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older. |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# HRM-ANTIDEPRESSANTS

## Products Affected

- *amitriptyline hcl oral*
- *clomipramine hcl oral*
- *doxepin hcl oral*
- *imipramine hcl oral*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | The drug is being prescribed for an FDA-approved indication AND prescriber attestation that benefit outweighs risk of drugs found to be high risk medications for beneficiaries age 65 and older. |
| **Age Restrictions** | Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older. |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | This criteria applies to new starts only |

# HRM-ANTIEMETIC DRUGS

## Products Affected

- *hydroxyzine hcl oral tablet*
- *promethazine hcl oral tablet*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | The drug is being prescribed for an FDA-approved indication AND If formulary non HRM alternatives (Nausea and Vomiting: granisetron, ondansetron or Allergic Reactions: desloratadine,) considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 1 of the alternative(s) AND the prescribing physician attests to the medical necessity for using this high risk medication and intent to monitor for side effects, AND anticipated treatment course duration. |
| **Age Restrictions** | Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older. |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Must try and fail, have contraindication or intolerance to at least 2 non-HRM alternatives: Nausea/Vomiting: granisetron, ondansetron_Allergic Reactions: cetirizine solution, desloratadine, levocetirizine. Part D coverage is not allowed if a hospice program drug benefit is available for the drug in question. |

# HRM-ANTIHYPERTENSIVE AGENTS

## Products Affected

- *methyldopa oral*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | The drug is being prescribed for an FDA-approved indication AND If formulary non HRM alternatives (Low dose thiazide or a second generation calcium channel blocker OR ACE inhibitor, ARB, beta-blocker or combination product based on specific chronic conditions) considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 2 of the alternative(s) AND the prescribing physician attests to the medical necessity for using this high risk medication and intent to monitor side effects, AND anticipated treatment course/duration |
| **Age Restrictions** | Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older. |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Low dose thiazide or a second generation calcium channel blocker OR ACE inhibitor, ARB, beta-blocker or combination product based on specific chronic conditions |

# HRM-ANTIPARKINSON AGENTS

## Products Affected

- *benztropine mesylate oral*
- *trihexyphenidyl hcl*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | The drug is being prescribed for an FDA-approved indication AND prescriber attestation that benefit outweighs risk of drugs found to be high risk medications for beneficiaries age 65 and older |
| **Age Restrictions** | Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older. |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# HRM-ANTIPSYCHOTICS

## Products Affected

- SAPHRIS
- *thioridazine hcl oral*
- ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION RECONSTITUTED 210 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | The drug is being prescribed for an FDA-approved indication AND If formulary non HRM alternatives (haloperidol, quetiapine, risperidone, aripiprazole, asenapine, iloperidone, lurasidone, olanzapine, paliperidone, ziprasidone) considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 2 of the alternative(s) AND the prescribing physician attests to the medical necessity for using this high risk medication and intent to monitor for side effects, AND anticipated treatment course/duration |
| **Age Restrictions** | Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older. |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Applies to New Starts only. Must try/fail, have contraindication or intolerance to at least 2 of the following: haloperidol, quetiapine, risperidone, aripiprazole, asenapine, iloperidone, lurasidone, olanzapine, paliperidone, ziprasidone |

# HRM-BARBITURATES

## Products Affected

- *butalbital-acetaminophen oral tablet 50-325 mg*
- *butalbital-apap-caffeine oral capsule 50-325-40 mg*
- *butalbital-apap-caffeine oral tablet 50-325-40 mg*
- *butalbital-asa-caff-codeine*
- *butalbital-aspirin-caffeine oral capsule*
- BUTISOL SODIUM ORAL TABLET 30 MG
- *phenobarbital oral elixir*
- *phenobarbital oral tablet 100 mg, 15 mg, 16.2 mg, 30 mg, 32.4 mg, 60 mg, 64.8 mg, 97.2 mg*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | The drug is being prescribed for an FDA-approved indication AND prescriber attestation that benefit outweighs risk of drugs found to be high risk medications for beneficiaries age 65 and older |
| **Age Restrictions** | Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older. |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | This criteria applies to new starts only |

# HRM-ONCOLOGY

## Products Affected

- *megestrol acetate oral suspension 40 mg/ml*
- *megestrol acetate oral tablet*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | The drug is being prescribed for an FDA-approved indication AND If formulary non HRM alternatives for diagnosis of cachexia secondary to chronic illness ( dronabinol, oxandrolone) considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 2 of the alternative(s) AND the prescribing physician attestts to tthe medical necessity for using this high risk medication and the intent to monitor for side effects, AND anticipated treatment course/duration. For treatment of cancer related diagnosis or endometrial hyperplasia, or endometriosis, requests will be automatically approved. |
| **Age Restrictions** | Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older. |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | This criteria applies to new starts only |

# HRM-ORAL AND TRANSDERMAL ESTROGENS AND PROGESTINS

## Products Affected

- BIJUVA
- *estradiol oral*
- *estradiol transdermal*
- *megestrol acetate oral suspension 625 mg/5ml*
- MENEST ORAL TABLET 0.3 MG, 0.625 MG, 1.25 MG
- PREMPHASE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | The drug is being prescribed for an FDA-approved indication AND If formulary non HRM alternatives considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 2 of the alternative(s) AND the prescribing physician attests to the medical necessity for using this high risk medication and intent to monitor for side effects, AND anticipated treatment course/duration. Non-HRM Alternatives: IF BEING USED TO TREAT Bone Density issues must try 2 of the safer alternatives: alendronate, risedronate, ibandronate, raloxifene OR (zoledronic acid for bed-bound patients or for post-hip fracture). IF BEING USED TO TREAT vaginal symptoms member must have had an inadequate response, intolerable side effect, or contraindication to Estrace Vaginal Cream or Vagifem. |
| **Age Restrictions** | Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older. |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Bone Density: alendronate, risedronate, ibandronate, raloxifene (zoledronic acid for bed-bound patients or for post-hip fracture). Vaginal Symptoms: Estrace vaginal cream |

# HRM-SEDATIVE HYPNOTIC AGENTS

## Products Affected

- *zaleplon oral capsule 10 mg*
- *zolpidem tartrate oral tablet 10 mg, 5 mg*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | The drug is being prescribed for an FDA-approved indication AND If formulary non HRM alternatives , Silenor(less than or equal to 6mg/d)) considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to the alternative(s) AND the prescribing physician attests to the medical necessity for using this high risk medication, AND Monitoring plan for adverse side effects, AND anticipated treatment course/duration. |
| **Age Restrictions** | Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older. |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Non-HRM alternatives, must inadequate response, intolerable side effect, or contraindication to both: Rozerem (8 mg/d), Silenor (less than or equal to 6mg/d) |

# HRM-SKELETAL MUSCLE RELAXANTS

## Products Affected

- *carisoprodol oral tablet 350 mg*
- *carisoprodol-aspirin*
- *cyclobenzaprine hcl oral*
- *metaxalone oral tablet 800 mg*
- *methocarbamol oral*
- *orphenadrine citrate er*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | The drug is being prescribed for an FDA-approved indication AND the prescribing physician attests that the benefit outweighs risk of therapy and intent to monitor for side effects, AND anticipated treatment course/duration. |
| **Age Restrictions** | Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older. |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# HRM-UTI ANTIBACTERIALS

## Products Affected

- *nitrofurantoin*
- *nitrofurantoin macrocrystal oral capsule 100 mg, 25 mg*
- *nitrofurantoin monohyd macro*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | The drug is being prescribed for an FDA-approved indication AND If formulary non HRM alternatives (Non-HRM alternatives: sulfamethoxazole/trimethoprim) considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to the alternative AND the prescribing physician attests to the medical necessity for using this high risk medication and intent to monitor for side effects, AND anticipated treatment course/duration |
| **Age Restrictions** | Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older. |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# HUMIRA

## Products Affected

- HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT
- HUMIRA PEN SUBCUTANEOUS PEN-INJECTOR KIT
- HUMIRA PEN-CD/UC/HS STARTER
- HUMIRA PEN-PS/UV/ADOL HS START
- HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT

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

| PA Criteria | Criteria Details |
|---|---|
| | of the following following: systemic or topical corticosteroids or opthalmic antimuscarinics. OR H) moderate to severe hidradenitis suppurativa |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Patient has been tested for TB and latent TB has been ruled out or is being treated as per guidelines. For renewal, patient has stable disease or has improved while on therapy (For pJIA, reduction in disease flares, improvement in ACR scoring. For RA, improvement in tender, swollen joint count, improvement in ACR scoring. For PsA, improvement in number of swollen/tender joints, pain, stiffness. For AS, improvement in AS symptoms, such as stiffness and back pain. For CD, symptomatic remission. For UC, clinical remission, reduction in steroid use.) |

# IBRANCE

## Products Affected

- IBRANCE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of locally advanced or metastatic, hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative breast cancer AND One of the following: 1) Used in combination with Faslodex (fulvestrant) and disease has progressed following endocrine therapy, OR 2) Used in combination with an aromatase inhibitor AND One of the following: 1) patient is a postmenopausal woman, 2) patient is a man, or 3) both of the following: patient is a premenopausal or perimenopausal woman and patient is receiving a luteinizing hormone-releasing hormone (LHRH) agonist [eg, Zoladex (goserelin)]. |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | Prescribed by or in consultation with an oncologist. |
| **Coverage Duration** | 12 months |
| **Other Criteria** | This criteria applies to new starts only |

# ICLUSIG

## Products Affected

- ICLUSIG ORAL TABLET 15 MG, 45 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of chronic myelogenous leukemia(CML) AND One of the following: A) History of failure, resistance, relapse, contraindication, or intolerance to at least TWO other tyrosine kinase inhibitors (i.e., imatinib, SPRYCEL, TASIGNA, and BOSULIF), or B) Patient has the T315I mutation. OR Diagnosis of Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ ALL) AND One of the following: A) History of failure, resistance relapse, contraindication, or intolerance to at least TWO other FDA-approved tyrosine kinase inhibitors (i.e., imatinib, SPRYCEL), or B) Patient has the T315I mutation. |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | Prescribed by or in consultation with an oncologist or hematologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | This criteria applies to new starts only |

