GuildNet Gold HMO SNP

2018 Prior Authorization (PA) Criteria

Certain drugs require prior authorization from GuildNet Gold Medicare Plan. This means that your doctor must contact us to get approval before prescribing the drug to you. If your doctor does not get prior approval, the drug may not be covered.

This list also includes drugs that may be covered under Medicare Part B or Part D depending on how the drugs are used or administered. If your drug is on this list, your doctor should call us and to provide information describing the use and administration of the drug so we can advise on whether the drug will be covered.

To see if your drug is on the list, refer to the index located at the end of this document for the medication you are looking for.

H6864_GN263_PA Criteria_Accepted

ACTHAR

Products Affected

- Acthar H.P.

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Use in patients with multiple sclerosis (MS) as pulse therapy on a monthly basis. Use as maintenance therapy in patients with psoriatic arthritis, rheumatoid arthritis, or ankylosing spondylitis. Treatment of proteinuria in diabetic nephropathy.
Required Medical Information	MS exacerbation, rheumatic disorder exacerbation, history of corticosteroid use, concomitant use of disease-modifying antirheumatic drugs (DMARDs).
Age Restrictions	N/A
Prescriber Restrictions	Infantile spasms, prescribed by or in consultation with a neurologist or an epileptologist. MS exacerbation, prescribed by or in consultation with a neurologist or physician that specializes in the treatment of MS. Rheumatic disorder exacerbation, prescribed by or in consultation with a rheumatologist.
Coverage Duration	One month
Other Criteria	For MS exacerbation and rheumatic disorder exacerbation, approve if the patient cannot use high-dose IV corticosteroids because IV access is not possible or if the patient has tried high-dose corticosteroids administered IV for an acute exacerbation and has experienced a severe or limiting adverse effect.

ACTIMMUNE

Products Affected

- Actimmune

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ADCIRCA

Products Affected

- Adcirca

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Nitrate therapy
Required Medical Information	PAH been confirmed by right heart catheterization.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ADEMPAS

Products Affected

- Adempas

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

AFINITOR

Products Affected

- Afinitor
- Afinitor Disperz

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Plan Year
Other Criteria	N/A

ALECENSA

Products Affected

- Alecensa

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Patients already started on Alecensa for a covered use
Exclusion Criteria	Xalkori (Crizotinib) treatment naive patients
Required Medical Information	Confirmed ALK-positive NSCLC as detected by an FDA-approved test and prior therapies tried
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	Plan Year
Other Criteria	Anaplastic lymphoma kinase (ALK)-positive, metastatic non-small cell lung cancer (NSCLC): The patient has metastatic ALK-positive NSCLC as detected by an FDA-approved test AND The patient has progressed on or are intolerant to Xalkori (crizotinib)

ALOSETRON

Products Affected

- alosetron

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D coverage
Exclusion Criteria	Patient has a history of any of the following conditions: Chronic or severe constipation or sequelae from constipation. Intestinal obstruction, stricture, toxic megacolon, gastrointestinal perforation, and/or adhesions. Ischemic colitis. Impaired intestinal circulation, thrombophlebitis or hypercoagulable state. Crohn's disease or ulcerative colitis. Diverticulitis. Severe hepatic impairment.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	For diagnosis of severe diarrhea-predominant irritable bowel syndrome (IBS) alosetron is being prescribed for a woman AND chronic IBS symptoms have lasted at least 6 months AND gastrointestinal tract abnormalities have been ruled out AND the patient has had inadequate response to conventional therapy.

ALUNBRIG

Products Affected

- Alunbrig

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Concurrent use with other chemotherapy, patients with ALK-negative NSCLC, pediatric patients less than 18 years of age
Required Medical Information	Diagnosis, prior therapies, ALK-positive NSCLC confirmed by an FDA-approved test
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	Plan Year
Other Criteria	For NSCLC, patient has metastatic or recurrent disease that is ALK-positive as detected by an FDA-approved test AND Alunbrig is being used as a single agent AND patient has progressed on Xalkori (crizotinib)

AMPYRA

Products Affected

- Ampyra

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

ANADROL

Products Affected

- Anadrol-50

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ANTICONVULSANTS

Products Affected

- topiramate oral capsule, sprinkle
- topiramate oral capsule,sprinkle,ER 24hr
- topiramate oral tablet
- zonisamide

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

APOKYN

Products Affected

- APOKYN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

APTIOM

Products Affected

- Aptiom

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ARCALYST

Products Affected

- Arcalyst

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patient already started on rilonacept for Muckle Wells Syndrome (MWS) or Familial Cold Autoinflammatory Syndrome (FCAS).
Exclusion Criteria	Rilonacept should not be given in combination with biologic therapy (e.g. tumor necrosis factor (TNF) blocking agents (eg, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab), anakinra, or canakinumab).
Required Medical Information	N/A
Age Restrictions	Initial tx CAPS-Greater than or equal to 12 years of age.
Prescriber Restrictions	Initial tx CAPS-prescribed by, or in consultation with, a rheumatologist, geneticist, dermatologist or immunologist.
Coverage Duration	Plan Year
Other Criteria	CAPS renewal - approve if they have had a response and are continuing therapy to maintain response/remission.

AUBAGIO

Products Affected

- Aubagio

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Concurrent use of Aubagio with other disease-modifying agents used for multiple sclerosis (MS)
Required Medical Information	MS, patient must have a relapsing form of MS (RRMS, SPMS with relapses, or PRMS). MS, previous MS therapies tried.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist or physician who specializes in the treatment of MS.
Coverage Duration	Plan Year
Other Criteria	N/A

AVONEX

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Concurrent use of other disease-modifying agents used for multiple sclerosis (MS)
Required Medical Information	Multiple Sclerosis (MS) diagnosis worded or described as patients with a diagnosis of MS or have experienced an attack and who are at risk of MS.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist or physician who specializes in the treatment of MS.
Coverage Duration	Plan Year
Other Criteria	N/A

BANZEL

Products Affected

- Banzel oral tablet

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

BAVENCIO

Products Affected

- Bavencio

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	For urothelial carcinoma, treatment naive patients
Required Medical Information	For urothelial carcinoma, previous treatment with platinum-containing chemotherapy
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist
Coverage Duration	Plan Year
Other Criteria	For Locally Advanced or Metastatic Urothelial Carcinoma patient must have disease progression during or after platinum-containing chemotherapy or within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy

BOSULIF

Products Affected

- Bosulif

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D. Plus patients already started on Bosulif for a Covered Use.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis for which Bosulif is being used. For chronic myelogenous leukemia (CML), the Philadelphia chromosome (Ph) status of the leukemia must be reported. For CML, prior therapies tried must be reported to confirm resistance or intolerance.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	Plan Year
Other Criteria	For CML, patient must have Ph-positive CML and must have resistance or intolerance to any one prior therapy for approval.

BRIVIACT

Products Affected

- Briviact

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

CABOMETYX

Products Affected

- Cabometyx

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, medication history, histology, RET gene rearrangement status
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	Plan Year
Other Criteria	Advance Renal Cell Carcinoma-Patients must meet both 1 AND 2-1. Patient has RCC with predominant clear-cell histology 2. Patient has tried one tyrosine kinase inhibitor therapy (e.g., Sutent [sunitinib malate capsules], Votrient [pazopanib tablets], Inlyta [axitinib tablets], Nexavar [sorafenib tosylate tablets]).

CHOLBAM

Products Affected

- Cholbam

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	baseline liver function tests
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with hepatologist, metabolic specialist, or GI
Coverage Duration	Initial approval for 3 months, continuation approval for plan year
Other Criteria	For continuation of therapy to be approved patient must meet 2 of the 3 following lab criteria or meet 1 of the 3 follow lab criteria and have body weight increased by 10% or stable at greater than the 50th percentile. Lab criteria: (1) patient alanine aminotransferase (ALT) or aspartate aminotransferase (AST) less than 50 U/L or the baseline levels reduced by 80%, (2) patient total bilirubin level must be reduced to less than or equal to 1 mg/dL, (3) patient must not have evidence of cholestasis on liver biopsy.

CHORIONIC GONADOTROPINS (HCG)

Products Affected

- chorionic gonadotropin, human
- Novarel intramuscular recon soln 10,000 unit
- Pregnyl

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

CIALIS

Products Affected

- Cialis oral tablet 2.5 mg, 5 mg

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Indication for which tadalafil is being prescribed.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Benign prostatic hyperplasia (BPH), after confirmation that tadalafil is being prescribed to treat the signs and symptoms of BPH and not for the treatment of erectile dysfunction (ED) and after a trial of an alpha-1 blocker (eg, doxazosin [Cardura XL], terazosin, tamsulosin [Flomax], alfuzosin extended-release [UroXatral]) or 5 alpha reductase inhibitor (eg, finasteride, dutasteride [Avodart]).

CINRYZE

Products Affected

- Cinryze

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Must be prescribed by, or in consultation with, an allergist/immunologist or a physician that specializes in the treatment of HAE or related disorders.
Coverage Duration	Plan Year
Other Criteria	N/A

COMETRIQ

Products Affected

- Cometriq

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D. Plus patients already started on Cometriq for a Covered Use.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of progressive, metastatic medullary thyroid cancer.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	Plan Year
Other Criteria	N/A

CORLANOR

Products Affected

- Corlanor

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

COTELLIC

Products Affected

- Cotellic

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Previous therapies tried, presence of BRAF V600E or V600K mutation confirmed by an FDA approved test
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	Plan Year
Other Criteria	Melanoma - being prescribed in combination with vemurafenib

CRINONE

Products Affected

- Crinone

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

CYRAMZA

Products Affected

- Cyramza

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Previous therapies tried
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	Plan Year
Other Criteria	For gastric cancer or malignant neoplasm of cardio-esophageal junction of stomach, prior therapy with fluoropyrimidine- or platinum-containing therapy. For metastatic colorectal cancer, in combination with 5-fluorouracil, leucovorin, irinotecan (FOLFIRI) and prior therapy with Avastin (bevacizumab), oxaliplatin, and a fluoropyrimidine. For metastatic NSCLC, in combination with docetaxel and prior therapy with platinum-based chemotherapy. Part B versus D determination per CMS guidance.

DARAPRIM

Products Affected

- Daraprim

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D coverage
Exclusion Criteria	hypersensitivity to pyrimethamine, documented megaloblastic anemia due to folate deficiency
Required Medical Information	Medication history, patient's immune status
Age Restrictions	N/A
Prescriber Restrictions	Toxoplasma gondii Encephalitis, Chronic Maintenance and Prophylaxis (Primary)-prescribed by or in consultation with an infectious diseases specialist. Toxoplasmosis Treatment-prescribed by or in consultation with an infectious diseases specialist, a maternal-fetal medicine specialist, or an ophthalmologist.
Coverage Duration	Plan Year
Other Criteria	Malaria Prophylaxis, approve if the patient has tried at least two other antimalarials (eg, atovaquone-proguanil, chloroquine phosphate, hydroxychloroquine sulfate, doxycycline, mefloquine, and primaquine). Malaria Treatment, approve if the patient has tried at least two other antimalarials (eg, Coartem [artemether-lumefantrine tablets], quinine sulfate or quinidine gluconate in combination with doxycycline, tetracycline, or clindamycin, quinine sulfate in combination with primaquine and either doxycycline or tetracycline, or the following medications as monotherapy or in combination with primaquine: atovaquone-proguanil, mefloquine, chloroquine phosphate, and hydroxychloroquine). Toxoplasma gondii Encephalitis, Chronic Maintenance, approve if the patient is immunosuppressed. Toxoplasma gondii Encephalitis Prophylaxis (Primary), approve if the patient is immunosuppressed and the patient has tried one other recommended therapy, unless contraindicated (eg, trimethoprim-sulfamethoxazole [TMP-SMX], atovaquone).