# IDHIFA

## Products Affected

- IDHIFA ORAL TABLET 100 MG, 50 MG

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

# IMATINIB

## Products Affected

- *imatinib mesylate oral tablet 100 mg, 400 mg*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of one of the following: A) Philadelphia chromosome-positive chronic myelogenous leukemia (Ph+ CML), B) Ph+ acute lymphoblastic leukemia (ALL), C) Gastrointestinal tumor (GIST) where patient has documented c-KIT (CD117) positive unresectable or metastatic malignant GIST or patient had resection of c-KIT positive GIST and imatinib will be used as an adjuvant therapy, D) Dermatofibrosarcoma protuberans that is unresectable, recurrent, or metastatic, E) hypereosinophilic syndrome or chronic eosinophilic leukemia, F) myelodysplastic syndrome or myeloproliferative disease associated with platelet-derived growth factor receptor gene re-arrangements, G) aggressive systemic mastocytosis without the D816V c-KIT mutation or with c-KIT mutational status unknown |
| **Age Restrictions** | 1 year of age and older - newly diagnosed CML in the chronic phase and newly diagnosed, Ph+ ALL. 18 years of age and older for other indications. |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | This criteria applies to new starts only |

# IMBRUVICA

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of mantle cell lymphoma (MCL) who have received at least one prior therapy OR chronic lymphocytic leukemia (CLL)/Small lymphocytic lymphoma (SLL) OR chronic lymphocytic leukemia (CLL)/Small lymphocytic lymphoma (SLL) with 17p deletion OR Waldenstrom's macroglobulinemia (WM) OR marginal zone lymphoma who require systemic therapy and have received at least one prior anti-CD20-based therapy OR chronic graft versus host disease after failure of at least one first line corticosteroid therapy |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | This criteria applies to new starts only |

# INCRELEX

## Products Affected

- INCRELEX

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Increlex is contraindicated in patients with allergies to mecasermin or any component of the Increlex formulation, for growth promotion in patients with closed epiphyses, for IV administration, in patients with active or suspected neoplasia. Increlex should be discontinued if neoplasia develops while on therapy. |
| **Required Medical Information** | Increlex (mecasermin [rDNA origin] injection) is indicated for the long-term treatment of growth failure in children with severe primary IGF-1 deficiency (Primary IGFD) or with growth hormone (GH) gene deletion who have developed neutralizing antibodies to GH. Child has one of the following conditions: Severe primary IGF-1 deficiency, OR Growth hormone gene deletion with developed neutralizing antibodies to growth hormone, OR Genetic mutation of GH receptor (i.e. Laron Syndrome), AND Child has severe growth retardation with height standard deviation score (SDS) more than 3 SDS below the mean for chronological age and sex, AND Child with IGF-1 level greater than or equal to 3 standard deviations below normal based on lab reference range for age and sex, AND Child with normal or elevated growth hormone (GH) levels based on at least one growth hormone stimulation test, AND Evidence of open epiphyses |
| **Age Restrictions** | 2 years of age and older |
| **Prescriber Restrictions** | Pediatric or Endocrinologist |
| **Coverage Duration** | 6 months |
| **Other Criteria** | None |

# INLYTA

## Products Affected

- INLYTA ORAL TABLET 1 MG, 5 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of advanced renal cell carcinoma AND patient failed one or more systemic therapies for renal cell carcinoma (e.g., sunitinib-, bevacizumab-, temsirolimus-, or cytokine-containing regimens) |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | This criteria applies to new starts only |

# INTRAROSA

## Products Affected

- INTRAROSA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Vaginal bleeding or dysfunctional uterine bleeding of an undetermined origin, known or suspected estrogen-dependent neoplasia. |
| **Required Medical Information** | Diagnosis of moderate to severe dyspareunia or atrophic vaginitis AND A) Patient must be female, B) Patient must be menopausal or postmenopausal, C) Patient has tried and failed, has a contraindication or intolerance to a low dose vaginal estrogen preparation (e.g. Premarin vaginal cream, Estrace vaginal cream, Estring, Vagifem), D) Patient does not have renal or hepatic impairment. |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | Initial: 3 months, Reauthorization: 12 months |
| **Other Criteria** | None |

# INTRON A

## Products Affected

- INTRON A

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Uncontrolled depression. Solid organ transplant other than liver. Autoimmune hepatitis or other autoimmune condition known to be exacerbated by interferon and ribavirin. |
| **Required Medical Information** | Diagnosis of hairy cell leukemia OR Diagnosis of Condylomata acuminata OR Diagnosis of AIDS-related Kaposi's sarcoma OR Clinically aggressive follicular lymphoma and the medication will be used concurrently with anthracycline-containing chemotherapy or is not a candidate for anthracycline-containing chemotherapy OR Malignant melanoma and the request for coverage is within 56 days of surgery and the patient is at high risk of disease recurrence OR Diagnosis of chronic hepatitis B with compensated liver disease and patient has evidence of hepatitis B viral replication and patient has been serum hepatitis B surface antigen-positive for at least 6 months OR Diagnosis of chronic hepatitis C with compensated liver disease and is receiving combination therapy with ribavirin, unless ribavirin is contraindicated, and the medication will not be used as part of triple therapy with a protease inhibitor and patient has a clinical reason for not using peginterferon |
| **Age Restrictions** | 1 year of age and older for HBV. 3 years of age and older for HCV. 18 years of age and older for other indications. |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | Condylomata: 3 mos. HBV e antigen pos: 16 wks, e antigen neg: 48 wks. KS: 16 wks. Others: 12 mos |
| **Other Criteria** | This criteria applies to new starts only |

# IRESSA

## Products Affected

- IRESSA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Non-small cell lung cancer (NSCLC): Diagnosis of metastatic NSCLC AND Patient has known active epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations as detected by an FDA-approved test or Clinical Laboratory Improvement Amendments-approved facility |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | This criteria applies to new starts only |

# ITRACONAZOLE

## Products Affected

- *itraconazole oral capsule*

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

# JAKAFI

## Products Affected

- JAKAFI

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Myelofibrosis: Diagnosis of primary myelofibrosis, OR post-polycythemia vera myelofibrosis, OR post-essential thrombocythemia myelofibrosis. Polycythemia vera: Diagnosis of polycythemia vera, AND history of failure, contraindication, or intolerance to hydroxyurea. |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 6 months |
| **Other Criteria** | This criteria applies to new starts only |

# JUXTAPID

## Products Affected

- JUXTAPID ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG, 5 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Moderate to severe liver impairment or active liver disease including unexplained persistent abnormal liver function tests. Pregnancy. Concomitant use with strong or moderate CYP3A4 inhibitors. |
| **Required Medical Information** | Diagnosis of HoFH as confirmed by one of the following: a) genetic confirmation of 2 mutations in the LDL receptor, ApoB, PCSK9, or LDL receptor adaptor protein 1 (ie, LDLRAP1 or ARH), or b) both of the following: 1) either untreated LDL-C greater than 500 mg/dL or treated LDL-C greater than 300 mg/dL AND 2) either xanthoma before 10 years of age or evidence of heterozygous FH in both parents. Patient has been receiving at least 12 consecutive weeks of ONE LDL-C lowering prescription therapy and will continue to receive an LDL-C lowering prescription therapy. History of failure after 12 consecutive weeks or intolerance to PCSK9 inhibitor therapy. One of the following LDL-C values while on maximally tolerated lipid-lowering regimen within the last 30 days: LDL-C greater than or equal to 100 mg/dL with ASCVD OR LDL-C greater than or equal to 130 mg/dL without ASCVD. Not used in combination with Kynamro (mipomersen). Not used in combination with a proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor. Patient is not pregnant. Patient does not have moderate or severe hepatic impairment (ie, Child-Pugh category B or C) or active liver disease including unexplained persistent abnormal liver function tests. Patient is not concomitantly on moderate or strong CYP 3A4 inhibitors (eg, clarithromycin). |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | HoFH (initial): 6 months. (reauth): 12 months |
| **Other Criteria** | None |

# KALYDECO

## Products Affected

- KALYDECO ORAL PACKET 50 MG, 75 MG
- KALYDECO ORAL TABLET

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of cystic fibrosis AND the patient has 1 mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to ivacaftor potentiation based on clinical and/or in vitro assay data. |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# KISQALI

## Products Affected

- KISQALI 200 DOSE ORAL TABLET THERAPY PACK
- KISQALI 400 DOSE ORAL TABLET THERAPY PACK
- KISQALI 600 DOSE ORAL TABLET THERAPY PACK
- KISQALI FEMARA 200 DOSE
- KISQALI FEMARA 400 DOSE
- KISQALI FEMARA 600 DOSE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of hormone receptor (HR)-positive, HER2-negative advanced or metastatic breast cancer and intended to be used in combination with an aromatase inhibitor in pre/perimenopausal or postmenopausal women OR used in combination with fulvestrant in postmenopausal women (requirement of fulvestrant applies to single agent Kisqali only, NOT Kisqali-Femara Co-pack). |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | This criteria applies to new starts only |

# KORLYM

## Products Affected

- KORLYM

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Pregnancy |
| **Required Medical Information** | Supporting statement of diagnosis from the physician |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | This criteria applies to new starts only |

# KUVAN

## Products Affected

- KUVAN

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of hyperphenylalaninemia (HPA) due to tetrahydrobiopterin (BH4)-responsive phenylketonuria (PKU). Appropriate for use in patients who: a) have been diagnosed with PKU, b) have a baseline blood Phe measured within 2 weeks prior to initiating therapy. Also require that the prescriber be a specialist with knowledge and expertise in metabolic diseases or genetic diseases or has consulted with a specialist in metabolic or genetic diseases. Initial approval will be for two months of therapy if the initial dose is 5 mg/kg/day to less than 20 mg/kg/day, it will be for one month if the initial dose is 20 mg/kg/day. Renewal for continued use will be for 6 months if patient response is seen based on prescriber determination. |
| **Age Restrictions** | 1 month of age and older |
| **Prescriber Restrictions** | Specialist knowledgeable in the management of PKU |
| **Coverage Duration** | Initial Approval: 2 months. Extended Approval: 6 month intervals |
| **Other Criteria** | None |

# KYNAMRO

## Products Affected

- KYNAMRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Moderate to severe liver impairment or active liver disease including unexplained persistent abnormal liver function tests. |
| **Required Medical Information** | Diagnosis of homozygous familial hypercholesterolemia as evidenced by one of the following: A) genetic confirmation of 2 mutant alleles at the LDL receptor, ApoB, PCSK9, or autosomal recessive hypercholesterolemia (ARH) adaptor protein gene locus OR B) untreated/pre-treatment LDL greater than 500 mg/dL with at least one of the following: cutaneous or tendonous xanthoma before age 10 years, history of early vascular disease (men younger than 55 years, women younger than 60 years) on both sides of the family if parenteral LDL levels are unknown, elevated LDL cholesterol levels before lipid-lowering therapy consistent with heterozygous FH in both parents AND Patient has tried and had an inadequate response to the maximum tolerated dose of a high potency statin (e.g., atorvastatin, rosuvastatin), unless all statins are contraindicated. |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 6 months - initial. 12 months - renewal |
| **Other Criteria** | None |