DARZALEX

Products Affected

- Darzalex

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Treatment-naive patients
Required Medical Information	History of previous treatments
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	Plan Year
Other Criteria	For the treatment of Multiple myeloma as monotherapy, patients must have received at least three prior lines of therapy including a proteasome inhibitor (PI) and an immunomodulatory agent or are double-refractory to a PI and an immunomodulatory agent. For the treatment of Multiple myeloma in combination with pomalidomide and dexamethasone, patients must have received at least two prior therapies including lenalidomide and a proteasome inhibitor. For the treatment of Multiple myeloma, In combination with lenalidomide plus dexamethasone or bortezomib plus dexamethasone patients must have received at least one prior therapy.

DEMSER

Products Affected

- Demser

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

DICLOFENAC GEL

Products Affected

- diclofenac sodium topical gel 3 %

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

DIGOXIN

Products Affected

- Digitek
- digoxin injection solution
- digoxin oral solution 50 mcg/mL
- digoxin oral tablet

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D coverage
Exclusion Criteria	N/A
Required Medical Information	The physician has documented the indication for the continued use of the HRM (high risk medication) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician will continue to monitor for side effects, AND the physician has documented that the patient has tried and failed digoxin 0.125mg daily or provided clinical rationale as to why the lower dose is not appropriate for the patient.
Age Restrictions	This prior authorization only applies to members 65 years of age or older to ensure safe use of a potentially high risk medication in the elderly population. Members under 65 years of age are not subject to the prior authorization requirements.
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

EGRIFTA

Products Affected

- Egrifta subcutaneous recon soln 1 mg

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis.
Age Restrictions	Adults
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist or a physician specializing in the treatment of HIV (eg, infectious disease, oncology).
Coverage Duration	Plan Year
Other Criteria	HIV-infected adult patients (18 years of age or older) with lipodystrophy AND Egrifta is being used to reduce excessive abdominal fat

EMPLICITI

Products Affected

- Empliciti

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Treatment-naive patients
Required Medical Information	History of previous treatments
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	Plan Year
Other Criteria	For the treatment of multiple myeloma, patient must have received at least one prior therapy. Part B versus Part D determination will be made at time of prior authorization review per CMS guidance.

EPCLUSA

Products Affected

- Epclusa

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Combination use with other direct acting antivirals, excluding ribavirin.
Required Medical Information	Documentation from the medical record of diagnosis including genotype, HCV RNA viral levels prior to treatment, history of previous HCV therapies, and presence/absence of cirrhosis. For patients with cirrhosis, cirrhosis must be documented by FibroScan, FibroTest ActiTest, liver biopsy, or radiological imaging.
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician, or a liver transplant physician.
Coverage Duration	12 weeks, based on indication and current AASLD/IDSA guidance.
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance

ERIVEDGE

Products Affected

- Erivedge

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus, patient already started on Erivedge for a covered use.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	Plan Year
Other Criteria	Locally advanced basal cell carcinoma (LABCC), approve if the patients BCC has recurred following surgery or the patient is not a candidate for surgery or radiation therapy.

ERWINAZE

Products Affected

- Erwinaze

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Documentation of hypersensitivity to Escherichia coli derived asparaginase as a component of a multi-agent chemotherapeutic regimen.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist or Hematologist
Coverage Duration	Plan Year
Other Criteria	N/A

ESBRIET

Products Affected

- Esbriet

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

EXTAVIA

Products Affected

- Extavia subcutaneous kit

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Concurrent use of any of the following medications: Interferon-beta therapy (Avonex, Betaseron, Extavia, or Rebif), mitoxantrone, fingolimod, teriflunomide, or dimethyl fumarate.
Required Medical Information	Multiple Sclerosis (MS) diagnosis worded or described as patients with a diagnosis of MS or have experienced an attack and who are at risk of MS.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist or physician who specializes in the treatment of MS.
Coverage Duration	Plan Year
Other Criteria	Patients with previous use (12 or more months) of Extavia must demonstrate one of the following clinical responses: decrease in the frequency of relapses, slowing of disease progression, MRI lesions have diminished with therapy, OR patient is stable on therapy.

FABRAZYME

Products Affected

- Fabrazyme intravenous recon soln 35 mg

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

FARYDAK

Products Affected

- Farydak

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist or Hematologist
Coverage Duration	Plan Year
Other Criteria	Must be used in combination with Velcade and dexamethasone AND previously tried Velcade and one immunomodulatory drug (i.e., Thalomid, Revlimid, or Pomalyst).

FERRIPROX

Products Affected

- Ferriprox oral tablet

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

FIRAZYR

Products Affected

- Firazyr

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

FYCOMPA

Products Affected

- Fycompa oral suspension
- Fycompa oral tablet

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a Neurologist
Coverage Duration	Plan Year
Other Criteria	N/A

GATTEX

Products Affected

- Gattex 30-Vial

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

GILOTRIF

Products Affected

- Gilotrif

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	For metastatic non-small cell lung cancer (NSCLC) documentation of epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations as detected by an FDA-approved test. For metastatic squamous NSCLC, documentation of prior platinum-based chemotherapy.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	Plan Year
Other Criteria	N/A

GLATOPA/COPAXONE

Products Affected

- Glatopa

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrent use of any of the following medications: Interferon-beta therapy (Avonex, Betaseron, Extavia, or Rebif), mitoxantrone, fingolimod, teriflunomide, or dimethyl fumarate.
Required Medical Information	Previous therapies tried. Multiple Sclerosis (MS) diagnosis worded or described as patients with a diagnosis of MS or have experienced an attack and who are at risk of MS.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist or physician who specializes in the treatment of MS.
Coverage Duration	Plan year
Other Criteria	Patients with previous use (12 or more months) of Glatopa must demonstrate one of the following clinical responses: decrease in the frequency of relapses, slowing of disease progression, diminished MRI lesions, OR patient is stable on therapy.

GROWTH HORMONE

Products Affected

- Norditropin FlexPro

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	For pediatric GHD in neonate with hypoglycemia: patient has a randomly assessed GH level less than 20 ng/mL, other causes of hypoglycemia have been ruled out, and other treatments have been ineffective. For all pediatric patients: patients have short stature or slow growth velocity and have been evaluated for other causes of growth failure. For pediatric GHD, patient has delayed bone age. For pediatric GHD without pituitary disease, patient failed 2 stimulation tests. For pediatric GHD with a pituitary or CNS disorder, patient has clinical evidence of GHD and low IGF-1/IGFBP3. For TS and SHOX patients: diagnosis confirmed by genetic testing. For CRI patients: metabolic, endocrine and nutritional abnormalities have been treated or stabilized and patient has not had a kidney transplant. For SGA: patient has a low birth weight or length for gestational age. For ISS: pediatric GHD has been ruled out with one stimulation test. For adult GHD, patient was assessed for other causes of GHD-like symptoms. For adult GHD without pituitary disease, patient failed 2 stimulation tests. For adult GHD with at least 3 pituitary hormone deficiencies (PHD) or panhypopituitarism: have a low IGF-1. For adult GHD with less than 3 PHD, low IGF-1 and failed one stimulation test. For renewal: patient has seen clinical improvement.
Age Restrictions	For Turner syndrome and SGA, 2 years of age and older. For Noonan syndrome and SHOX, 3 years of age and older.
Prescriber Restrictions	Endocrinologist, Pediatric Nephrologist, Gastroenterologist, Nutritional Support Specialist, Infectious Disease Specialist
Coverage Duration	Plan Year
Other Criteria	N/A

HARVONI

Products Affected

- Harvoni

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Combination use with other direct acting antivirals, excluding ribavirin.
Required Medical Information	Documentation from the medical record of diagnosis including genotype, HCV RNA viral levels prior to treatment, history of previous HCV therapies, and presence/absence of cirrhosis. For patients with cirrhosis, cirrhosis must be documented by FibroScan, FibroTest ActiTest, liver biopsy, or radiological imaging.
Age Restrictions	12 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician, or a liver transplant physician.
Coverage Duration	12 to 24 weeks, based on indication and current AASLD/IDSA guidance.
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance

HETLIOZ

Products Affected

- Hetlioz

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	For the indication of Non-24-Hour Sleep-Wake Disorder (Non-24), approval will only be granted for patients who are totally blind.

HRM

Products Affected

- benztropine oral
- butalbital-acetaminop-caf-cod
- butalbital-acetaminophen-caff oral capsule 50-325-40 mg
- butalbital-aspirin-caffeine oral capsule
- clemastine oral tablet 2.68 mg
- cyclobenzaprine oral tablet
- cyproheptadine
- ergoloid
- meprobamate
- metaxalone
- methyldopa-hydrochlorothiazide
- promethazine oral tablet
- trihexyphenidyl

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve when the provider has assessed the risk versus benefit in using this High Risk Medication (HRM) in the patient and has confirmed that they would still like to initiate or continue therapy

HRM - BENZODIAZEPINES

Products Affected

- alprazolam oral tablet extended release 24 hr 1 mg, 2 mg, 3 mg
- Lorazepam Intensol
- lorazepam oral tablet
- oxazepam
- temazepam

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
Prescriber Restrictions	N/A
Coverage Duration	Procedure-related sedation = 1mo. All other conditions = Plan Year.
Other Criteria	All medically accepted indications other than insomnia, authorize use. Insomnia, approve lorazepam, oxazepam, or temazepam if the patient has had a trial with two of the following: ramelteon, trazodone, doxepin 3mg or 6 mg, eszopiclone, zolpidem, or zaleplon.

HRM BENZODIAZEPINES/ANTICONVULSANTS

Products Affected

- clonazepam oral tablet,disintegrating
- clorazepate dipotassium
- Diazepam Intensol
- diazepam oral solution 5 mg/5 mL (1 mg/mL)
- diazepam oral tablet

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve when the provider has assessed the risk versus benefit in using this High Risk Medication (HRM) in the patient and has confirmed that they would still like to initiate or continue therapy

HRM PD

Products Affected

- amitriptyline
- clomipramine
- doxepin oral
- estradiol oral
- imipramine HCl
- imipramine pamoate
- megestrol oral tablet
- perphenazine-amitriptyline
- phenobarbital
- trimipramine

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Approve when the provider has assessed the risk versus benefit in using this High Risk Medication (HRM) in the patient and has confirmed that they would still like to initiate or continue therapy

HYDROXYPROGESTERONE

Products Affected

- hydroxyprogesterone caproate

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

IBRANCE

Products Affected

- Ibrance

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	Plan Year
Other Criteria	N/A

ICLUSIG

Products Affected

- Iclusig

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Diagnosis the Philadelphia chromosome (Ph) status of the leukemia must be reported. T315I status
Age Restrictions	CML/ALL - Adults
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	Plan Year
Other Criteria	CML Ph+, T315I-positive or has tried TWO other TKIs indicated for use in Philadelphia chromosome positive CML (e.g., Gleevec, Sprycel, Tasigna). ALL Ph+, T315I-posistive or has tried TWO other TKIs indicated for use in Ph+ ALL (e.g. Gleevec, Sprycel.)

ILARIS

Products Affected

- Ilaris (PF) subcutaneous recon soln

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	When used in combination with concurrent biologic therapy (e.g.TNF antagonists, etanercept, adalimumab, certolizumab pegol, golimumab, infliximab), anakinra, or rilonacept.
Required Medical Information	N/A
Age Restrictions	CAPS-4 years of age and older. SJIA-2 years of age and older.
Prescriber Restrictions	CAPS/MWS/FCAS initial- Prescribed by or in consultation with a rheumatologist, geneticist, immunologist or dermatologist. SJIA initial-prescribed by or in consultation with a rheumatologist
Coverage Duration	Plan Year
Other Criteria	For renewal of CAPS/MWS/FCAS - after pt had been started on Ilaris, approve if the pt had a response to therapy as determined by prescribing physician and the pt is continuing therapy to maintain a response/remission. For treatment of SJIA, initial therapy approve if the pt meets one of the following 1. has tried at least 2 other biologics for SJIA (tocilizumab, abatacet, TNF antagonists (e.g. etanercept, adalimumab, infliximab) OR 2. pt has features of poor prognosis (e.g. arthritis of the hip, radiographic damage, 6-month duration of significant active systemic disease, defined by fever, elevated inflammatory markers, or requirement for treatment with systemic glucocorticoids AND tried Actemra or Kineret. SJIA renewal approve if it patient was already started on Ilaris and the pt had a response (e.g. resolution of fever, improvement in limitations of motion, less joint pain or tenderness, decreased duration of morning stiffness or fatigue, improved function or ADLs, reduced dosage of CS) and the pt is continuing therapy to maintain response/remission.