# LENVIMA

## Products Affected

- LENVIMA 10 MG DAILY DOSE
- LENVIMA 12 MG DAILY DOSE
- LENVIMA 14 MG DAILY DOSE
- LENVIMA 18 MG DAILY DOSE
- LENVIMA 20 MG DAILY DOSE
- LENVIMA 24 MG DAILY DOSE
- LENVIMA 4 MG DAILY DOSE
- LENVIMA 8 MG DAILY DOSE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of locally recurrent or metastatic, progressive, radioactive iodine-refractory differentiated thyroid cancer OR advanced renal cell carcinoma following one prior anti-angiogenic therapy in combination with everolimus OR unresectable hepatocellular carcinoma (HCC) |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | This criteria applies to new starts only |

# LETAIRIS

## Products Affected

- LETAIRIS

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of pulmonary arterial hypertension that was confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.) AND Patient has WHO Group I PAH AND pregnancy must be excluded prior to the start of therapy and will be prevented thereafter with two forms of reliable contraception in female patients of reproductive potential. |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 6 months - initial. 12 months - renewal |
| **Other Criteria** | None |

# LEUKINE

## Products Affected

- LEUKINE INTRAVENOUS

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Concurrent use with myelosuppresive chemotherapy or radiation or excessive (greater than or equal to 10%) leukemic myeloid blasts in bone marrow or peripheral blood |
| **Required Medical Information** | Diagnosis of one of the following: A) Patient has undergone allogeneic or autologous bone marrow transplant (BMT) and engraftment is delayed or failed OR B) Patient is undergoing autologous peripheral-blood progenitor cell transplant to mobilize progenitor cells for collection by leukapheresis OR C) Medication will be used for myeloid reconstitution after an autologous or allogeneic BMT OR D) Patient has acute myeloid leukemia and administration will be after completion of induction chemotherapy |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# LIDOCAINE PATCH

## Products Affected

- *lidocaine external patch 5 %*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of pain associated with diabetic neuropathy OR pain asociated with cancer-related neuropathy OR post-herpetic neuralgia. |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For the FDA-labeled indication of post-herpetic neuralgia, no additional criteria are required to be met. For diabetic neuropathy: the patient must have previous use and inadequate response or intolerance to Cymbalta or Lyrica. |

# LINEZOLID

## Products Affected

- *linezolid intravenous solution 600 mg/300ml*
- *linezolid oral*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Not covered with concomitant use of MAOI therapy |
| **Required Medical Information** | Supporting statement of diagnosis from the physician |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | VRE: 4 weeks. Nosocomial and community acquired pneumonia: 3 weeks. All other indications: 2 weeks |
| **Other Criteria** | None |

# LONSURF

## Products Affected

- LONSURF ORAL TABLET 15-6.14 MG, 20-8.19 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of one of the following A.) metastatic colorectal cancer, previously treated with fluoropyrimidine, oxaliplatin, and irinotecan-based regimens, an anti-VEGF therapy, and if RAS wild-type, an anti-EGFR therapy, or B.) metastatic gastric or gastroesophageal junction adenocarcinoma previously treated with at least 2 prior lines of chemotherapy that include a fluoropyrimidine, a platinum, either a taxane or irinotecan, and if appropriate HER2/neu-targeted therapy |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For initial treatment: Absolute neutrophil count 1,500/mm(3) or greater or febrile neutropenia resolved, platelet count 75,000/mm(3) or greater, and grade 3 or 4 nonhematological reactions resolved to grade 0 or 1 |

# LORBRENA

## Products Affected

- LORBRENA ORAL TABLET 100 MG, 25 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Current use of strong CYP3A inducers, due to potential for hepatotoxicity |
| **Required Medical Information** | Diagnosis of anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer (NSCLC) in patients which have disease progression on alectinib OR ceritinib OR crizotinib AND at least 1 other ALK inhibitor for metastatic disease |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | Prescribed by or in consultation with a oncologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# LUPRON

## Products Affected

- *leuprolide acetate injection*
- LUPRON DEPOT (1-MONTH) INTRAMUSCULAR KIT 3.75 MG, 7.5 MG
- LUPRON DEPOT (3-MONTH) INTRAMUSCULAR KIT 11.25 MG, 22.5 MG
- LUPRON DEPOT (4-MONTH)
- LUPRON DEPOT (6-MONTH)

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Pregnancy in patients with child-bearing potential. Breastfeeding. Undiagnosed abnormal vaginal bleeding. |
| **Required Medical Information** | Diagnosis of one of the following: A) advanced or metastatic prostate cancer (7.5 mg 1-month, 22.5 mg 3-month, 30 mg 4-month, & 45 mg 6-month depots only), B) Endometriosis (3.75 mg 1-month & 11.25 mg 3-month depots only) and for initial, patient has had an inadequate pain control response or patient has an intolerance or contraindication to one of the following: Danazol OR Combination [estrogen/progesterone] Oral Contraceptives OR Progestins and for retreatment course, Patient is experiencing recurrence of symptoms after an initial course of therapy with leuprolide acetate and Norethindrone acetate 5 mg daily will be co-administered, or C) Anemia due to uterine Leiomyomata (Fibroids) (3.75 mg 1-month &11.25 mg 3-month depots only) and Patient is preoperative |
| **Age Restrictions** | Uterine fibroids, ednometriosisand prostate cancer - 18 years of age and older, CPP- age 2-11 female and 2-12 male |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | Endometriosis- 6 months, Uterine fibroids -3 months, Prostate cancer, Precocious Puberty -12 months |
| **Other Criteria** | For endometriosis and uterine fibroids, patient will be using nonhormonal contraception during and for 12 weeks after therapy. |

# LYNPARZA

## Products Affected

- LYNPARZA ORAL TABLET 100 MG, 150 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Appropriate diagnosis and testing for BRCA mutation (deleterious or suspected deleterious germline BRCA mutated (as detected by an FDA approved test) advanced ovarian cancer that has been treated with 3 or more prior lines of chemotherapy) OR Diagnosis of deleterious or suspected deleterious germline or somatic BRCA-mutated (gBRCAm or sBRCAm) advanced epithelial ovarian, fallopian tube, or primary peritoneal cancer in patients with complete or partial response to first-line platinum-based chemotherapy (tablets) OR diagnosis of metastatic (gBRCAm, HER2-negative) breast cancer (tablets) |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | This criteria applies to new starts only |

# MATULANE

## Products Affected

- MATULANE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Part B coverage |
| **Required Medical Information** | Treatment of Hodgkin's Lymphoma OR medulloblastoma in combination with nitrogen mustard, vincristine and prednisone OR high-grade malignant glioma in combination with lomustine and vincristine |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | Prescribed by or in consultation with an oncologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | This criteria applies to new starts only |

# MEKINIST

## Products Affected

- MEKINIST ORAL TABLET 0.5 MG, 2 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of locally advanced or metastatic anaplastic thyroid cancer with documented positive BRAF V600E or V600K mutation as detected by an FDA-approved test as single agent or used in combination with Tafinlar OR Diagnosis of metastatic or unresectable melanoma and metastatic non-small cell lung cancer (NSCLC) with BRAF V600E mutation as detected by an FDA-approved test OR Diagnosis of BRAF V600K mutation-positive unresectable or metastatic melanoma or use as adjuvant treatment of BRAF V600K mutation-positive melanoma |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | Oncologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# MEKTOVI

## Products Affected

- MEKTOVI

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of unresectable or metastic malignant melanoma with documented BRAF V600E or V600K mutation as detected by an FDA-approved test used in combination with encorfenib |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | Prescribed by or in consultation with a oncologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# MS INTERFERONS

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of relapsing form of multiple sclerosis OR diagnosis of first clinical episode and MRI features consistent with multiple sclerosis. |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For renewal, patient has experienced an objective response to therapy (i.e. no or slowed progression of disease) |

# MYTESI

## Products Affected

- MYTESI

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Clinical notes to support a diagnosis of chronic diarrhea, defined as diarrhea persisting for more than four weeks, caused by their medication regimen or hiv enteropathy proven by biopsy, and not a virus, parasite or bacterium as evidenced by stool sample taken in the previous 3 months. Patient must have tried and failed or had intolerance to loperamide or diphenoxylate-atropine trials of a minimum of 30 days. |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | Infectious Disease Specialist or GI Consult for new starts |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# NERLYNX

## Products Affected

- NERLYNX

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

# NEUPOGEN

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of one of the following: A) congenital, cyclic, or idiopathic neutropenia, B) severe febrile neutropenia (FN) with the following: Has not received prophylactic pegfilgrastim and Used as adjunct to appropriate antibiotics in high-risk patients and any one of the following: 65 years or older, Uncontrolled primary disease, Pneumonia, Hypotension and multiorgan dysfunction (sepsis syndrome), Invasive fungal infection, Hospitalization when developed fever, Prior FN, Severe (ANC less than 100/mcL) or anticipated prolonged (more than 10 days) neutropenia, C) Autologous peripheral-blood progenitor cell transplant to mobilize progenitor cells for collection by leukapheresis, D) Undergoing myeloablative chemotherapy followed by autologous or allogeneic BMT, E) Acute myeloid leukemia and will be given after completion of induction or consolidation chemotherapy, F) Acute lymphoblastic leukemia and will be given after completion of the first few days of chemotherapy of the initial induction or first post-remission course, G) Myelodysplastic syndrome with severe neutropenia and recurrent infection, H) Receiving radiation therapy, not on chemotherapy, and expected to have prolonged delays in treatment due to neutropenia, I) Neutropenia associated with HIV infection and antiretroviral therapy, J) Aplastic anemia, K)Primary prophylaxis of FN in one of the following patients: 20% or higher risk of FN based on chemotherapy regimen OR Less than 20% risk of FN based on chemotherapy regimen with one of the following: 65 years or older, Poor performance status, Poor nutritional status, Previous FN, Extensive prior treatment including large radiation ports, Cytopenias due to bone marrow involvement by tumor, Administration of combined chemoradiotherapy, Presence of open wounds or active infections, Other serious comorbidities (including renal or liver dysfunction) or Receiving dose-dense chemotherapy regimen in breast or small cell lung cancer or non-Hodgkins lymphoma. |
| **Age Restrictions** | None |

| PA Criteria | Criteria Details |
|---|---|
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# NEXAVAR

## Products Affected

- NEXAVAR

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Squamous cell lung cancer being treated with carboplatin and paclitaxel. |
| **Required Medical Information** | Diagnosis of unresectable hepatocellular carcinoma OR Diagnosis of advanced renal cell carcinoma OR Diagnosis of locally recurrent or metastatic, progressive, differentiated thyroid carcinoma refractory to radioactive iodine treatment |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Diagnosis of advanced renal cell carcinoma AND prior therapy with Sutent (sunitinib) or Votrient (Pazopanib) OR For the treatment of patients with locally recurrent or metastatic, progressive, differentiated thyroid carcinoma that is refractory to radioactive iodine treatment OR For the treatment of patients with unresectable hepatocellular carcinoma |

# NINLARO

## Products Affected

- NINLARO

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of multiple myeloma, documentation of combination therapy with lenalidomide and dexamethasone. History of 1 prior therapy. |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | This criteria applies to new starts only |

# NORTHERA

## Products Affected

- NORTHERA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Request will be approved for the following indication(s): orthostatic dizziness, light-headedness, or the feeling that you are about to black out in adults with neurogenic orthostatic hypotension (NOH) caused by primary autonomic failure (i.e., Parkinson disease, multiple system atrophy, pure autonomic failure), dopamine beta-hydroxylase deficiency, and non-diabetic autonomic neuropathy). |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# NOXAFIL

## Products Affected

- NOXAFIL ORAL SUSPENSION
- NOXAFIL ORAL TABLET DELAYED RELEASE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Concomitant treatment with sirolimus, CYP 3A4 substrates that prolong QT interval (pimozide, quinidine), HMG-CoA Reductase inhibitors primarily metabolized through CYP 3A4, or ergot alkaloids |
| **Required Medical Information** | Diagnosis of oropharyngeal candidiasis and patient tried itraconazole and/or fluconazole OR Medication will be used as prophylaxis of invasive Aspergillus and Candida infections and the patient is at high risk of developing these infections due to being severely immunocompromised, such as hematopoietic stem cell transplant (HSCT) recipients with graft-versus-host disease (GVHD) or those with hematologic malignancies with prolonged neutropenia from chemotherapy. |
| **Age Restrictions** | 13 years of age and older for prophylaxis of invasive aspergillus and candidal infection |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 weeks |
| **Other Criteria** | None |

# NUEDEXTA

## Products Affected

- NUEDEXTA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Patient diagnosis of pseudobulbar affect. |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# NUVIGIL

## Products Affected

- NUVIGIL ORAL TABLET 200 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of one of the following: A) excessive sleepiness associated with obstructive sleep apnea (OSA)/hypopnea syndrome confirmed by sleep lab evaluation (e.g., multiple sleep latency test, polysomnography) and documentation of residual excessive sleepiness B) excessive sleepiness associated with narcolepsy confirmed by sleep lab evaluation (e.g., multiple sleep latency test, polysomnography) and patient has tried and failed, is unable to tolerate, or has contraindication(s) to at least one other central nervous system stimulant (e.g., methylphenidate, mixed amphetamine salts, dextroamphetamine) OR Diagnosis of excessive sleepiness associated with shift work disorder by either a primary complaint of excessive sleepiness or insomnia which is temporally associated with a work period (usually night work) that occurs during the habitual sleep phase or polysomnography and the MSLT demonstrate loss of a normal sleep-wake pattern. |
| **Age Restrictions** | 17 years of age and older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | OSA/hypopnea syndrome - 6 months (initial), 12 months (renewal). Other diagnoses - 12 months |
| **Other Criteria** | None |

# OCTREOTIDE

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Supporting statement of diagnosis from the physician |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# ODOMZO

## Products Affected

- ODOMZO

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of  locally advanced basal cell carcinoma of the skin and specific documentation of negative pregnancy status |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | This criteria applies to new starts only |

# OPSUMIT

## Products Affected

- OPSUMIT

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Pregnancy |
| **Required Medical Information** | Diagnosis of pulmonary arterial hypertension WHO group I AND diagnosis was confirmed by right heart catheterization AND female patients are enrolled in the OPSUMIT REMS program. |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 6 months - initial. 12 months - renewal |
| **Other Criteria** | For renewal, medication was effective (i.e. improved 6 minute walk distance, oxygen saturation, etc.) |

# ORENCIA

## Products Affected

- ORENCIA CLICKJECT
- ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Active infection (including TB). Concurrent therapy with other biologics. |
| **Required Medical Information** | Screening for latent TB infection and assessment for Hep B risk. For positive latent TB, patient must have completed treatment or is currently receiving treatment for LTBI. HBV infection ruled out or treatment initiated for positive infection. Rheumatoid arthritis - Must have one of following: 1) inadequate response to methotrexate (MTX), 2) inadequate response to another nonbiologic DMARD (e.g., leflunomide, hydroxychloroquine, sulfasalazine) if contraindicated or intolerant to MTX, 3) intolerance or contraindication to at least 2 nonbiologic DMARDs or, 4) use Orencia as first-line therapy with MTX for severely active RA. Polyarticular JIA - Must have an inadequate response to at least one nonbiologic DMARD or intolerance/contraindication to at least 2 nonbiologic DMARDs. For PAJIA, member needs trial or intolerance/contraindication to Humira. For RA, member needs trial or intolerance/contraindication to Humira and Enbrel. |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For re-authorization, patient's condition must have improved or stabilized. |

# ORFADIN

## Products Affected

- ORFADIN ORAL CAPSULE

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

# ORILISSA

## Products Affected

- ORILISSA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Pregnancy, known osteoporosis, severe hepatic impairment, current use of strong organic anion transporting polypeptide (OATP) 1B1 inhibitors |
| **Required Medical Information** | Diagnosis of endometriosis with moderate to severe pain |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | Initial: 6 months, Renewal: 12 months, Total: 24 months |
| **Other Criteria** | None |

# ORKAMBI

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Initial Therapy: Diagnosis of cystic fibrosis (CF) with documented homozygous F508del mutation confirmed by FDA-approved CF mutation test AND if less than 18 years of age, baseline ophthalmological exam completed. Continuation of therapy: Documentation patient is tolerating and responding to medication (i.e. improved FEV1, weight gain, decreased exacerbations, etc.) |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | Must be prescribed by, or in conjunction with, a pulmonologist or is from a CF center accredited by the Cystic Fibrosis Foundation |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# OSPHENA

## Products Affected

- OSPHENA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Vaginal bleeding or dysfunctional uterine bleeding of an undetermined origin, known or suspected estrogen-dependent neoplasia, acute thromboembolism or a past history of thromboembolic disease (including patients with a history of DVT, pulmonary embolism, retinal vein thrombosis, stroke, or myocardial infarction, known or suspected pregnancy. |
| **Required Medical Information** | Diagnosis of moderate to severe dyspareunia or atrophic vaginitis or moderate to severe vaginal dryness AND A) Patient must be female, B) Patient must be menopausal or postmenopausal, C) Patient has tried and failed, has a contraindication or intolerance to a low dose vaginal estrogen preparation (e.g. Premarin vaginal cream, Estrace vaginal cream, Estring, Vagifem), D) Dose must not exceed 1 tablet per day, E) Patient does not have hepatic impairment. |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# OXANDRIN

## Products Affected

- *oxandrolone oral*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Breast or prostate cancer in men. Breast cancer in women with hypercalcemia. Pregnancy. Nephrosis or nephrotic phase of nephritis. Hypercalcemia. |
| **Required Medical Information** | Patient is receiving treatment as an adjunct therapy to promote weight gain and has one of the following: Extensive surgery, Chronic infections, Severe trauma, Failure to gain or maintain at least 90% of ideal body weight without definite pathophysiologic reasons OR Oxandrin (oxandrolone) will be used to counterbalance protein catabolism associated with chronic corticosteroid administration OR Patient has bone pain associated with osteoporosis. |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | Osteoporosis bone pain: 1 month. Other diagnoses: 3 months |
| **Other Criteria** | For renewal, patient has experienced an objective improvement (i.e. weight gain, increase in  lead body mass, or reduction in muscle pain/weakness) |

# OXERVATE

## Products Affected

- OXERVATE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of A) Neurotrophic keratitis |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | Prescribed by or in consultation with an Ophthalmologist or Optometrist |
| **Coverage Duration** | 2 months |
| **Other Criteria** | None |

# PCSK9 INHIBITOR

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | For PRALUENT: MUST MEET CRITERIA #1 OR #3. For REPATHA: MUST MEET CRITERIA #1, #2, OR #3. 1. Diagnosis of heterozygous familial hypercholesterolemia (HeFH) confirmed by genotyping OR Simon Broome criteria: Total cholesterol greater than 290mg/dL or LDL cholesterol greater than 190mg/dL, PLUS ONE OF THE FOLLOWING: Tendon xanthomas in patient or 1st degree relative (parent, sibling, child) or 2nd degree relative (grandparent, uncle, aunt) OR DNA-based evidence of LDL receptor mutation, familial defective apo B-100, or PCSK9 mutation. 2a. Myocardial infarction prophylaxis, stroke prophylaxis, and to reduce risk of coronary revascularization in patients with established CVD OR 2b. Diagnosis of homozygous familial hypercholesterolemia (HoFH) confirmed by genotyping OR diagnosis based on the following: a. History of untreated LDL-C greater than 500 mg/dL AND xanthoma before 10 years of age OR b. Documentation of HeFH in both parents. 3. Diagnosis of clinical atherosclerotic cardiovascular disease as defined as one of the following: a. acute coronary syndrome, b. history of myocardial infarction, c. stable/unstable angina, d. coronary or other arterial revascularization, e. stroke, f. transient ischemic stroke, g. peripheral arterial disease presumed to be atherosclerotic region AND MEETS CRITERIA #4, #5, and #6. 4. Provide baseline and current LDL-C. 5. LDL-C greater than or equal to 70mg/dL. 6. Used in combination with maximally tolerated high-intensity statin OR MEETS CRITERIA #7 AND #8. 7. Statin intolerant 8. LDL-C greater than or equal to 70mg/dL. CONTINUING THERAPY: 1. Documented response to Praluent or Repatha, defined as ONE of the following: a. The patient is tolerating medication b. Will continue to be used in combination with maximally tolerated statin (unless statin intolerant). |
| **Age Restrictions** | Repatha: 13 years of age and older for diagnosis HoFM, Diagnosis CVD and HeFH AND Praluent and Repatha : 18 years of age and older |

| PA Criteria | Criteria Details |
|---|---|
| **Prescriber Restrictions** | Must be prescribed by, or in consultation with, a cardiologist, endocrinologist, or lipid specialist |
| **Coverage Duration** | Initial approval: 8 weeks, Renewal approval: 12 months |
| **Other Criteria** | None |