IMATINIB/GLEEVEC

Products Affected

- imatinib oral tablet 100 mg, 400 mg

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Chronic myeloid leukemia (CML) and acute lymphoblastic leukemia (ALL) must be positive for the Philadelphia chromosome or BCR-ABL gene. For CML, patient meets one of the following: 1) newly diagnosed, 2) resistance or intolerance to prior therapy, or 3) recurrence after stem cell transplant. For ALL, patient meets one of the following: 1) newly diagnosed and imatinib is used in combination with chemotherapy, or 2) ALL is relapsed or refractory. For GIST, patient meets one of the following: 1) unresectable, recurrent, or metastatic disease, or 2) use of imatinib for adjuvant therapy following resection, or 3) use of imatinib for pre-operative therapy and patient is at risk for significant surgical morbidity.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	Plan Year
Other Criteria	N/A

IMBRUVICA

Products Affected

- Imbruvica

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	For patients with mantle cell lymphoma (MCL)-history of prior treatment.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	Plan Year
Other Criteria	N/A

IMFINZI

Products Affected

- Imfinzi

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Treatment naive patients, pregnancy
Required Medical Information	Diagnosis, prior treatment with platinum-based chemotherapy
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	Plan Year
Other Criteria	For locally advanced or metastatic urothelial carcinoma, patient had disease progression during or following platinum-containing chemotherapy or patient had disease progression within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy

INLYTA

Products Affected

- Inlyta

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus, patients already started on Inlyta for a Covered Use.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	Plan Year
Other Criteria	Advanced renal cell carcinoma, approve the patient has failed at least one prior systemic therapy (eg, Torisel, Avastin, Sutent, IFN-alpha, IL-2, Votrient, Nexavar).

IRESSA

Products Affected

- Iressa

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	Plan Year
Other Criteria	Metastatic NSCLC - The patient has epidermal growth factor receptor (EGFR) exon 19 deletions OR has exon 21 (L858R) substitution mutations as detected by an FDA-approved test.

IVIG

Products Affected

- Gammagard Liquid
- Gamunex-C injection solution 1 gram/10 mL (10 %)

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

JAKAFI

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus, patients already started on Jakafi for a Covered Use.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist or Hematologist
Coverage Duration	Plan Year
Other Criteria	For polycythemia vera patients must have tried hydroxyurea

JUXTAPID

Products Affected

- Juxtapid

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

KADCYLA

Products Affected

- Kadcyla intravenous recon soln 100 mg

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	HER2 overexpression status. Prior therapies tried.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	Plan Year
Other Criteria	N/A

KALYDECO

Products Affected

- Kalydeco

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Patients with cystic fibrosis who are homozygous for the F508del mutation in the CFTR gene.
Required Medical Information	CF mutation test documenting a G551D, G1244E, G1349D, G178R, G551S, R117H, S1251N, S1255P, S549N, or S549R mutation in the CFTR gene.
Age Restrictions	2 years of age and older for packets. 6 years of age and older for tablets.
Prescriber Restrictions	Prescribed by or inconsultation with a pulmonologist or a physician who specializes in CF
Coverage Duration	Plan Year
Other Criteria	N/A

KEVEYIS

Products Affected

- Keveyis

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Patient with history of hypersensitivity to diclorphenamide or other sulfonamides, Patient on high dose aspirin, Patient with severe pulmonary disease, Patient with hepatic insufficiency
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial therapy - 2 months, Continuing therapy - plan year
Other Criteria	Hyperkalemic Periodic Paralysis (HyperPP) and Related Variants: Patient has a confirmed diagnosis of primary hyperkalemic periodic paralysis by meeting at least ONE of the following criteria: Patient has had an increase from baseline in serum potassium concentration of greater than or equal to 1.5 mEq/L during a paralytic attack OR Patient has had a serum potassium concentration during a paralytic attack of greater than 5.0 mEq/L OR Patient has a family history of the condition OR Patient has a genetically confirmed skeletal muscle sodium channel mutation AND The prescribing physician has excluded other reasons for acquired hyperkalemia (e.g., drug abuse, renal and adrenal dysfunction) For Continuation of treatment a patient has decrease in the frequency or severity of paralytic attacks with treatment as determined by the prescribing physician. For Hypokalemic Periodic Paralysis (HypoPP) and Related Variants for Initiation of treatment: Patient has a confirmed diagnosis of primary hypokalemic periodic paralysis by meeting at least ONE of the following: Patient has had a serum potassium concentration of less than 3.5 mEq/L during a paralytic attack OR Patient has a family history of the condition OR Patient has a genetically confirmed skeletal muscle calcium or sodium channel mutation AND Patient has had improvements in paralysis attack symptoms with potassium intake. For Continuation of treatment: Patient has decrease

PA Criteria	Criteria Details
	in the frequency or severity of paralytic attacks with treatment as determined by the prescribing physician

KEYTRUDA

Products Affected

- Keytruda

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For NSCLC, PD-L1 status and prior therapies tried.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	Plan Year
Other Criteria	N/A

KISQALI

Products Affected

- Kisqali Femara Co-Pack oral tablet 200 mg/day(200 mg x 1)-2.5 mg, 400 mg/day(200 mg x 2)-2.5 mg, 600 mg/day(200 mg x 3)-2.5 mg
- Kisqali oral tablet 200 mg/day (200 mg x 1), 400 mg/day (200 mg x 2), 600 mg/day (200 mg x 3)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Use as monotherapy, pregnancy
Required Medical Information	Estrogen receptor (ER) status, human epidermal growth factor receptor 2 (HER2) status, menopause status, previous therapies tried
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist
Coverage Duration	Plan Year
Other Criteria	For advanced (metastatic) breast cancer, patient has estrogen receptor-positive, human epidermal growth factor receptor 2-negative (ER-positive, HER2-negative) breast cancer and patient is postmenopausal and, for patients who have not previously received endocrine therapy for advanced disease, Kisqali must be used in combination with an aromatase inhibitor (anastrozole, exemestane, letrozole)

KORLYM

Products Affected

- Korlym

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Pregnancy. Patients taking simvastatin, lovastatin, and CYP3A substrates with narrow therapeutic ranges, such as cyclosporine, dihydroergotamine, ergotamine, fentanyl, pimozide, quinidine, sirolimus, and tacrolimus. Concomitant treatment with systemic corticosteroids for serious medical conditions or illnesses. Women with a history of unexplained vaginal bleeding. Women with endometrial hyperplasia with atypia or endometrial carcinoma.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

KUVAN

Products Affected

- Kuvan oral tablet,soluble

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Blood phenylalanine (Phe) levels. Pretreatment blood phenylalanine (Phe) levels greater than 10mg/dL if the patient is older than 12 years of age or greater than 6mg/dL if less than or equal to 12 years of age. Response to a therapeutic trial (greater than or equal to a 30% reduction in blood Phe levels) is required for long-term authorization.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	2 months initial, plan year on renewal
Other Criteria	Blood Phe levels should be checked after 1 week of therapy and periodically up to one month during a therapeutic trial.

KYNAMRO

Products Affected

- Kynamro

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Current LDL-C (within the past 30 days), prior therapies tried
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	For HoFH approve after trial of Repatha.

KYPROLIS

Products Affected

- Kyprolis

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapies
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by or in consultation with Oncologist or hematologist
Coverage Duration	Plan Year
Other Criteria	For Relapsed or Refractory Multiple Myeloma, patient has tried at least one prior therapy.

LARTRUVO

Products Affected

- Lartruvo

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapies
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by or in consultation with Oncologist
Coverage Duration	Plan Year
Other Criteria	For the treatment of adult patients with soft tissue sarcoma (STS) must be used in combination with doxorubicin.

LENVIMA

Products Affected

- Lenvima

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	Plan Year
Other Criteria	DTC - must be locally recurrent or metastatic, progressive refractory to radioactive iodine treatment for approval

LETAIRIS

Products Affected

- Letairis

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Pregnancy, idiopathic pulmonary fibrosis, including idiopathic pulmonary fibrosis patients with pulmonary hypertension (WHO group 3).
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist or pulmonologist
Coverage Duration	Plan Year
Other Criteria	UD or two appropriate contraceptive methods will be used for women of childbearing potential.

LEUKINE

Products Affected

- Leukine injection recon soln

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Administration within 24 hours preceding or following chemotherapy or radiotherapy, hypersensitivity to yeast-derived products. For prophylaxis of febrile neutropenia: use to increase the chemotherapy dose intensity or dose schedule above established regimens. For treatment of febrile neutropenia, when patient receives Neulasta during the current chemotherapy cycle. For AML only, excessive (greater than or equal to 10%) leukemic myeloid blasts in the bone marrow or peripheral blood.
Required Medical Information	For patients with nonmyeloid malignancies receiving myelosuppressive chemotherapy: Leukine may be used for the prevention of chemotherapy-induced febrile neutropenia if the patient experienced febrile neutropenia with a prior chemotherapy cycle OR the patient is at risk of developing febrile neutropenia. Leukine is allowable for the treatment of febrile neutropenia in patients who have received prophylaxis with Leukine (or Neupogen) OR in patients at risk for infection-related complications.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

LEUPROLIDE

Products Affected

- Eligard
- Eligard (3 month)
- Eligard (4 month)
- Eligard (6 month)
- leuprolide subcutaneous kit
- Lupron Depot
- Lupron Depot (3 month)
- Lupron Depot (4 month)
- Lupron Depot (6 Month)
- Lupron Depot-Ped intramuscular kit 11.25 mg, 15 mg

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D but specific to the following drugs as follows: Prostate cancer (Lupron Depot [7.5 mg-1mo, 22.5 mg-3-mo, 30 mg-4-mo, 45 mg-6-mo] OR Eligard [7.5 mg-1-mo, 22.5mg-3-mo, 30 mg-4-mo, 45 mg-6-mo]), Endometriosis (Lupron Depot [3.75 mg-1-mo, 11.25 mg-3-mo]), Uterine leiomyomata (Lupron Depot [3.75 mg-1-mo, 11.25 mg-3-mo]), Treatment of central precocious puberty (Lupron Depot Ped [11.25 mg-1-mo, 15 mg-1-mo]). Ovarian cancer (Lupron Depot [7.5 mg-1-mo]). Breast cancer (Lupron Depot [3.75 mg-1-mo, 11.25 mg-3-mo]). Prophylaxis or treatment of uterine bleeding in premenopausal women with hematologic malignancy or prior to bone marrow/stem cell transplantation (BMT/SCT) (Lupron Depot [3.75 mg-1-mo, 7.5 mg-1-mo]).
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	For abnrml uterine bleeding, uterine leiomyomata,endometriosis-6 mo.All other=Plan Year
Other Criteria	N/A

LIDOCAINE PATCH

Products Affected

- lidocaine topical adhesive patch,medicated

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus diabetic neuropathic pain.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	For diabetic neuropathic pain: the patient must have previous use and inadequate response or intolerance to any ONE medication that is FDA-labeled for diabetic peripheral neuropathy, including (but not limited to) duloxetine and Lyrica.