# PEGYLATED INTERFERON

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Uncontrolled depression. Autoimmune hepatitis or other autoimmune condition known to be exacerbated by interferon. |
| **Required Medical Information** | Chronic Hepatitis C: Criteria will be applied consistent with current AASLD-IDSA guidance OR Chronic Hepatitis B: Diagnosis of HBeAg-posistive or HBeAg-negative infection |
| **Age Restrictions** | 5 years of age and older. Hepatitis B: 3 years of age and older. |
| **Prescriber Restrictions** | Prescribed by or in consultation with a hepatologist, gastroenterologist, oncologist or infectious disease specialist |
| **Coverage Duration** | HepC: Initial: 28 wks. Reauth: 20 wks. HepB: 48 weeks |
| **Other Criteria** | For renewal, approval is based on the requirements outlined in the FDA-approved labeling, including viral load, presence of cirrhosis , and response to prior therapy. |

# PHENYLBUTYRATE

## Products Affected

- *sodium phenylbutyrate oral powder 3 gm/tsp*
- *sodium phenylbutyrate oral tablet*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Supporting statement of diagnosis from the physician |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# POMALYST

## Products Affected

- POMALYST

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Documentation of ALL of the following: 1. Disease has progressed within 60 days of completion of the last therapy 2. If female of reproductive potential ALL of the below: Two negative pregnancy tests obtained prior to initiating therapy with Pomalyst, monthly negative pregnancy tests during therapy 3. Patient has been counseled about the use of reliable contraception before, during, and 1 month after initiation of therapy with Pomalyst 4. Patient assessment to determine if prophylactic aspirin or antithrombic treatment (warfarin, clopidogrel) will need to be taken to reduce the risk of VTE (embolism, stroke) 5. Registered and certified to be compliant with Pomalyst REMS (Risk Evalutation and Mitigation Strategy) program |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | Oncologist or hematologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | A documented diagnosis of multiple myeloma and received at least two prior therapies including lenalidomide (Revlimid) and bortezomib (Velcade) |

# PROMACTA

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of one of the following: A) Relapsed/refractory chronic immune (idiopathic) thrombocytopenic purpura (ITP) for greater than 6 months AND Baseline platelet count is less than 50,000/mcL AND Degree of thrombocytopenia and clinical condition increase the risk of bleeding AND Patient had an insufficient response, intolerance, contraindication to corticosteroids or immune globulin or inadequate response or contraindication to splenectomy, B)Chronic hepatitis C and patient has thrombocytopenia defined as platelets less than 90,000/mcL for initiation (pre-treatment) of interferon therapy, C) Severe aplastic anemia in patients who have had an insufficient response to immunosuppressive therapy OR in combination with standard immunosuppressive therapy. |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Requests for coverage for thrombocytopenia in chronic hepatitis C patients will be approved if the platelet count is less than 50 billion cells/L. Promacta should be withheld when platelet counts exceed 400,000/mcL or if there is no response within 4 weeks of treatment at the maximum dose (75mg/day). Not covered in the presence of clinical symptoms of liver injury or evidence of hepatic decompensation. |

# PULMONARY FIBROSIS

## Products Affected

- OFEV

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

# PULMOZYME

## Products Affected

- PULMOZYME

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of cystic fibrosis |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For renewal, Patient is benefiting from treatment (i.e. improvement in lung function [FEV1], decreased number of pulmonary exacerbations). Part D if patient in long term care (defined by customer location code on claim) otherwise Part B. |

# QUININE SULFATE

## Products Affected

- *quinine sulfate oral*

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

# RAVICITI

## Products Affected

- RAVICTI

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | acute hyperammonemia. N-acetylglutamate synthase (NAGS) deficiency |
| **Required Medical Information** | Diagnosis of urea cycle disorder involving deficiencies of carbamoyl phosphate synthetase (CPS), ornithine transcarbamoylase (OTC), or argininosuccinic acid synthetase (AAS) confirmed via enzymatic, biochemical, or genetic testing AND patient has tried and had an inadequate response, is intolerant, or has a contraindication to Buphenyl |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# REGRANEX

## Products Affected

- REGRANEX

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

# REVATIO

## Products Affected

- *sildenafil citrate oral tablet 20 mg*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Supporting statement of diagnosis from the physician |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# REVLIMID

## Products Affected

- REVLIMID

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Pregnancy |
| **Required Medical Information** | Diagnosis of multiple myeloma and medication will be used in combination with dexamethasone OR diagnosis of multiple myeloma following autologous hematopoietic stem cell transplantation OR diagnosis of transfusion-dependent anemia due to low- or intermediate-1-risk myelodysplastic syndromes associated with a deletion 5q cytogenetic abnormality with or without additional cytogenetic abnormalities OR diagnosis of mantle cell lymphoma whose disease has relapsed or progressed after two prior therapies, one of which included bortezomib AND patient is enrolled in the Revlimid REMS Program |
| **Age Restrictions** | 12 years of age and older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | This criteria applies to new starts only |

# RUBRACA

## Products Affected

- RUBRACA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of deleterious BRCA mutation (germline and/or somatic)-associated epithelial ovarian, fallopian tube, or primary peritoneal cancer and all of the following criteria: 1. BRCA mutation detected by an approved FDA laboratory test, 2. Previous trial/failure with two or more chemotherapy regimens, 3. Used as monotherapy, 4. Agreement of provider to perform a complete blood count (CBC) at baseline and monthly thereafter, 5. Women of reproductive potential must use an effective method of contraception during therapy and for 6 months after the last dose OR Diagnosis of recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer and all of the following: 1. Complete or partial response to platinum-based chemotherapy 2. Used as monotherapy 3. Agreement of provider to perform a complete blood count (CBC) at baseline and monthly thereafter, 4. Women of reproductive potential must use an effective method of contraception during therapy and for 6 months after the last dose. |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | Hematologist or Oncologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | This criteria applies to new starts only |

# RYDAPT

## Products Affected

- RYDAPT

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Angioedema |
| **Required Medical Information** | Diagnosis of treatment naive FLT3 mutation-positive acute myelogenous leukemia (AML) and must be used in combination with standard cytarabine and daunorubicin induction and consolidation therapy or diagnosis of systemic mastocytosis. |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | Prescribed by or in consultation with a oncologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | This criteria applies to new starts only |

# SABRIL

## Products Affected

- *vigabatrin*
- VIGADRONE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of one of the following: A) infantile spasms B) complex partial seizures and patient had an inadequate response to at least one generic first-line agents (carbamazepine, lamotrigine, levetiracetam, oxcarbazepine, valproic acid, divalproex sodium) and at least one adjunctive agent (carbamazepine, clobazam, gabapentin, lamotrigine, levitiracetam, oxcarbazepine, valproic acid, divalproex sodium, topiramate) AND patient and prescriber are enrolled in the SHARE restricted distribution program. |
| **Age Restrictions** | Seizures - 10 years of age and older. Infantile spasms - at least one month to 2 years of age |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | This criteria applies to new starts only |

# SIGNIFOR

## Products Affected

- SIGNIFOR

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Acromegaly (initial): Diagnosis of acromegaly AND History of failure to surgery or patient is not a candidate for surgery. Cushing's disease (initial): Diagnosis of endogenous Cushing's disease (i.e, hypercortisolism is not a result of chronic administration of high dose glucocorticoids). Either pituitary surgery has not been curative for the patient OR patient is not a candidate for pituitary surgery. (Reauthorization): Documentation of positive clinical response to Signifor therapy. |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | Initial: 6 months trial. Reauthorization: 12 months if demonstrated benefit |
| **Other Criteria** | None |

# SIRTURO

## Products Affected

- SIRTURO

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Supporting statement of diagnosis from the physician |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | Infectious Disease Specialist |
| **Coverage Duration** | 24 weeks |
| **Other Criteria** | Administer in combination with at least 3 other drugs proven to be or at least 4 other drugs suspected of being effective against the patient's Mycobacterium tuberculosis isolate. |

# SOLTAMOX

## Products Affected

- SOLTAMOX

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis for use. Documentation of inability to swallow tablet formulation. |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | Oncologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | This criteria applies to new starts only |

# SOMATULINE

## Products Affected

- SOMATULINE DEPOT

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis for use: Acromegaly in patients who have had an inadequate response to surgery and/or radiotherapy, or for whom surgery and/or radiotherapy is not an option OR Unresectable, well- or moderately-differentiated, locally advanced or metastatic carcinoid gastroenteropancreatic neuroendocrine tumor, OR treatment of hyperthyroidism secondary to thyrotropinoma OR Carcinoid syndrome |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | Initial approval: 3 months. Extended approval: 3 months with dose adjusted according to response |
| **Other Criteria** | If this medication is administered by a physician incident to a physicians visit this would be covered by Medicare Part B |

# SOMAVERT

## Products Affected

- SOMAVERT

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | IV administration of Somavert, concomitant use of Sandostatin or Somatuline. |
| **Required Medical Information** | Diagnosis of acromegaly was confirmed by an elevated IGF-1 level or elevated GH level with a glucose tolerance test. Patient has tried and failed at least a 3 month trial of Sandostatin or Somatuline. For renewal, reduction in IGF-1 level from baseline. |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | Endocrinologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# SPRYCEL

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of Philadelphia chromosome-positive chronic myelogenous leukemia (Ph+ CML) that is newly diagnosed in the chronic phase OR Ph+ CML with resistance or intolerance to prior therapy, including imatinib OR Diagnosis of Ph+ acute lymphoblastic leukemia with resistance or intolerance to prior therapy OR Diagnosis of Ph+ acute lymphoblastic leukemia in combination with chemotherapy OR Gastrointestinal stromal tumors (GIST) after disease progression on imatinib or Sutent (sunitinib) |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | Oncologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# STIVARGA

## Products Affected

- STIVARGA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | A documented diagnosis of metastatic colorectal cancer AND documentation of prior therapy with ALL of the following per the indication: 1. (fluoropyrimidine-, oxaliplatin-, and irinotecan)-based chemotherapy 2. bevacizumab (Avastin) 3. panitumumab (Vectibix) OR cetuximab (Erbitux) (for KRAS mutation-negative patients only) OR a documented diagnosis of locally advanced, unresectable or metastatic gastrointestinal stromal tumor (GIST) who have been previously treated with imatinib mesylate (Gleevec) and sunitinib malate (Sutent) OR a documented diagnosis of hepatocellular carcinoma in patients previously treated with sorafenib (Nexavar). |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | Oncologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | A documented diagnosis of metastatic colorectal cancer AND documentation of prior therapy with ALL of the following per the indication: 1. (fluoropyrimidine-, oxaliplatin-, and irinotecan)-based chemotherapy 2. bevacizumab (Avastin) 3. panitumumab (Vectibix) OR cetuximab (Erbitux) (for KRAS mutation-negative patients only) OR a documented diagnosis of locally advanced, unresectable or metastatic gastrointestinal stromal tumor (GIST) who have been previously treated with imatinib mesylate (Gleevec) and sunitinib malate (Sutent) OR a documented diagnosis of hepatocellular carcinoma (HCC) in patients previously treated with sorafenib (Nexavar) |

# SUTENT

## Products Affected

- SUTENT

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of advanced/metastatic renal cell carcinoma OR Diagnosis of gastrointestinal stromal tumors after disease progression on or intolerance to Gleevec OR Diagnosis of progressive, well-differentiated pancreatic neuroendocrine tumors in a patient with unresectable locally advanced or metastatic disease OR Diagnosis of high risk recurrent renal cell carcinoma following nephrectomy, used as adjuvant therapy. |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | Oncologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Gastrointestinal stromal tumor AND after disease progression on or intolerance to imatinib |

# SYLATRON

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Autoimmune hepatitis. Hepatic decompensation (Child-Pugh score greater than 6 [Class B or C]) |
| **Required Medical Information** | Melanoma: Diagnosis of melanoma with microscopic or gross nodal involvement AND The prescribed medication will be used as adjuvant therapy within 84 days of definitive surgical resection, including complete lymphadenectomy. |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | This criteria applies to new starts only |

# SYMDEKO

## Products Affected

- SYMDEKO

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

# SYNAREL

## Products Affected

- SYNAREL

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Synarel should not be administered to patients who are hypersensitive to GnRH, GnRH agonist analogues or any of the excipients of SYNAREL, have undiagnosed vaginal bleeding, are pregnant or may become pregnant as major fetal abnormalities were observed in rats (not applicable when used in invitro fertilization programs), are breast feeding. |
| **Required Medical Information** | Diagnosis of central precocious puberty OR endometriosis |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# SYNRIBO

## Products Affected

- SYNRIBO

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of chronic myelogenous leukemia AND patient has tried and failed or has a contraindication or intolerance to 2 tyrosine kinase inhibitors |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | This criteria applies to new starts only |

# SYPRINE

## Products Affected

- *trientine hcl*

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

# TABLOID

## Products Affected

- TABLOID

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Supporting statement of diagnosis from the physician |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | Oncologist or hematologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Approve for continuation of prior therapy |

# TAFINLAR

## Products Affected

- TAFINLAR ORAL CAPSULE 50 MG, 75 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of locally advanced or metastatic anaplastic thyroid cancer with documented positive BRAF V600E or V600K mutation as detected by an FDA-approved test as single agent or used in combination with Mekinist OR Diagnosis of metastatic or unresectable melanoma and metastatic non-small cell lung cancer (NSCLC) with BRAF V600E mutation as detected by an FDA-approved test |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | Oncologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Tafinlar should not be used in patients with wild-type BRAF melanoma due to the potential risk of tumor promotion in these patients |

# TAGRISSO

## Products Affected

- TAGRISSO

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of metastatic, non-small cell lung cancer with one of the following- confirmed presence of T790M EGFR tumor mutation OR confirmed presence of epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R tumor mutations, as detected by an FDA-approved test. |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | This criteria applies to new starts only |

# TAKHZYRO

## Products Affected

- TAKHZYRO

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of hereditary angioedema and used for prophylaxis |
| **Age Restrictions** | 12 years of age and older |
| **Prescriber Restrictions** | Prescribed by or in consultation with an allergist or immunologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# TALZENNA

## Products Affected

- TALZENNA ORAL CAPSULE 0.25 MG, 1 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of deleterious or suspected deleterious germline BRCA-mutated HER2-negative locally advanced or metastatic breast cancer |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | Prescribed by or in consultation with a oncologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# TARCEVA

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of locally advanced, unresectable, or metastatic pancreatic cancer and Tarceva will be used in combination with gemcitabine OR Diagnosis of locally advanced or metastatic (stage III or IV) non-small cell lung cancer with one of the following: A) failure with at least one prior chemotherapy regimen and Tarceva will be used as monotherapy, or B) no evidence of disease progression after four cycles of first-line platinum-based chemotherapy and Tarceva will be used as maintenance treatment and Tarceva will be used as monotherapy, or C) Patient has known active epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutation as detected by an FDA-approved test or Clinical Laboratory Improvement Amendments-approved facility. |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | Oncologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For the diagnosis of locally advanced, unresectable, or metastatic carcinoma of pancreas, Tarceva is used in combination with gemcitabine. For the diagnosis of locally advanced or metastatic non-small cell lung cancer, the patient has met one of the following: 1. The patient has failed one or more prior chemotherapy regimens, such as platinum based chemotherapy OR 2. The patient has an epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 (L858R) substitution mutation which requires no prerequisite therapy. |

# TARGRETIN

## Products Affected

- *bexarotene*
- TARGRETIN EXTERNAL

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Supporting statement of diagnosis from the physician |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | Oncologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Definite diagnosis of cutaneous T-cell lymphoma (CTCL) AND refractory to any prior systemic therapy (such as methotrexate) |

# TASIGNA

## Products Affected

- TASIGNA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Long QT syndrome. Uncorrected hypokalemia. Uncorrected hypomagnesemia. Concomitant use with a drug known to prolong the QT interval or strong cytochrome P450 3A4 inhibitors |
| **Required Medical Information** | Diagnosis of newly diagnosed Philadelphia chromosome-positive chronic myelogenous leukemia (Ph+ CML) in the chronic phase OR Diagnosis of Ph+ CML with resistance or intolerance to prior therapy that include imatinib. |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | Oncologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# TECFIDERA

## Products Affected

- TECFIDERA ORAL
- TECFIDERA ORAL CAPSULE DELAYED RELEASE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of relapsing forms of multiple sclerosis (relapsing-remitting MS or progressive-relapsing MS, or secondary-progressive MS) OR patient has experienced a first clinical episode and has MRI features consistent with multiple sclerosis. |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# TEGSEDI

## Products Affected

- TEGSEDI

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | One of the following A) Platelet count less than 100,000 per microliter OR B) urinary protein to creatinine ratio (UPCR) of 1000 mg/g or higher |
| **Required Medical Information** | Diagnosis of A) Polyneuropathy of hereditary transthyretin-mediated amyloidosis |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Tegsedi REMS program enrollment |

# TESTOSTERONE

## Products Affected

- *testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml*
- *testosterone enanthate intramuscular solution*
- *testosterone transdermal gel 10 mg/act (2%), 12.5 mg/act (1%), 20.25 mg/1.25gm (1.62%), 20.25 mg/act (1.62%), 25 mg/2.5gm (1%), 40.5 mg/2.5gm (1.62%), 50 mg/5gm (1%)*
- *testosterone transdermal solution*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of hypogonadism (primary or hypogonadotropic) AND patient is male AND patient's serum testosterone (total or free) value and the laboratory reference value range reported by laboratory service AND diagnosis has been confirmed by a low-for-age serum testosterone (total or free) level defined by the normal laboratory reference value OR diagnosis of inoperable, metastatic breast cancer AND patient is female |
| **Age Restrictions** | 12 years of age and older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For renewal, patient experienced an objective response to therapy. |

# THALOMID

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Supporting statement of diagnosis from the physician |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | Oncologist or infectious disease specialist |
| **Coverage Duration** | Ulcers-1 month. ENL, MM-End of year. WM, GVHD, primary brain tumor-6 months. Other uses-3 months |
| **Other Criteria** | This criteria applies to new starts only |

# TIBSOVO

## Products Affected

- TIBSOVO

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of acute myeloid leukemia in relasped or refractory patients, with susceptible isocitrate dehydrogenase-1 mutation |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | Prescribed by or in consultation with a oncologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# TOREMIFENE

## Products Affected

- *toremifene citrate*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of metastatic breast cancer and patient must have previous inadequate response or intolerance to tamoxifen |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | Prescribed by or in consultation with an oncologist or hematologist |
| **Coverage Duration** | 6 months |
| **Other Criteria** | None |

# TRACLEER

## Products Affected

- TRACLEER ORAL TABLET
- TRACLEER ORAL TABLET SOLUBLE

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Receiving concomitant cyclosporine A or glyburide therapy. Aminotransferase elevations are accompanied by signs or symptoms of liver dysfunction or injury or increases in bilirubin at least 2 times the upper limit of normal. |
| **Required Medical Information** | Diagnosis of pulmonary arterial hypertension that was confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization (e.g., patient is frail, elderly, etc.) AND Patient has WHO Group I PAH AND Patient has New York Heart Association (NYHA) Functional Class II-IV AND pregnancy must be excluded prior to the start of therapy and will be prevented thereafter with two forms of reliable contraception in female patients of reproductive potential. |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 6 months - initial. 12 months - renewal |
| **Other Criteria** | Liver aminotransferases will be measured prior to initiation of treatment and then monthly. |

# TRELSTAR

## Products Affected

- TRELSTAR MIXJECT
  INTRAMUSCULAR SUSPENSION
  RECONSTITUTED 11.25 MG, 3.75 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of FDA approved indications not otherwise excluded from Part D AND palliative treatment of advanced prostate cancer, central precocious puberty, endometrial hyperplasia, endometriosis, fibrocystic disease of breast, uterine leiomyoma |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | This criteria applies to new starts only |