LINEZOLID

Products Affected

- linezolid

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Culture and sensitivity and CBC within normal limits
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	28 days
Other Criteria	N/A

LONSURF

Products Affected

- Lonsurf

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Treatment-naive patients
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	Plan year
Other Criteria	For Metastatic colorectal cancer, patient must have previously been treated with a fluoropyrimidine (e.g., capecitabine, 5-FU) AND oxaliplatin AND irinotecan AND an anti-VEGF therapy And if RAS wild type, ananti-EGFR therapy.

LYNPARZA

Products Affected

- Lynparza oral capsule

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	A deleterious or suspected deleterious germline BRCA-mutated advanced ovarian cancer as detected by an FDA-approved test.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	Plan Year
Other Criteria	A documented diagnosis of advanced ovarian cancer which has been treated with at least three prior lines of chemotherapy.

MEGESTROL

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

MEKINIST

Products Affected

- Mekinist

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Documentation of the detected BRAFV600E or BRAFV600K mutation
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

METHAMPHETAMINE

Products Affected

- methamphetamine

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

NAMENDA

Products Affected

- memantine oral solution
- memantine oral tablet
- memantine oral tablets,dose pack
- Namenda XR

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

NATPARA

Products Affected

- Natpara

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Hypoparathyroidism caused by calcium-sensing receptor mutations. Patients with acute post-surgical hypoparathyroidism.
Required Medical Information	Serum calcium level
Age Restrictions	18 years of age and older
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	For diagnosis of hypocalcemia in patients with hypoparathyroidism, documentation required to show hypocalcemia is not corrected by calcium supplements and active forms of vitamin D alone.

NEUPOGEN

Products Affected

- Neupogen

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Administration within 24 hours preceding or following chemotherapy or radiotherapy, E coli hypersensitivity. For prophylaxis of febrile neutropenia: use to increase the chemotherapy dose intensity or dose schedule beyond established regimen. For treatment of febrile neutropenia, when patient receives Neulasta during the current chemotherapy cycle.
Required Medical Information	For patients with nonmyeloid malignancies receiving myelosuppressive chemotherapy: Neupogen may be used for the prevention of chemotherapy-induced febrile neutropenia if the patient experienced febrile neutropenia with a prior chemotherapy cycle OR the patient is at risk of developing febrile neutropenia. Neupogen is allowable for the treatment of febrile neutropenia in patients who have received prophylaxis with Neupogen (or Leukine) OR in patients at risk for infection-related complications.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

NEUPRO

Products Affected

- Neupro

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

NEXAVAR

Products Affected

- Nexavar

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Combination with carboplatin and paclitaxel in patients with squamous cell lung cancer
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Plan Year
Other Criteria	N/A

NINLARO

Products Affected

- Ninlaro

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Previous therapies tried and failed, baseline CBC
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	Plan Year
Other Criteria	For multiple myeloma, patient has received at least one prior therapy AND will be used in combination with lenalidomide and dexamethasone.

NORTHERA

Products Affected

- Northera

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Documentation from the medical record of diagnosis and prior medication history
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist or a neurologist
Coverage Duration	Initial 4 weeks, renewal 6 months
Other Criteria	NOH, approve if the patient meets ALL of the following criteria: a) Patient has been diagnosed with symptomatic NOH due to primary autonomic failure (Parkinsons disease, multiple system atrophy, pure autonomic failure), dopamine beta-hydroxylase deficiency, or non-diabetic autonomic neuropathy, AND b) Patient has tried midodrine

NUPLAZID

Products Affected

- Nuplazid

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

NUVIGIL/PROVIGIL

Products Affected

- modafinil

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patients must be greater than or equal to 17 years of age.
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Excessive sleepiness due to SWSD if the patient is working at least 5 overnight shifts per month.

OCTREOTIDE

Products Affected

- octreotide acetate injection solution

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ODOMZO

Products Affected

- Odomzo

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	Plan year
Other Criteria	For locally advanced basal cell carcinoma (BCC) has recurred following surgery or radiation therapy or if the patient is not a candidate for surgery and the patient is not a candidate for radiation therapy, according to the prescribing physician.

OFEV

Products Affected

- Ofev

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

ONFI

Products Affected

- Onfi oral suspension
- Onfi oral tablet 10 mg, 20 mg

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	The patient will receive Onfi for the treatment of seizures associated with Lennox-Gastaut syndrome.
Age Restrictions	2 years of age and older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

OPDIVO

Products Affected

- Opdivo intravenous solution 40 mg/4 mL

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	For NSCLC, EGFR or ALK status. Prior therapies tried
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	Plan Year
Other Criteria	For NSCLC, patient must have prior platinum-based chemotherapy or FDA-approved therapy for EGFR or ALK aberrations. For RCC, patient must have prior antiangiogenic therapy.

OPSUMIT

Products Affected

- Opsumit

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	PAH WHO group, right heart catheterization
Age Restrictions	N/A
Prescriber Restrictions	PAH - must be prescribed by or in consultation with a cardiologist or a pulmonologist.
Coverage Duration	Plan Year
Other Criteria	Pulmonary arterial hypertension (PAH) WHO Group 1 patients not currently on Opsumit or another agent indicated for WHO Group 1 PAH are required to have had a right-heart catheterization to confirm the diagnosis of PAH to ensure appropriate medical assessment. PAH WHO Group 1 patients currently on Opsumit or another agent indicated for WHO Group 1 PAH may continue therapy without confirmation of a right-heart catheterization. For patients not currently on Opsumit with confirmed diagnosis of PAH, approval will be given after a trial of Letairis, unless contraindicated.

ORKAMBI

Products Affected

- Orkambi

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Combination use with Kalydeco
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	CF - homozygous for the Phe508del (F508del) mutation in the CFTR gene (meaning the patient has two copies of the Phe508del mutation)

PEGASYS

Products Affected

- Pegasys subcutaneous solution
- Pegasys subcutaneous syringe

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

PENICILLAMINE

Products Affected

- Depen Titratabs

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

PERJETA

Products Affected

- Perjeta

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	HER2 overexpression status.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	For breast cancer and metastatic breast cancer, must be used in combination with trastuzumab and docetaxel.

PHENOXYBENZAMINE

Products Affected

- phenoxybenzamine

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

POMALYST

Products Affected

- Pomalyst

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Pregnancy
Required Medical Information	For active myeloma, patient meets the following: 1) Pomalyst is used after at least two prior therapies or as salvage therapy. 2) Pomalyst may be used with dexamethasone. For female patients of childbearing potential, pregnancy is excluded by 2 negative serum or urine pregnancy tests. For all patients, complete blood counts are monitored for hematologic toxicity while receiving Pomalyst.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist or Hematologist
Coverage Duration	Plan Year
Other Criteria	Male and female patients of child-bearing potential should be instructed on the importance of proper utilization of appropriate contraceptive methods for Pomalyst use. Patients should be monitored for signs and symptoms of thromboembolism.

PRALUENT

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrent use of Praluent with Repatha, Juxtapid or Kynamro.
Required Medical Information	Current LDL-C (within the past 30 days), prior therapies tried, medication adverse event history
Age Restrictions	18 years of age and older.
Prescriber Restrictions	Prescribed by, or in consultation with, a cardiologist, endocrinologist, or a physician who focuses in the treatment of CV risk management and/or lipid disorders
Coverage Duration	Plan Year
Other Criteria	Hyperlipidemia in pts w/ (ASCVD) apprv if the pt has a curr LDL-C lvl of grtr or eq to 70 mg/dL w/in the past 30 ds (after tx with antihyperlipidemic agnts but prior to PCSK9 inh tx such as Praluent or Repatha) AND the pt has had one of the following conds or dxs: prev MI,OR has a hx of an acute coronary syndrome, OR The pt has a dx of angina (stable or unstable) ,OR The pt has a past hx of stroke or TIA, OR The pt has PAD, The pt has undergone a coronary or other arterial revascularization procedure AND The pt has tried 1 high-intensity statin tx (i.e., atorvastatin 80 mg daily or Crestor 40 mg daily) for equal or more than 12 cont wks AND the LDL-C lvl remains equal or more than70 mg/dL unless pt experienced statin-related rhabdomyolysis, OR the pt experienced skeletal-related muscle symptoms while receiving separate trials of atorvastatin and Crestor and during both trials the skeletal-related symptoms resolved during d/c. AND If pt able to tolerate statins cont to rec. the max tolerated dose of a statin while rec. Praluent tx. Heterozygous Familial Hypercholesterolemia apprve if the pt has a curnt LDL-C lvl eq or more than 100 mg/dL w/in the past 30 days, AND the pts dx of HeFH is def as probable or definite by WHO/Dutch Lipid grp criteria OR definite by Simon-Broome Criteria OR genetic testing, AND The pt has tried 1 high-intensity statin txs (i.e.,

PA Criteria	Criteria Details
	atorvastatin 80 mg daily or Crestor 40 mg daily) for equal or more than 12 cont wks, AND the LDL-C lvl remains eq or more than 100 mg/dL, unless pt experienced statin-related rhabdomyolysis, OR the pt experienced skeletal-related muscle symptoms while receiving separate trials of atorvastatin and Crestor and during both trials the skeletal-related symptoms resolved during d/c. AND If pt able to tolerate statins cont to rec. the max tolerated dose of a statin while rec. Praluent tx.

PROCRIT

Products Affected

- Procrit injection solution 10,000 unit/mL, 2,000 unit/mL, 20,000 unit/mL, 3,000 unit/mL, 4,000 unit/mL, 40,000 unit/mL

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D worded as anemia associated with chronic renal failure (CRF), including patients on dialysis and not on dialysis, and worded as anemia secondary to myelosuppressive anticancer chemotherapy in solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia, . Plus anemia in patients with HIV who are receiving zidovudine. Anemic patients (Hb of 13.0 g/dL or less) at high risk for perioperative transfusions (secondary to significant, anticipated blood loss and are scheduled to undergo elective, noncardiac, nonvascular surgery to reduce the need for allogeneic blood transfusions). Additional off-label coverage is provided for Anemia due to myelodysplastic syndrome (MDS), Anemia associated with use of ribavirin therapy for hepatitis C, and Anemia in HIV-infected patients.
Exclusion Criteria	N/A
Required Medical Information	CRF anemia in patients on and not on dialysis. Hemoglobin (Hb) of less than 10.0 g/dL to start. Hb less than or equal to 10 g/dL for adults (CKD, not on dialysis), 11 g/dL (CKD on dialysis) or 12 g/dL or less for pediatric CKD. Anemia w/myelosuppressive chemotx.pt must be currently receiving myelosuppressive chemo and Hb less than or equal to 10.0 g/dL. MDS, approve if Hb is 10 g/dL or less. Surgical pts to reduce RBC transfusions - pt is unwilling or unable to donate autologous blood prior to surgery
Age Restrictions	MDS anemia/HepC anemia = 18 years of age and older
Prescriber Restrictions	MDS anemia, prescribed by or in consultation with, a hematologist or oncologist. Hep C anemia, prescribed by or in consultation with hepatologist, gastroenterologist, hematologist or infectious disease physician who specializes in the management of hepatitis C.
Coverage Duration	Anemia w/myelosuppress = 4 mos.Transfus=1 mo.Other= 6mo. HIV + zidovudine = 4 mo

PA Criteria	Criteria Details
Other Criteria	Part B versus Part D determination will be made at time of prior authorization review per CMS guidance to establish if the drug prescribed is to be used for an end-stage renal disease (ESRD)-related condition.