# TYKERB

## Products Affected

- TYKERB

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of breast cancer with tumors that overexpress human epidermal growth factor receptor 2 (HER2) AND a) the medication will be used in combination with Xeloda in a patient with advanced or metastatic disease and the patient has received prior therapy including an anthracycline, a taxane, and trastuzumab or b) The medication will be used in combination with Femara for the treatment of a postmenopausal woman with hormone receptor-positive metastatic disease for whom hormonal therapy is indicated. |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | Oncologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Coverage is provided in combination with capecitabine, for the treatment of patients with advanced or metastatic breast cancer whose tumors overexpress HER2 and who have received prior therapy including an anthracycline, a taxane, and trastuzumab OR in combination with letrozole for the treatment of postmenopausal women with hormone receptor positive metastatic breast cancer that overexpresses the HER2 receptor for whom hormonal therapy is indicated. |

# TYMLOS

## Products Affected

- TYMLOS

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Patients at increased risk of osteogenic sarcoma. |
| **Required Medical Information** | Diagnosis of osteoporosis in post-menopausal women at high risk for fracture. Member must have failed therapy with a bisphosphonate (defined by a fracture while on therapy or worsening bone density) unless such a trial is shown to be inappropriate or contraindicated (i.e., presence of severe osteoporosis [T-scores -3.0 or worse in lumbar spine, femoral neck, or total hip region], history of major osteoporotic fracture, presence of renal insufficiency, etc) AND member has at least one of the following: T-score equal to or worse than -2.5 in the lumbar spine, femoral neck, or total hip region OR a FRAX calculator based 10-year risk of at least 20% for a major osteoporotic fracture (spine, shoulder, hip, or wrist), or a 10-year risk of at least 3% for a hip fracture OR presence or history of osteoporotic fracture. |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | Initial: 12 months. Reauth: Treatment duration has not exceeded 24 months during patient lifetime. |
| **Other Criteria** | None |

# UPTRAVI

## Products Affected

- UPTRAVI

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of pulmonary arterial hypertension (WHO Group 1) confirmed by right heart catheterization AND patient has tried and had an insufficient response to at least one other PAH agent (e.g., sildenafil) therapy and one other ERA agent (e.g. letairis, opsumit, tracleer). |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# VALCHLOR

## Products Affected

- VALCHLOR

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of mycosis fungoides-type cutaneous T-cell lymphoma AND patient has early stage disease (defined as Stage 1A or 1B) AND patient has received prior skin-directed therapy (e.g., very high potency class I topical corticosteroids for at least 3 months (i.e. clobetasol, diflorasone, halobetasol, augmented betamethasone diproprionate), phototherapy, topical nitrogen mustard, or a topical retinoid (e.g., bexarotene)). |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | This criteria applies to new starts only |

# VENCLEXTA

## Products Affected

- VENCLEXTA
- VENCLEXTA STARTING PACK

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of chronic lymphocytic leukemia (CLL) OR small lymphocytic lymphoma, with or without 17p deletion and patient has had at least 1 prior therapy OR Newly-diagnosed acute myeloid leukemia used in combination with azacitidine, decitabine or low-dose cytarabine in patients 75 years or older or in patients with comorbidities that preclude use of intensive induction chemotherapy |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | This criteria applies to new starts only |

# VERZENIO

## Products Affected

- VERZENIO ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG

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

# VITRAKVI

## Products Affected

- VITRAKVI ORAL CAPSULE 100 MG, 25 MG
- VITRAKVI ORAL SOLUTION

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of A) Solid tumors that have a neurotrophic receptor tyrosine kinase (NTRK) gene fusion without a known acquired resistance mutation, are metastatic or where surgical resection is likely to result in severe morbidity, and have no satisfactory alternative treatments or that have progressed following treatment |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | Prescribed by or in consultation with an Oncologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# VIZIMPRO

## Products Affected

- VIZIMPRO

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of metastatic non-small cell lung cancer with confirmed epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 L858R substitution mutations as detected by an FDA-approved test |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | Prescribed by or in consultation with a oncologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# VORICONAZOLE

## Products Affected

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

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Supporting statement of diagnosis from the physician |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | Infectious Disease Specialist |
| **Coverage Duration** | 6 months |
| **Other Criteria** | None |

# VOTRIENT

## Products Affected

- VOTRIENT

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of advanced/metastatic renal cell carcinoma OR Diagnosis of advanced soft tissue sarcoma and patient received at least one prior chemotherapy (e.g., doxorubicin, dacarbazine, ifosfamide, epirubicin, docetaxel, or vinorelbine). |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | This criteria applies to new starts only |

# XALKORI

## Products Affected

- XALKORI

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of locally advanced or metastatic (stage III or IV) non-small cell lung cancer AND patient has non-squamous cell histology AND Patient has anaplastic lymphoma kinase (ALK)-positive disease as detected with an FDA-approved test or Clinical Laboratory Improvement Amendments-approved facility or are ROS1-positive |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | Must be prescribed by an oncologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | This criteria applies to new starts only |

# XENAZINE

## Products Affected

- *tetrabenazine oral tablet 12.5 mg, 25 mg*

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Actively suicidal. Untreated or inadequately treated depression. Impaired hepatic function. Concomitant use of monoamine oxidase inhibitors. Concomitant use of reserpine or within 20 days of discontinuing reserpine. |
| **Required Medical Information** | Diagnosis of chorea associated with Huntington's disease AND any medication possibly contributing to the underlying symptoms of chorea has been discontinued (e.g., antipsychotics, metoclopramide, amphetamines, methylphenidate, dopamine agonists, etc.) unless cessation would be detrimental to the underlying condition AND patient has been genotypes to CYP2D6 to determine whether the patient is a poor, intermediate or extensive metabolizer. |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Dosing will be approved per the FDA labeling based on CYP2D6 testing. For renewal, patient had an objective response to therapy. |

# XGEVA

## Products Affected

- XGEVA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of hypercalcemia of malignancy, refractory to bisphosphonate therapy OR diagnosis of giant cell tumor of bone that is unresectable or where surgical resection is likely to result in severe morbidity OR treatment used for prevention of skeletal-related events in patients with multiple myeloma or bone metastases from solid tumors. |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# XOLAIR

## Products Affected

- XOLAIR

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Documentation of the following: A)moderate to severe chronic idiopathic urticaria and has remained symptomatic despite at least 2 weeks of H1 antihistamine therapy OR intolerance or contraindication of H1 antihistamine therapy OR B)Mod-severe persistent asthma (NHLBI definition) meeting all the following criteria: Evidence of reversible disease (12% or greater improvement in FEV1 with at least a 200ml increase or 20% or greater improvement in PEF as a result of a short-acting bronchodilator challenge). Evidence of specific allergic sensitivity to a perennial aeroallergen (+ skin test or in vitro test). Failure of an adequate trial of standard therapy as defined by a trial of at least a 3 month course of high-dose inhaled corticosteroids and long-acting beta2-agonists OR maximally tolerated doses of standard therapy OR intolerance or contraindication to standard therapy. Extended approval for 6 months if demonstrated benefit, meeting at least 2 of the following criteria: PEF improvement (12% or greater from baseline (prior to start of Xolair)), OR FEV1 improvement (12% or greater from baseline (prior to start of Xolair)), OR reduction in symptoms (wheezing, sob, cough, chest tightness), OR reduction in systemic corticosteroids and rescue drug use, OR reduction of asthma-related hospitalizations and other medical contacts. |
| **Age Restrictions** | 6 years of age and older |
| **Prescriber Restrictions** | Allergist, immunologist, pulmonologist or dermatologist |
| **Coverage Duration** | Initial: 6 months trial. Extended approval: 6 months if demonstrated benefit |
| **Other Criteria** | If this medication is administered by a physician incident to a physicians visit this would be covered by Medicare Part B |

# XOSPATA

## Products Affected

- XOSPATA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of A) Acute myeloid leukemia, relapsed or refractory, with presence of FLT3 mutation as detected by an FDA-approved test |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | Prescribed by or in consultation with an Oncologist or Hematologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | None |

# XTANDI

## Products Affected

- XTANDI

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Metastatic castration-resistant prostate cancer (mCRPC): Diagnosis of mCRPC. History of failure, contraindication or intolerance to Zytiga (abiraterone) OR Diagnosis of Non-metastatic castration-resistant prostate cancer (Zytiga (abiraterone) will not be required) |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | Prescribed or in consultation with an oncologist or urologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | This criteria applies to new starts only |

# XURIDEN

## Products Affected

- XURIDEN

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

# XYREM

## Products Affected

- XYREM

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | Concomitant treatment with sedative hypnotic agents. Succinic semialdehyde dehydrogenase deficiency. |
| **Required Medical Information** | Diagnosis of narcolepsy with excessive daytime sleepiness, confirmed by sleep lab evaluation (e.g., multiple sleep latency test, polysomnography) and for patients with excessive daytime sleepiness, patient has had a previous trial with or has a contraindication, intolerance, or allergy to modafinil, armodafinil, methylphenidate, dextroamphetamine, or mixed amphetamine salts. For diagnosis of cataplexy alone, request will be approved. |
| **Age Restrictions** | 7 years of age and older |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For renewal, the patient had a positive response to the medication (increased sleep quality for patients with narcolepsy) |

# YONSA

## Products Affected

- YONSA

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

# ZAVESCA

## Products Affected

- *miglustat*

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

# ZEJULA

## Products Affected

- ZEJULA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of recurrent epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer and patient had a complete or partial response to platinum-based chemotherapy. |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | Prescribed by or in consultation with a oncologist or gynecologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | This criteria applies to new starts only |

# ZELBORAF

## Products Affected

- ZELBORAF

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of unresectable or metastatic melanoma OR Erdheim-Chester disease. Patient has positive BRAF-V600E mutation documented by an FDA-approved test or Clinical Laboratory Improvement Amendments-approved facility. |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | Oncologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | This criteria applies to new starts only |

# ZOLINZA

## Products Affected

- ZOLINZA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of cutaneous T-cell lymphoma AND progressive, persistent or recurrent disease or patient is not a candidates for or following 2 systemic therapies (e.g., bexarotene, romidepsin, etc.) |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | This criteria applies to new starts only |

# ZORTRESS

## Products Affected

- ZORTRESS ORAL TABLET 0.25 MG, 0.5 MG, 1 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Medication is being used for: A) Prevention of kidney transplant organ rejection AND patient is at low-to-moderate immunologic risk AND member is prescribed concurrent therapy with reduced doses of cyclosporine and corticosteroids, or B) Prevention of liver transplant organ rejection AND 30 or more days have passed since the transplant procedure AND the member is prescribed concurrent therapy with reduced doses of tacrolimus and corticosteroids |
| **Age Restrictions** | 18 years of age and older |
| **Prescriber Restrictions** | Prescriber is experienced in immunosuppressive therapy and management of transplant patients. |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Part B if transplant covered by Medicare. otherwise Part D |