PROLIA

Products Affected

- Prolia

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

PROMACTA

Products Affected

- Promacta

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Thrombocytopenia due to hepatitis C virus (HCV)-related cirrhosis.
Exclusion Criteria	Use in the management of thrombocytopenia in myelodysplastic syndrome (MDS). Use in combination with Nplate for treatment of thrombocytopenia in patients with chronic immune (idiopathic) thrombocytopenia purpura.
Required Medical Information	Cause of thrombocytopenia.
Age Restrictions	N/A
Prescriber Restrictions	Treatment of thrombocytopenia due to chronic immune (idiopathic) thrombocytopenic purpura (ITP), approve if prescribed by, or after consultation with, a hematologist. Treatment of thrombocytopenia due to HCV-related cirrhosis, approve if prescribed by, or after consultation with, either a hematologist, gastroenterologist, a hepatologist, or a physician who specializes in infectious disease.
Coverage Duration	Plan Year
Other Criteria	Thrombocytopenia in patients with chronic immune (idiopathic) thrombocytopenia purpura, approve if the patient has tried corticosteroids or IVIG or has undergone a splenectomy. Treatment of thrombocytopenia due to HCV-related cirrhosis, approve to allow for initiation of antiviral therapy if the patient has low platelet counts (eg, less than 75,000 mm3) and the patient has chronic HCV infection and is a candidate for hepatitis C therapy .

QUININE

Products Affected

- quinine sulfate

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

RAVICTI

Products Affected

- Ravicti

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

REBIF

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

REMICADE

Products Affected

- Remicade

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Active infection (including TB), concurrent use with other biologics, unstable moderate to severe HF (NYHA Functional Class III/IV).
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 - An inadequate response or intolerance to Enbrel or Humira and one of the 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 2 nonbiologic DMARDs. Psoriatic arthritis with predominantly peripheral symptoms - Must meet both of the following: 1) have an inadequate response or intolerance to either Enbrel or Humira, and 2) have an inadequate response to at least an 8-week maximum tolerated dose trial of at least 1 nonbiologic DMARD unless contraindicated or intolerant to such therapy. For plaque psoriasis - More than 10% BSA affected or has crucial body areas (e.g., feet, hands, face) affected. An inadequate response to at least a 60-day trial of 2 conventional therapies (e.g., phototherapy, calcipotriene, MTX, acitretin) unless contraindicated or intolerant to such therapies. Crohn's disease - Must meet both of the following: 1) have an inadequate response to at least a 60-day trial of 1 conventional therapy (e.g., corticosteroids, sulfasalazine, azathioprine, mesalamine) unless contraindicated or intolerant to such therapy, and 2) have an inadequate response or intolerance to either Humira or Cimzia. Ulcerative colitis - An inadequate response to at least a 60-day trial of 2 conventional therapies (e.g., corticosteroids, mesalamine) unless contraindicated or intolerant to such therapies.
Age Restrictions	For plaque psoriasis, patient must be 18 years of age and older.
Prescriber Restrictions	Adult with RA (initial course). Prescribed by a rheumatologist or in consultation with a rheumatologist.

PA Criteria	Criteria Details
Coverage Duration	Initial: 3 months for Crohn's disease and UC, plan year for all others. Renewal: plan year
Other Criteria	For continuation of therapy, patient's condition must have improved or stabilized.

REPATHA

Products Affected

- Repatha Pushtronex
- Repatha SureClick
- Repatha Syringe

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrent use of Repatha with Praluent, Juxtapid or Kynamro
Required Medical Information	Current LDL-C (within the past 30 days), prior therapies tried, medication adverse event history
Age Restrictions	ASCVD/HeFH - 18 yo and older, HoFH 13 yo and older.
Prescriber Restrictions	Prescribed by, or in consultation with, a cardiologist, endocrinologist, or a physician who focuses in the treatment of CV risk management and/or lipid disorders
Coverage Duration	Plan Year
Other Criteria	Hyperlipidemia in pts w/ (ASCVD) apprv if the pt has a curr LDL-C lvl of grtr or eq to 70 mg/dL w/in the past 30 ds (after tx with antihyperlipidemic agnts but prior to PCSK9 inh tx such as Praluent or Repatha) AND the pt has had one of the following conds or dxs: prev MI,OR has a hx of an acute coronary syndrome, OR The pt has a dx of angina (stable or unstable) ,OR The pt has a past hx of stroke or TIA, OR The pt has PAD, The pt has undergone a coronary or other arterial revascularization procedure AND The pt has tried 1 high-intensity statin tx (i.e., atorvastatin 80 mg daily or Crestor 40 mg daily) for equal or more than 12 cont wks AND the LDL-C lvl remains equal or more than70 mg/dL unless pt experienced statin-related rhabdomyolysis, OR the pt experienced skeletal-related muscle symptoms while receiving separate trials of atorvastatin and Crestor and during both trials the skeletal-related symptoms resolved during d/c. AND If pt able to tolerate statins cont to rec. the max tolerated dose of a statin while rec. Repatha tx. Heterozygous Familial Hypercholesterolemia apprve if the pt has a curnt LDL-C lvl eq or more than 100 mg/dL w/in the past 30 days, AND the pts dx of HeFH is def as probable or definite by WHO/Dutch Lipid grp criteria OR definite by Simon-Broome Criteria OR genetic testing, AND The pt has tried 1 high-intensity statin txs (i.e., atorvastatin 80 mg daily or Crestor 40 mg daily) for equal or more than 12

PA Criteria	Criteria Details
	cont wks, AND the LDL-C lvl remains eq or more than 100 mg/dL, unless pt experienced statin-related rhabdomyolysis, OR the pt experienced skeletal-related muscle symptoms while receiving separate trials of atorvastatin and Crestor and during both trials the skeletal-related symptoms resolved during d/c. AND If pt able to tolerate statins cont to rec. the max tolerated dose of a statin while rec. Repatha tx. HoFH - approve if meets all of the following has one of the following genetic confirmation of two mutant alleles at the LDLR, APOB, PCSK9, or LDLRAP1 gene locus AND LDL-C lvl grtr or eq to 100 mg/dL within the past 30 ds AND tried 1 high-intensity statin therapystatin tx (i.e., atorvastatin 80 mg daily or Crestor 40 mg daily) for equal or more than 12 cont wks AND the LDL-C lvl remains equal or more than 100 mg/dL unless pt experienced statin-related rhabdomyolysis, OR the pt experienced skeletal-related muscle symptoms while receiving separate trials of atorvastatin and Crestor and during both trials the skeletal-related symptoms resolved during d/c. AND If pt able to tolerate statins cont to rec. the max tolerated dose of a statin while rec. Repatha tx.

REVATIO

Products Affected

- sildenafil (antihypertensive) oral

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Nitrate therapy
Required Medical Information	Diagnosis of pulmonary arterial hypertension (PAH), (WHO Group 1). PAH been confirmed by right heart catheterization.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

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	For active myeloma patient meets one of the following: 1) Revlimid is used in combination with dexamethasone. 2) Revlimid is used as maintenance monotherapy following response to either stem cell transplant or primary induction therapy. For mantle cell lymphoma (MCL): Revlimid is used after 2 prior therapies, 1 of which is bortezomib. For Low or Intermediate-1 Risk myelodysplastic syndrome (MDS): for those with 5q deletion, patients should have transfusion-dependent anemia or symptomatic anemia with clinically significant cytopenias. For those with non-5q deletion MDS and symptomatic anemia, patients should have failed to respond to epoetin alfa or darbepoetin or have a pretreatment serum erythropoietin levels greater than 500 mU/mL and a low probability of response to immunosuppressive therapy. For female patients of childbearing potential, pregnancy is excluded by 2 negative serum or urine pregnancy tests. For all patients, complete blood counts are monitored for hematologic toxicity while receiving Revlimid.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Male and female patients of child-bearing potential should be instructed on the importance of proper utilization of appropriate contraceptive methods for Revlimid use. Patients should be monitored for signs and symptoms of thromboembolism.

RIBAVIRIN

Products Affected

- ribavirin oral capsule
- ribavirin oral tablet 200 mg

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Hemoglobinopathy. History of pre-existing heart disease. Creatinine clearance less than 50 mL/minute and unwilling to use modified dose of ribavirin. Pregnancy (self or partner).Unwilling to use effective contraception. Coadministration with didanosine in HIV coinfected patients.
Required Medical Information	Prior to initiating therapy, detectable levels of HCV RNA in the serum. Must use in combination with Harvoni, interferon, Viekira, Daklinza, Technivie, Zepatier or Sovaldi. Cirrhosis documented by FibroScan, liver biopsy, or radiological imaging. genotype
Age Restrictions	N/A
Prescriber Restrictions	ID specialist, gastroenterologist, or oncologist
Coverage Duration	12 wks, 24 wks, or 48 wks as specified in Other Criteria.
Other Criteria	Criteria will be applied consistent with current AASLD-IDSA guidance

RITUXAN

Products Affected

- Rituxan

PA Criteria	Criteria Details
Covered Uses	All medically-accepted indications not otherwise excluded from Part D. Patients already started on Rituxan for a Covered Use.
Exclusion Criteria	Concurrent use with a biologic agent (TNF alpha antagonists (eg, adalimumab, certolizumab pegol, etanercept, golimumab, infliximab), or anakinra, abatacept, tocilizumab or tofacitinib.
Required Medical Information	N/A
Age Restrictions	RA, adults.
Prescriber Restrictions	Adult with RA (initial course). Prescribed by a rheumatologist or in consultation with a rheumatologist.
Coverage Duration	RA,3 mo. Othr= Plan Year.
Other Criteria	Adult with RA (initial course), approve if Rituxan is prescribed in combination with methotrexate or another traditional DMARD (eg, leflunomide or sulfasalazine) unless the patient has been shown to be intolerant or has a contraindication to one or more traditional DMARDs AND the patient has tried one of certolizumab pegol, etanercept, adalimumab, infliximab, golimumab (ie, a TNF antagonist) OR if the patient has not yet tried a TNF antagonist, the patient must have a trial with etanercept or adalimumab.

RUBRACA

Products Affected

- Rubraca oral tablet 200 mg, 300 mg

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, Prior therapies, documentation of the presence of a deleterious BRCA mutation (germline and/or somatic)
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by or in consultation with Oncologist
Coverage Duration	Plan Year
Other Criteria	Patient selection must be based on an FDA-approved companion diagnostic. Patient must have been treated with two or more chemotherapies prior to Rubraca. Rubraca must be used as monotherapy.

RYDAPT

Products Affected

- Rydapt

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	For AML, use as monotherapy and patients with FLT3-mutation negative disease, Pediatric patients
Required Medical Information	Diagnosis, for AML, patients must have the FLT3-mutation, as detected by an FDA approved test
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	For AML - 6 months, for Systemic Mast Cell Disease - Plan Year
Other Criteria	For AML, patient is newly diagnosed, AND Rydapt will be used in combination with standard cytarabine and daunorubicin induction and cytarabine consolidation therapy AND the patient has FLT3-mutation positive AML as detected by an FDA approved test AND patient is receiving Rydapt on days 8-21 of each cycle of induction with cytarabine and daunorubicin and on days 8-21 of each cycle of consolidation with high-dose cytarabine

SABRIL

Products Affected

- Sabril

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Patients with or at high risk of vision loss (except patients who have blindness). Patients using other medications associated with serious adverse ophthalmic effects such as retinopathy or glaucoma.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Infantile spasms: initial 4 wks, reauth 6 mths. CPS: initial 3 mths, reauth to plan year
Other Criteria	N/A

SAMSCA

Products Affected

- Samsca oral tablet 15 mg, 30 mg

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Up to 30 days
Other Criteria	N/A

SIGNIFOR

Products Affected

- Signifor

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis for which Signifor is being used.
Age Restrictions	Cushing's, 18 years of age and older.
Prescriber Restrictions	Initial course, prescribed by or in consultation with an endocrinologist.
Coverage Duration	Initial therapy, approve for 3 months. Continuation therapy, approve for the plan year.
Other Criteria	Cushing's disease, approve if according to the prescribing physician the patient is not a candidate for surgery or surgery has not been curative. Patients who have already been started on Signifor for Cushing's disease will be approved if the patient has had a response, as determined by the prescribing physician and the patient is continuing therapy to maintain response.

SOVALDI

Products Affected

- Sovaldi

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Combination use with other direct acting antivirals, excluding ribavirin, daclatasvir, and simeprevir.
Required Medical Information	Documentation from the medical record of diagnosis including genotype, HCV RNA viral levels prior to treatment, history of previous HCV therapies, and presence/absence of cirrhosis. For patients with cirrhosis, cirrhosis must be documented by FibroScan, FibroTest ActiTest, liver biopsy, or radiological imaging.
Age Restrictions	12 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician, or a liver transplant physician.
Coverage Duration	12 to 48 weeks, based on indication and current AASLD/IDSA guidance.
Other Criteria	Must be used with other concurrent therapy based on indication and established treatment guidelines. Criteria will be applied consistent with current AASLD/IDSA guidance.

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 FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Acute lymphoblastic leukemia (ALL) and newly diagnosed chronic myeloid leukemia (CML) must be positive for the Philadelphia chromosome or BCR-ABL gene. For CML, patient meets one of the following: 1) newly diagnosed in chronic phase, 2) resistance or intolerance to imatinib, or 3) relapse after stem cell transplant. For ALL, resistance or intolerance to prior therapy.
Age Restrictions	18 years of age and older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

STIVARGA

Products Affected

- Stivarga

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D. Plus patients already started on Stivarga for a Covered Use.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis for which Stivarga is being used. For metastatic colorectal cancer (CRC)and gastrointestinal stromal tumors (GIST), prior therapies tried. For metastatic CRC, KRAS mutation status.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	Plan Year
Other Criteria	For metastatic CRC with KRAS mutation, patient must have previously been treated with each of the following for approval: a fluoropyrimidine (eg, Xeloda, 5-FU), oxaliplatin, irinotecan, anti-VEGF therapy (eg, Avastin, Zaltrap). For metastatic CRC with no detected KRAS mutations (ie, KRAS wild-type), patient must have previously been treated with each of the following for approval: a fluoropyrimidine (eg, Xeloda, 5-FU), oxaliplatin, irinotecan, anti-VEGF therapy (eg, Avastin, Zaltrap), anti-EGFR therapy (eg, Eribitux, Vectibix). For GIST, patient must have previously been treated with imatinib (Gleevec) and sunitinib (Sutent).

SUTENT

Products Affected

- Sutent

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Clinical manifestations of congestive heart failure.
Required Medical Information	For gastrointestinal stromal tumor (GIST), disease progression while on an at least 30-day regimen of Gleevec or intolerance to Gleevec is required. LFT monitoring at initiation of therapy and throughout treatment.
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Plan Year
Other Criteria	Therapy will be interrupted for serious hepatic adverse events and discontinued if serious hepatic adverse events do not resolve.

SYLATRON

Products Affected

- Sylatron

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

SYNAGIS

Products Affected

- Synagis intramuscular solution 50 mg/0.5 mL

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prophylaxis of Respiratory Syncytial Virus (RSV): One of the following: (criteria 1) all of the following: Infant is less than 24 months of age, infant has chronic lung disease (CLD), infant required medical therapy (supplemental oxygen, bronchodilator, diuretic or corticosteroid therapy) within 6 months prior to the start of RSV season, (criteria 2) all of the following: infant was born at 28 weeks of gestation or earlier, infant does not have chronic lung disease (CLD), and infant was less than 12 months of age at the start of RSV season, (criteria 3) all of the following: infant was born at 29 to 32 weeks of gestation (ie, 31 weeks, 6 days or less), infant does not have chronic lung disease (CLD), and infant was less than 6 months of age at the start of RSV season. (criteria 4): infant was born at 32 to less than 35 weeks of gestation (ie, between 32 weeks, 0 days through 34 weeks, 6 days), infant does not have CLD, infant was less than 3 months of age at the start of the RSV season, and infant has one of the following risk factors: (1) Child care attendance defined as a home or facility in which care is provided for any number of infants or toddlers OR (2) Infant has a sibling younger than 5 years of age, (criteria 5) both of the following: Infants and children 24 months of age and younger, or Infant or child has one of the following: (1) Congenital abnormalities of the airways, or (2) Neuromuscular condition that compromises handling of respiratory secretions, (criteria 6) both of the following: Infants and children 24 months of age or younger, or infant or child has hemodynamically significant cyanotic or acyanotic congenital heart disease (CHD) (eg, receiving medication to control congestive heart failure, moderate to severe pulmonary hypertension), (criteria 7) both of the following: Infants and children 24 months of age and younger, infant or child has severe immunodeficiency (eg, severe combined immunodeficiency or advanced AIDS) (off label).
Age Restrictions	N/A

PA Criteria	Criteria Details
Prescriber Restrictions	N/A
Coverage Duration	5 months
Other Criteria	Synagis will not be approved for the following conditions unless one of the required criteria is met: 1) Infants and children with hemodynamically insignificant heart disease (eg, secundum atrial septal defect, small ventricular septal defect, pulmonic stenosis, uncomplicated aortic stenosis, mild coarctation of the aorta, and patent ductus arteriosus), 2) Infants with lesions adequately corrected by surgery, unless they continue to require medication for congestive heart failure, 3) Infants with mild cardiomyopathy who are not receiving medical therapy for the condition.

TAFINLAR

Products Affected

- Tafinlar

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Documentation of the detected BRAF V600E or V600K mutations
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TAGRISSO

Products Affected

- Tagrisso

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients already started on Tagrisso for a covered use.
Exclusion Criteria	EGFR tyrosine kinase inhibitor treatment naive patients
Required Medical Information	Confirmed T790M mutation-positive NSCLC as detected by an FDA approved test and Prior therapies tried
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	Plan Year
Other Criteria	The patient has metastatic epidermal growth factor receptor (EGFR) T790M mutation-positive NSCLC as detected by an FDA approved test AND The patient has progressed on or after one of Tarceva (erlotinib tablets), Iressa (gefitinib tablets), or Gilotrif (afatinib tablets) therapy.

TARCEVA

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	For 1st line therapy of locally advanced or metastatic NSCLC, patient should have a known active EGFR exon 19 deletions or exon 21 substitution mutation or amplification of the EGFR gene.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TARGRETIN

Products Affected

- bexarotene

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Pregnancy
Required Medical Information	For capsules, patient meets one of the following: 1) cutaneous T cell lymphoma (includes mycosis fungoides [MF] and Sezary syndrome [SS]) refractory to prior systemic therapy, 2) advanced-stage MF/Sezary syndrome, 3) early-stage MF refractory/progressive to skin-directed therapy, or 4) early-stage MF with blood involvement or folliculotropic/large cell transformation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Patient has been instructed on the importance of and proper utilization of contraception.

TASIGNA

Products Affected

- Tasigna

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Long QT syndrome, uncorrected electrolyte disorders (hypokalemia, hypomagnesemia).
Required Medical Information	ECG obtained at baseline, 7-10 days after initiation of therapy and periodically throughout therapy. Newly diagnosed chronic myeloid leukemia (CML) must be positive for the Philadelphia chromosome or BCR-ABL gene. For CML, patient meets one of the following: 1) newly diagnosed in chronic phase, 2) resistance to imatinib, 3) intolerance/toxicity to imatinib or dasatinib, or 4) relapse after stem cell transplant.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	Plan Year
Other Criteria	Patient has been instructed to avoid eating food 2 hours before and 1 hour after taking Tasigna. Concomitant use of drugs known to prolong the QT interval and strong CYP3A4 inhibitors should be avoided.

TECENTRIQ

Products Affected

- Tecentriq

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	N/A

TETRABENAZINE

Products Affected

- tetrabenazine

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

THALOMID

Products Affected

- Thalomid

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Pregnancy
Required Medical Information	For active myeloma, patient meets one of the following: 1) Thalomid is used as salvage or palliative therapy. 2) Thalomid is used for newly diagnosed disease or as primary induction therapy in combination with dexamethasone or in combination with melphalan and prednisone in nontransplant candidates. 3) Thalomid is used as maintenance monotherapy following response to either stem cell transplant or primary induction therapy. For female patients of childbearing potential, pregnancy is excluded by a negative pregnancy test.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Patients are monitored for signs and symptoms of thromboembolism. Male and female patients of child-bearing potential are instructed on the importance of proper utilization of appropriate contraceptive methods.

THIORIDAZINE

Products Affected

- thioridazine

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

THIOTEPA

Products Affected

- thiotepa

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TIRF MEDICATIONS

Products Affected

- fentanyl citrate buccal lozenge on a handle 1,200 mcg, 1,600 mcg, 200 mcg, 400 mcg, 600 mcg, 800 mcg

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	For breakthrough pain in patients with cancer if patient is unable to swallow, has dysphagia, esophagitis, mucositis, or uncontrollable nausea/vomiting OR patient is unable to take 2 other short-acting narcotics (eg, oxycodone, morphine sulfate, hydromorphone, etc) secondary to allergy or severe adverse events AND patient is on or will be on a long-acting narcotic (eg, Duragesic), or the patient is on intravenous, subcutaneous, or spinal (intrathecal, epidural) narcotics (eg, morphine sulfate, hydromorphone, fentanyl citrate).

TRETINOIN

Products Affected

- adapalene topical cream
- adapalene topical gel
- tretinoin microspheres topical gel
- tretinoin topical topical cream 0.025 %, 0.05 %, 0.1 %
- tretinoin topical topical gel 0.01 %, 0.025 %

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

TYKERB

Products Affected

- Tykerb

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Liver function tests must be monitored at baseline and every four to six weeks during therapy and as clinically indicated. In patients with severe hepatic impairment, Tykerb is used at a reduced dose.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

TYSABRI

Products Affected

- Tysabri

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D. Plus patients already started on Tysabri for a Covered Use.
Exclusion Criteria	Concurrent use of another immunomodulator (eg, Rebif, Betaseron, Extavia, Copaxone or Avonex or Aubagio), Tecfidera, or fingolimod (Gilenya) or an immunosuppressant such as mitoxantrone, cyclophosphamide, rituximab (Rituxan), alemtuzumab (Campath), azathioprine, MTX, or mycophenolate mofetilin in multiple sclerosis (MS) patients. Concurrent use with immunosuppressants (eg, 6-mercaptopurine, azathioprine, cyclosporine, methotrexate) or tumor necrosis factor (TNF) alfa inhibitors (eg, infliximab, adalimumab, certolizumab pegol) in Crohn's disease (CD) patients. Per warning and precautions, coverage is not provided for immune compromised patients with MS or CD.
Required Medical Information	Adults with MS. Patient has a relapsing form of MS (relapsing forms of MS are relapsing remitting [RRMS], secondary progressive [SPMS] with relapses, and progressive relapsing [PRMS]). Adults with CD. Patient has moderately to severely active CD with evidence of inflammation (eg, elevated C-reactive protein).
Age Restrictions	Adults
Prescriber Restrictions	MS. Prescribed by, or in consultation with , a neurologist or physician who specializes in the treatment of MS.CD. Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	Plan Year
Other Criteria	Adults with a relapsing form of MS. Patient has had an inadequate response to, or is unable to tolerate, therapy with at least one of the following MS medications: interferon beta-1a (Avonex, Rebif), interferon beta-1b (Betaseron, Extavia), glatiramer acetate (Copaxone), fingolimod (Gilenya), Tecfidera, or Aubagio OR the patient has highly active or aggressive disease according to the prescribing physician. Adults with CD. Patient has moderately to severely active CD with evidence of inflammation (eg, elevated C-reactive protein) and patient has tried two TNF antagonists for CD for at least 2 months each, adalimumab,

PA Criteria	Criteria Details
	certolizumab pegol, or infliximab, and had an inadequate response or was intolerant to the TNF antagonists.