# ZYDELIG

## Products Affected

- ZYDELIG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | The patient has one of the following diagnoses: A) chronic lymphocytic leukemia AND The medication will be used in combination with rituximab AND The patient has relapsed on at least one prior therapy (e.g., purine analogues [fludarabine, pentostatin, cladribine], alkylating agents [chlorambucil, cyclophosphamide], or monoclonal antibodies [rituximab]) AND the patient does not have any co-morbidities that prevents the use of cytotoxic chemotherapy (i.e. severe neutropenia or thrombocytopenia, creatinine clearance less than 60 mL/minute), B) follicular lymphoma AND the patient has relapsed on at least two prior systemic therapies (e.g., rituximab, alkylating agents [cyclophosphamide, chlorambucil], anthracyclines [doxorubicin, daunorubicin], purine analogs [fludarabine]), or C) small lymphocytic lymphoma AND The patient has relapsed on at least two prior systemic therapies(e.g., rituximab, alkylating agents [cyclophosphamide, chlorambucil], anthracyclines [doxorubicin, daunorubicin], purine analogs [fludarabine]). |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | This criteria applies to new starts only |

# ZYKADIA

## Products Affected

- ZYKADIA

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer (NSCLC). |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | This criteria applies to new starts only |

# ZYTIGA

## Products Affected

- *abiraterone acetate*
- ZYTIGA ORAL TABLET 500 MG

| PA Criteria | Criteria Details |
|---|---|
| **Covered Uses** | All medically accepted indications not otherwise excluded from Part D |
| **Exclusion Criteria** | None |
| **Required Medical Information** | Diagnosis of metastatic prostate cancer AND Patient has castration-resistant disease (defined by tumor growth/disease progression, risk in PsA levels, new metastases) OR high-risk castration-sensitive prostate cancer AND Zytiga (abiraterone) will be used in combination with prednisone. |
| **Age Restrictions** | None |
| **Prescriber Restrictions** | None |
| **Coverage Duration** | 12 months |
| **Other Criteria** | This criteria applies to new starts only |

# PART B VERSUS PART D

## Products Affected

- ABELCET
- *acetylcysteine inhalation*
- *acyclovir sodium intravenous solution*
- *albuterol sulfate inhalation*
- AMBISOME
- *amikacin sulfate injection solution 500 mg/2ml*
- AMINOSYN II INTRAVENOUS SOLUTION 10 %, 8.5 %
- AMINOSYN II/ELECTROLYTES
- AMINOSYN/ELECTROLYTES
- AMINOSYN-HBC
- AMINOSYN-PF
- AMINOSYN-RF
- *amphotericin b intravenous*
- *ampicillin sodium injection solution reconstituted 1 gm, 125 mg*
- *ampicillin sodium intravenous solution reconstituted 10 gm*
- *ampicillin-sulbactam sodium injection*
- *aprepitant oral capsule 125 mg, 40 mg, 80 & 125 mg, 80 mg*
- ASTAGRAF XL
- AZACTAM INJECTION SOLUTION RECONSTITUTED 2 GM
- AZASAN
- *azathioprine oral*
- *azithromycin intravenous*
- *calcitonin (salmon)*
- *calcitriol oral*
- *caspofungin acetate*
- *cefazolin sodium injection solution reconstituted 1 gm, 10 gm, 500 mg*
- *cefepime hcl injection*
- *cefoxitin sodium*
- *ceftriaxone sodium injection solution reconstituted 1 gm, 2 gm, 250 mg, 500 mg*
- *ceftriaxone sodium intravenous solution reconstituted 10 gm*
- *cefuroxime sodium injection solution reconstituted 7.5 gm, 750 mg*
- *cefuroxime sodium intravenous solution reconstituted 1.5 gm*
- *chlorpromazine hcl oral*
- *ciprofloxacin in d5w intravenous solution 200 mg/100ml*
- *clindamycin phosphate injection solution 300 mg/2ml, 600 mg/4ml, 900 mg/6ml*
- CLINIMIX E/DEXTROSE (2.75/5)
- CLINIMIX E/DEXTROSE (4.25/10)
- CLINIMIX E/DEXTROSE (4.25/5)
- CLINIMIX E/DEXTROSE (5/15)
- CLINIMIX E/DEXTROSE (5/20)
- CLINIMIX/DEXTROSE (4.25/10)
- CLINIMIX/DEXTROSE (4.25/25)
- CLINIMIX/DEXTROSE (4.25/5)
- CLINIMIX/DEXTROSE (5/15)
- CLINIMIX/DEXTROSE (5/20)
- CLINIMIX/DEXTROSE (5/25)
- *colistimethate sodium (cba)*
- *cromolyn sodium inhalation*
- *cyclophosphamide oral capsule*
- *cyclosporine modified*
- *cyclosporine oral capsule*
- *daptomycin*
- DEPO-PROVERA INTRAMUSCULAR SUSPENSION 400 MG/ML
- *dextrose intravenous solution 10 %, 5 %*
- *dextrose-nacl intravenous solution 10-0.2 %, 10-0.45 %, 2.5-0.45 %, 5-0.2 %, 5-0.225 %, 5-0.33 %, 5-0.45 %, 5-0.9 %*
- *diphtheria-tetanus toxoids dt*
- *doripenem intravenous solution reconstituted 500 mg*
- *doxercalciferol oral*
- DOXY 100
- *dronabinol*
- EMEND ORAL SUSPENSION RECONSTITUTED
- ENGERIX-B INJECTION
- ERAXIS INTRAVENOUS SOLUTION RECONSTITUTED 50 MG
- *ertapenem sodium*
- ERYTHROCIN LACTOBIONATE INTRAVENOUS SOLUTION RECONSTITUTED 500 MG

- *fluconazole in sodium chloride intravenous solution 200-0.9 mg/100ml-%, 400-0.9 mg/200ml-%*
- FREAMINE HBC
- *furosemide injection*
- GENGRAF ORAL CAPSULE 100 MG, 25 MG
- GENGRAF ORAL SOLUTION
- *gentamicin sulfate injection solution 40 mg/ml*
- *granisetron hcl oral*
- *heparin sodium (porcine) injection solution 1000 unit/ml, 10000 unit/ml, 20000 unit/ml, 5000 unit/ml*
- HEPATAMINE
- *hydromorphone hcl pf injection solution 10 mg/ml, 50 mg/5ml*
- *imipenem-cilastatin*
- IMOVAX RABIES
- INTRALIPID
- *ipratropium bromide inhalation*
- *ipratropium-albuterol*
- ISOLYTE-S
- *kcl in dextrose-nacl intravenous solution 10-5-0.45 meq/l-%-%, 20-5-0.2 meq/l-%-%, 20-5-0.33 meq/l-%-%, 20-5-0.45 meq/l-%-%, 20-5-0.9 meq/l-%-%, 30-5-0.45 meq/l-%-%, 40-5-0.45 meq/l-%-%, 40-5-0.9 meq/l-%-%*
- *levocarnitine oral solution*
- *levocarnitine oral tablet*
- *levofloxacin in d5w intravenous solution 500 mg/100ml, 750 mg/150ml*
- *levofloxacin intravenous*
- *magnesium sulfate injection solution 50 %, 50 % (10ml syringe)*
- *meropenem*
- *methotrexate oral*
- *methotrexate sodium (pf) injection solution 50 mg/2ml*
- *methotrexate sodium injection solution 250 mg/10ml*
- *metronidazole in nacl intravenous solution 500-0.79 mg/100ml-%*
- *moxifloxacin hcl in nacl*
- *mycophenolate mofetil*
- *mycophenolate sodium*
- *nafcillin sodium injection solution reconstituted 1 gm, 2 gm*
- *nafcillin sodium intravenous solution reconstituted 10 gm*
- NEBUPENT
- NEPHRAMINE
- NORMOSOL-M IN D5W
- NORMOSOL-R IN D5W
- NORMOSOL-R PH 7.4
- *nutrilipid*
- OCTAGAM INTRAVENOUS SOLUTION 1 GM/20ML, 2 GM/20ML
- *ondansetron*
- *ondansetron hcl oral solution*
- *ondansetron hcl oral tablet*
- PANZYGA
- *paricalcitol oral*
- *penicillin g potassium injection solution reconstituted 20000000 unit*
- *penicillin g sodium*
- PENTAM
- *perphenazine oral tablet 4 mg, 8 mg*
- *piperacillin sod-tazobactam so intravenous solution reconstituted 2.25 (2-0.25) gm, 3.375 (3-0.375) gm, 4.5 (4-0.5) gm, 40.5 (36-4.5) gm*
- PLASMA-LYTE 148
- PLASMA-LYTE A
- *potassium chloride in dextrose intravenous solution 20-5 meq/l-%, 40-5 meq/l-%*
- *potassium chloride in nacl intravenous solution 20-0.45 meq/l-%, 20-0.9 meq/l-%, 40-0.9 meq/l-%*
- *potassium chloride intravenous solution 2 meq/ml, 2 meq/ml (20 ml), 20 meq/100ml*
- PREMASOL
- PRIVIGEN INTRAVENOUS SOLUTION 20 GM/200ML
- PROCALAMINE
- *prochlorperazine maleate oral*
- PROGRAF ORAL PACKET
- PROSOL
- RABAVERT
- RECOMBIVAX HB

- *rifampin intravenous*
- SANDIMMUNE ORAL
- SENSIPAR ORAL TABLET 30 MG, 60 MG, 90 MG
- *sirolimus oral*
- *sodium chloride intravenous solution 0.45 %, 0.9 %, 3 %, 5 %*
- SYNDROS
- *tacrolimus oral*
- TDVAX
- TEFLARO
- TENIVAC
- *tigecycline*
- *tobramycin inhalation*
- *tobramycin sulfate injection solution 10 mg/ml, 80 mg/2ml*
- TPN ELECTROLYTES INTRAVENOUS SOLUTION
- TRAVASOL
- TROPHAMINE INTRAVENOUS SOLUTION 10 %
- TWINRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE
- *vancomycin hcl intravenous solution reconstituted 1 gm, 10 gm, 250 mg, 500 mg, 750 mg*
- VARUBI ORAL
- *voriconazole intravenous*
- XATMEP

## 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.

## Index of Drugs/Alphabetical Listing