UPTRAVI

Products Affected

- Uptravi oral tablet
- Uptravi oral tablets,dose pack

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Breast feeding mother, severe hepatic impairment (Child-Pugh Class C)
Required Medical Information	prior treatments
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Must have PAH (WHO Group 1) and had a right heart catheterization to confirm the diagnosis of PAH (WHO Group 1). Right heart catheterization is NOT required in pts who are currently receiving Uptravi or another agent indicated for PAH (WHO group 1). Patient must have previously tried or is currently taking at least one other agent indicated for PAH treatment (eg, sildenafil, Adcirca, Revatio, Tracleer, Letairis Opsumit, Adempas, Orenitram, Tyvaso, Ventavis, Remodulin, or epoprostenol injection).

VENCLEXTA

Products Affected

- Venclexta
- Venclexta Starting Pack

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy, 17p deletion status
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	CLL - approve if the patient has 17p deletion and has tried one prior therapy.

VIMPAT

Products Affected

- Vimpat intravenous
- Vimpat oral solution
- Vimpat oral tablet

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	17 years of age and older
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

VOTRIENT

Products Affected

- Votrient

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Alanine transaminase (ALT) greater than 3 times the upper limit of normal (ULN) and bilirubin greater than 2 times the ULN.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncologist
Coverage Duration	Plan Year
Other Criteria	N/A

XALKORI

Products Affected

- Xalkori

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus, patients with non-small cell lung cancer (NSCLC) already started on crizotinib.
Exclusion Criteria	N/A
Required Medical Information	For the FDA-approved indication of NSCLC for patients new to therapy, ALK status required. ROS1 Status
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	NSCLC, patient new to therapy must be ALK-positive for approval.

XERMELO

Products Affected

- Xermelo

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Treatment naive patients, use as a monotherapy
Required Medical Information	Diagnosis, previous therapies tried with dates of treatment, chart notes documenting number of bowel movements per day
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by, or in consultation with, an oncologist or gastroenterologist
Coverage Duration	Initiation - 12 weeks, Continuation - Plan year
Other Criteria	For initiation for carcinoid sydrome diarrhea, the patient has been on a long-acting somatostatin analog (SSA) therapy (e.g. Somatuline Depot [lanreotide for injection], Sandostatin LAR Depot [octreotide for injection], octreotide injection) for at least 3 consecutive months and while on long-acting somatostatin analog therapy (prior to starting Xermelo) the patient continues to have at least four bowel movements per day and iii. Xermelo will be used in combination with a long-acting somatostatin analog therapy. For continuation for carcinoid sydrome diarrhea, the patient has experienced a decrease in the number of bowel movements per day and the patient continues to take Xermelo in combination with a long-acting somatostatin analog therapy.

XOLAIR

Products Affected

- Xolair

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Body weight greater than 150 kg.
Required Medical Information	For IgE-mediated allergic asthma: pre-treatment serum IgE level greater than or equal to 30 IU/mL to less than or equal to 700 IU/mL and patient's body weight. For CIU - must have urticaria for more than 6 weeks, with symptoms present more than 3 days per week despite daily non-sedating H1-antihistamine therapy (e.g., cetirizine, desloratadine, fexofenadine, levocetirizine, loratadine) AND must have tried therapy with a leukotriene modifier (e.g., montelukast) with a daily non-sedating H1 antihistamine.
Age Restrictions	6 years of age and older
Prescriber Restrictions	Moderate to severe persistent asthma if prescribed by, or in consultation with an allergist, immunologist, or pulmonologist. CIU if prescribed by or in consultation with an allergist, immunologist, or dermatologist.
Coverage Duration	Plan Year
Other Criteria	Moderate to severe persistent asthma must meet all criteria patient's asthma symptoms have not been adequately controlled by concomitant use of at least 3 months of inhaled corticosteroid and a long-acting beta-agonist (LABA) or LABA alternative, if LABA contraindicated or patient has intolerance then alternatives include sustained-release theophylline or a leukotriene modifier (eg, montelukast), AND inadequate control demonstrated by hospitalization for asthma, requirement for systemic corticosteroids to control asthma exacerbation(s), or increasing need (eg, more than 4 times a day) for short-acting inhaled beta2 agonists for symptoms (excluding preventative use for exercise-induced asthma).

XTANDI

Products Affected

- Xtandi

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D. Plus patients already started on Xtandi for a Covered Use.
Exclusion Criteria	Pregnancy
Required Medical Information	Documentation from medical records of diagnosis. For metastatic castration-resistant prostate cancer, prior therapies tried.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an Oncologist
Coverage Duration	Plan Year
Other Criteria	For prostate cancer, patient must have metastatic, castration-resistant prostate cancer for approval. The patient must have a history of failure, intolerance or contraindication to Zytiga before Xtandi is authorized.

YERVOY

Products Affected

- Yervoy intravenous solution 50 mg/10 mL (5 mg/mL)

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

YONDELIS

Products Affected

- Yondelis

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, Prior therapies
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by or in consultation with Oncologist
Coverage Duration	Plan Year
Other Criteria	For unresectable or metastatic liposarcoma or leiomyosarcoma patient must have received a prior anthracycline containing regimen.

ZALTRAP

Products Affected

- Zaltrap intravenous solution 100 mg/4 mL (25 mg/mL)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prior therapies tried.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	For metastatic colorectal cancer, must be used in combination with 5-fluorouracil, leucovorin, irinotecan (FOLFIRI).

ZEJULA

Products Affected

- Zejula

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, confirmed complete or partial response to platinum-based chemotherapy
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	Plan Year
Other Criteria	For ovarian cancer, patient has had a complete or partial response to platinum-based chemotherapy AND Zejula therapy is to begin within 8 weeks after the most recent platinum-containing regimen

ZELBORAF

Products Affected

- Zelboraf

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus, patients with melanoma already started on vemurafenib.
Exclusion Criteria	N/A
Required Medical Information	For the FDA-approved indication of melanoma, for patients new to therapy, BRAFV600E status required.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Melanoma, patient new to therapy must have BRAFV600E mutation for approval.

ZOLEDRONIC ACID

Products Affected

- zoledronic acid-mannitol-water

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D and patients already started on zoledronic acid for a covered use.
Exclusion Criteria	Concurrent Use with Other Medications for Osteoporosis (e.g., other bisphosphonates, Prolia, Forteo, Evista, calcitonin nasal spray), except calcium and Vitamin D.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Paget's 1 month. Others 12 months.
Other Criteria	Treatment of osteoporosis in post menopausal women or osteoporosis in men, must meet ONE of the following patient had an inadequate response after a trial duration of 12 months (eg, ongoing and significant loss of BMD, lack of BMD increase) or patient had an osteoporotic fracture while receiving therapy or patient experienced intolerability (eg, severe GI-related adverse effects, severe musculoskeletal-related side effects, a femoral fracture), OR pt cannot take an oral bisphosphonate because the pt cannot swallow or has difficulty swallowing or the pt cannot remain in an upright position post oral bisphosphonate administration or pt has a pre-existing GI medical condition (eg, patient with esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]). Prevention or treatment of glucocorticoid induced osteoporosis (GIO), approve if: pt is initiating or continuing therapy with systemic glucocorticoids, AND has had an inadequate response after a trial duration of 12 months (eg, ongoing and significant loss of BMD, lack of BMD increase) or patient had an osteoporotic fracture while receiving therapy or patient experienced intolerability (eg, severe GI-related adverse effects, severe musculoskeletal-related side effects, a femoral fracture), OR pt cannot take an oral bisphosphonate because the pt

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

ZYDELIG

Products Affected

- Zydelig

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Documentation of AST/ALT less than 20 x ULN and Bilirubin less than 10 x ULN.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ZYKADIA

Products Affected

- Zykadia

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	For metastatic non-small cell lung cancer that is anaplastic lymphoma kinase positive, patient must have progressed or be intolerant to crizotinib for approval.

PART B VERSUS PART D

Products Affected

- Abelcet intravenous suspension
- ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION,EXTENDED RELEASE RECON 300 MG
- Abraxane intravenous suspension for reconstitution
- acetylcysteine solution
- Actemra intravenous solution
- acyclovir sodium intravenous solution
- Adagen intramuscular solution
- Adriamycin intravenous solution 20 mg/10 mL
- Adrucil intravenous solution 500 mg/10 mL
- albuterol sulfate inhalation solution for nebulization 0.63 mg/3 mL, 1.25 mg/3 mL, 2.5 mg /3 mL (0.083 %), 5 mg/mL
- Aldurazyme intravenous solution
- Alimta intravenous recon soln 500 mg
- allopurinol sodium intravenous recon soln
- AmBisome intravenous suspension for reconstitution
- amikacin injection solution 500 mg/2 mL
- amino acids 15 % intravenous parenteral solution
- Aminosyn 8.5 %-electrolytes intravenous parenteral solution
- Aminosyn II 10 % intravenous parenteral solution
- Aminosyn II 15 % intravenous parenteral solution
- Aminosyn II 7 % intravenous parenteral solution
- Aminosyn II 8.5 % intravenous parenteral solution
- Aminosyn II 8.5 %-electrolytes intravenous parenteral solution
- Aminosyn-HBC 7% intravenous parenteral solution
- Aminosyn-PF 10 % intravenous parenteral solution
- Aminosyn-PF 7 % Sulfite Free intravenous parenteral solution
- Aminosyn-RF 5.2 % intravenous parenteral solution
- amiodarone intravenous solution
- amphotericin B injection recon soln
- ampicillin sodium injection recon soln 1 gram, 10 gram, 125 mg
- ampicillin-sulbactam injection recon soln
- aprepitant oral capsule
- aprepitant oral capsule,dose pack
- Aralast NP intravenous recon soln 500 mg
- Astagraf XL oral capsule,extended release 24hr
- Avastin intravenous solution
- Avelox in NaCl (iso-osm) intravenous piggyback
- Azasan oral tablet
- azathioprine oral tablet
- azathioprine sodium injection recon soln
- azithromycin intravenous recon soln
- BCG vaccine, live (PF) percutaneous suspension for reconstitution
- Beleodaq intravenous recon soln
- Benlysta intravenous recon soln
- benztropine injection solution
- BiCNU intravenous recon soln
- bleomycin injection recon soln 30 unit
- budesonide inhalation suspension for nebulization 0.25 mg/2 mL, 0.5 mg/2 mL, 1 mg/2 mL
- buprenorphine HCl injection solution
- buprenorphine HCl injection syringe
- Busulfex intravenous solution
- calcitriol intravenous solution 1 mcg/mL
- calcitriol oral capsule
- calcitriol oral solution
- Cancidas intravenous recon soln
- Capastat injection recon soln
- carboplatin intravenous solution
- cefazolin injection recon soln 1 gram, 10 gram, 500 mg
- cefepime injection recon soln

- cefoxitin intravenous recon soln
- ceftriaxone injection recon soln 10 gram, 250 mg, 500 mg
- ceftriaxone intravenous recon soln
- cefuroxime sodium injection recon soln 750 mg
- cefuroxime sodium intravenous recon soln
- CELLCEPT INTRAVENOUS RECON SOLN
- CellCept oral suspension for reconstitution
- Cerezyme intravenous recon soln 400 unit
- chloramphenicol sod succinate intravenous recon soln
- cidofovir intravenous solution
- Cimzia Powder for Reconst subcutaneous kit
- ciprofloxacin lactate intravenous solution 400 mg/40 mL
- cisplatin intravenous solution
- cladribine intravenous solution
- clindamycin phosphate injection solution
- clindamycin phosphate intravenous solution 600 mg/4 mL
- CLINIMIX 5%/D15W SULFITE FREE INTRAVENOUS PARENTERAL SOLUTION
- Clinimix 5%/D25W sulfite free intravenous parenteral solution
- Clinimix 2.75%/D5W Sulfite Free intravenous parenteral solution
- Clinimix 4.25%/D10W Sulfite Free intravenous parenteral solution
- Clinimix 4.25%/D5W Sulfite Free intravenous parenteral solution
- Clinimix 4.25%-D20W Sulfite Free intravenous parenteral solution
- Clinimix 4.25%-D25W Sulfite Free intravenous parenteral solution
- Clinimix 5%-D20W Sulfite Free intravenous parenteral solution
- Clinimix E 2.75%/D10W Sulfite Free intravenous parenteral solution
- Clinimix E 2.75%/D5W Sulfite Free intravenous parenteral solution
- Clinimix E 4.25%/D10W Sulfite Free intravenous parenteral solution
- Clinimix E 4.25%/D25W Sulfite Free intravenous parenteral solution
- Clinimix E 4.25%/D5W Sulfite Free intravenous parenteral solution
- Clinimix E 5%/D15W Sulfite Free intravenous parenteral solution
- Clinimix E 5%/D20W Sulfite Free intravenous parenteral solution
- Clinimix E 5%/D25W Sulfite Free intravenous parenteral solution
- clofarabine intravenous solution
- colistin (colistimethate Na) injection recon soln
- cromolyn inhalation solution for nebulization
- cyclophosphamide oral capsule
- cyclosporine intravenous solution
- cyclosporine modified oral capsule
- cyclosporine modified oral solution
- cyclosporine oral capsule
- cytarabine injection solution
- D2.5 %-0.45 % sodium chloride intravenous parenteral solution
- D5 % and 0.9 % sodium chloride intravenous parenteral solution
- D5 %-0.45 % sodium chloride intravenous parenteral solution
- dacarbazine intravenous recon soln 200 mg
- daunorubicin intravenous solution
- decitabine intravenous recon soln
- Depo-Provera intramuscular solution
- dexamethasone sodium phosphate injection solution
- dexrazoxane HCl intravenous recon soln 250 mg
- dextrose 10 % and 0.2 % NaCl intravenous parenteral solution
- dextrose 10 % in water (D10W) intravenous parenteral solution
- dextrose 5 % in water (D5W) intravenous parenteral solution
- dextrose 5 %-lactated ringers intravenous parenteral solution
- dextrose 5%-0.2 % sod chloride intravenous parenteral solution

- dextrose 5%-0.3 % sod.chloride intravenous parenteral solution
- Dextrose With Sodium Chloride intravenous parenteral solution
- diltiazem HCl intravenous recon soln
- diltiazem HCl intravenous solution
- diphenhydramine HCl injection solution 50 mg/mL
- doxorubicin intravenous solution 50 mg/25 mL
- doxorubicin, peg-liposomal intravenous suspension
- dronabinol oral capsule
- Duramorph (PF) injection solution 0.5 mg/mL, 1 mg/mL
- Elaprase intravenous solution
- Elelyso intravenous recon soln
- Elitek intravenous recon soln
- Emend oral suspension for reconstitution
- Engerix-B (PF) intramuscular syringe
- Engerix-B Pediatric (PF) intramuscular suspension
- Engerix-B Pediatric (PF) intramuscular syringe
- Envarsus XR oral tablet extended release 24 hr
- epirubicin intravenous solution 200 mg/100 mL
- Erythrocin intravenous recon soln 500 mg
- esomeprazole sodium intravenous recon soln
- etoposide intravenous solution
- famotidine (PF) intravenous solution
- famotidine (PF)-NaCl (iso-osm) intravenous piggyback
- Faslodex intramuscular syringe
- fluconazole in NaCl (iso-osm) intravenous piggyback 200 mg/100 mL, 400 mg/200 mL
- fludarabine intravenous recon soln
- fluorouracil intravenous solution 2.5 gram/50 mL
- fluphenazine decanoate injection solution
- fluphenazine HCl injection solution
- fomepizole intravenous solution
- fosphenytoin injection solution 100 mg PE/2 mL
- furosemide injection syringe
- Gammagard S-D (IgA < 1 mcg/mL) intravenous recon soln
- ganciclovir sodium intravenous recon soln
- gemcitabine intravenous recon soln 1 gram
- Gengraf oral capsule
- Gengraf oral solution
- gentamicin injection solution 40 mg/mL
- Geodon intramuscular recon soln
- granisetron (PF) intravenous solution 100 mcg/mL
- granisetron HCl intravenous solution
- granisetron HCl oral tablet
- haloperidol decanoate intramuscular solution
- haloperidol lactate injection solution
- heparin (porcine) in 5 % dex intravenous parenteral solution 20,000 unit/500 mL (40 unit/mL), 25,000 unit/250 mL(100 unit/mL), 25,000 unit/500 mL (50 unit/mL)
- heparin (porcine) injection solution
- Hepatamine 8% intravenous parenteral solution
- Herceptin intravenous recon soln 440 mg
- hydralazine injection solution
- hydromorphone (PF) injection solution
- hydroxyzine HCl intramuscular solution
- idarubicin intravenous solution
- ifosfamide intravenous recon soln 1 gram
- imipenem-cilastatin intravenous recon soln
- Increlex subcutaneous solution
- Intralipid intravenous emulsion 20 %
- Intralipid intravenous emulsion 30 %
- Intron A injection recon soln
- Intron A injection solution 6 million unit/mL
- ipratropium bromide inhalation solution
- ipratropium-albuterol inhalation solution for nebulization
- irinotecan intravenous solution 100 mg/5 mL

- Istodax intravenous recon soln
- labetalol intravenous solution
- leucovorin calcium injection recon soln 100 mg, 350 mg
- levalbuterol HCl inhalation solution for nebulization 0.31 mg/3 mL, 0.63 mg/3 mL, 1.25 mg/0.5 mL, 1.25 mg/3 mL
- levetiracetam intravenous solution
- levocarnitine (with sugar) oral solution
- levocarnitine oral tablet
- levofloxacin intravenous solution
- levoleucovorin intravenous solution
- lidocaine (PF) injection solution 10 mg/mL (1 %), 5 mg/mL (0.5 %)
- lidocaine HCl injection solution 20 mg/mL (2 %)
- magnesium sulfate injection solution
- magnesium sulfate injection syringe
- melphalan HCl intravenous recon soln
- meropenem intravenous recon soln 500 mg
- mesna intravenous solution
- methadone injection solution
- methotrexate sodium (PF) injection recon soln
- methotrexate sodium (PF) injection solution
- methotrexate sodium oral tablet
- methylprednisolone acetate injection suspension
- methylprednisolone sodium succ injection recon soln 125 mg, 40 mg
- methylprednisolone sodium succ intravenous recon soln
- metoclopramide HCl injection solution
- metoprolol tartrate intravenous solution
- metoprolol tartrate intravenous syringe
- Miacalcin injection solution
- mitomycin intravenous recon soln
- mitoxantrone intravenous concentrate
- morphine intravenous syringe 10 mg/mL, 8 mg/mL
- Mozobil subcutaneous solution
- Mustargen injection recon soln
- mycophenolate mofetil HCl intravenous recon soln
- mycophenolate mofetil oral capsule
- mycophenolate mofetil oral suspension for reconstitution
- mycophenolate mofetil oral tablet
- mycophenolate sodium oral tablet,delayed release (DR/EC)
- nafcillin injection recon soln 1 gram, 10 gram
- Naglazyme intravenous solution
- nalbuphine injection solution 10 mg/mL, 20 mg/mL
- Nebupent inhalation recon soln
- Neoral oral capsule
- Neoral oral solution
- Nephramine 5.4 % intravenous parenteral solution
- nitroglycerin intravenous solution
- Normosol-M in 5 % dextrose intravenous parenteral solution
- Normosol-R in 5 % dextrose intravenous parenteral solution
- Normosol-R pH 7.4 intravenous parenteral solution
- Nulojix intravenous recon soln
- ondansetron HCl (PF) injection solution
- ondansetron HCl (PF) injection syringe
- ondansetron HCl oral solution
- ondansetron HCl oral tablet
- ondansetron oral tablet,disintegrating
- oxaliplatin intravenous solution 100 mg/20 mL
- paclitaxel intravenous concentrate
- pamidronate intravenous solution
- paricalcitol oral capsule
- penicillin G potassium injection recon soln 5 million unit
- penicillin G sodium injection recon soln
- Pentam injection recon soln
- Perforomist inhalation solution for nebulization
- phenytoin sodium intravenous solution
- piperacillin-tazobactam intravenous recon soln 3.375 gram, 4.5 gram, 40.5 gram
- Plasma-Lyte 148 intravenous parenteral solution

- Plasma-Lyte A intravenous parenteral solution
- potassium chlorid-D5-0.45%NaCl intravenous parenteral solution
- potassium chloride in 0.9%NaCl intravenous parenteral solution 20 mEq/L, 40 mEq/L
- potassium chloride in 5 % dex intravenous parenteral solution 20 mEq/L, 40 mEq/L
- potassium chloride in LR-D5 intravenous parenteral solution 20 mEq/L
- potassium chloride-D5-0.2%NaCl intravenous parenteral solution 20 mEq/L
- potassium chloride-D5-0.3%NaCl intravenous parenteral solution 20 mEq/L
- potassium chloride-D5-0.9%NaCl intravenous parenteral solution
- Premarin injection recon soln
- Premasol 10 % intravenous parenteral solution
- Premasol 6 % intravenous parenteral solution
- Procalamine 3% intravenous parenteral solution
- Proleukin intravenous recon soln
- propranolol intravenous solution
- Prosol 20 % intravenous parenteral solution
- Pulmozyme inhalation solution
- Rapamune oral solution
- Rapamune oral tablet
- Recombivax HB (PF) intramuscular suspension 10 mcg/mL, 40 mcg/mL
- Recombivax HB (PF) intramuscular syringe
- Remodulin injection solution
- rifampin intravenous recon soln
- Ringer's intravenous parenteral solution
- Risperdal Consta intramuscular syringe
- Sancuso transdermal patch weekly
- Sandimmune oral capsule
- Sandimmune oral solution
- Sensipar oral tablet 30 mg, 60 mg, 90 mg
- Simulect intravenous recon soln 20 mg
- sirolimus oral tablet
- Solu-Cortef (PF) injection recon soln 100 mg/2 mL, 250 mg/2 mL
- Somatuline Depot subcutaneous syringe
- Somavert subcutaneous recon soln
- streptomycin intramuscular recon soln
- sulfamethoxazole-trimethoprim intravenous solution
- Synercid intravenous recon soln
- Synribo subcutaneous recon soln
- tacrolimus oral capsule
- Teflaro intravenous recon soln
- testosterone cypionate intramuscular oil
- testosterone enanthate intramuscular oil
- tetanus-diphtheria toxoids-Td intramuscular suspension
- tobramycin in 0.225 % NaCl inhalation solution for nebulization
- tobramycin sulfate injection solution
- Toposar intravenous solution
- topotecan intravenous recon soln
- tranexamic acid intravenous solution
- Travasol 10 % intravenous parenteral solution
- Treanda intravenous recon soln 100 mg
- Trelstar intramuscular syringe
- Trisenox intravenous solution
- TrophAmine 10 % intravenous parenteral solution
- Trophamine 6% intravenous parenteral solution
- Twinrix (PF) intramuscular suspension
- valproate sodium intravenous solution
- vancomycin intravenous recon soln 1,000 mg, 10 gram, 500 mg
- Varubi oral tablet
- Velcade injection recon soln
- verapamil intravenous solution
- vinblastine intravenous solution
- Vincasar PFS intravenous solution 1 mg/mL
- vincristine intravenous solution 1 mg/mL
- vinorelbine intravenous solution 50 mg/5 mL
- voriconazole intravenous solution
- VPRIV intravenous recon soln
- Xgeva subcutaneous solution

- Zemplar intravenous solution
- zoledronic acid intravenous solution
- Zometa intravenous piggyback
- Zortress oral tablet
- Zyprexa Relprevv intramuscular suspension for reconstitution 210 mg

Details

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

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