2015 Prior Authorization (PA) Criteria

Certain drugs require prior authorization from GuildNet Gold Plus FIDA Plan Medicare Plans. 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.

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.
Required Medical Information	MS exacerbation, history of corticosteroid use.
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.
Coverage Duration	Infantile spasms, Plan Year. MS exacerbation, approve 1 month.
Other Criteria	For MS 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 MS 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

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

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

ANTICONVULSANTS

Products Affected

- Qudexy XR
- topiramate oral capsule, sprinkle
- 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

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, or dermatologist.
Coverage Duration	Initial approval of MWS/FCAS, 2 mos. Subsequent auth for Plan Year if pt had a response.
Other Criteria	CAPS renewal - approve if they have had a response and are continuing therapy to maintain response/remission.

AVONEX

Products Affected

- Avonex (with albumin)
- Avonex intramuscular syringe kit

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

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	N/A
Coverage Duration	Plan Year
Other Criteria	For CML, patient must have Ph-positive CML and must have resistance or intolerance to prior therapy for approval.

CHORIONIC GONADOTROPINS (HCG)

Products Affected

- chorionic gonadotropin, human
- Novarel
- 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. Plus for the acute treatment of Hereditary Angioedema (HAE).
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	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

COPAXONE

Products Affected

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

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), or mitoxantrone.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan year
Other Criteria	Patients with previous use (12 or more months) of Copaxone 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.

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

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

EGRIFTA

Products Affected

- Egrifta subcutaneous recon soln 2 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 treament 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

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	N/A
Coverage Duration	Plan Year
Other Criteria	Locally advanced basal cell carcinoma (LABCC), approve if the patient's 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	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

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, or Rebif), glatiramer acetate, or mitoxantrone.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
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.

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	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	Documentation of metastatic non-small cell lung cancer (NSCLC) whose tumors have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations as detected by an FDA-approved test
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

GLEEVEC

Products Affected

- Gleevec 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 Gleevec 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 Gleevec for adjuvant therapy following resection, or 3) use of Gleevec for pre-operative therapy and patient is at risk for significant surgical morbidity.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

GROWTH HORMONE

Products Affected

- Norditropin FlexPro subcutaneous pen injector 10 mg/1.5 mL (6.7 mg/mL), 15 mg/1.5 mL (10 mg/mL), 5 mg/1.5 mL (3.3 mg/mL)
- Norditropin Nordiflex

PA Criteria	Criteria Details
Covered Uses	All FDA approved 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 for pediatric patients, growing more than 2 cm per year and for PWS only: improved body composition. For renewal for adult patients: patient has seen clinical improvement and IGF-1 will be monitored.
Age Restrictions	For Turner syndrome and SGA, 2 years of age and older. For Noonan syndrome and SHOX, 3 years of age and older.
Prescriber Restrictions	Endocrinologist, Pediatric Nephrologist, Gastroenterologist, Nutritional Support Specialist, Infectious Disease Specialist
Coverage Duration	Plan Year

Other Criteria	N/A

HRM

Products Affected

- benztropine oral
- butalbital-acetaminop-caf-cod
- clemastine oral syrup
- clemastine oral tablet 2.68 mg
- cyclobenzaprine oral tablet
- cyproheptadine
- eszopiclone
- Lanoxin oral
- meprobamate
- metaxalone
- methyldopa-hydrochlorothiazide
- nitrofurantoin macrocrystal oral capsule 50 mg
- nitrofurantoin monohyd/m-cryst
- reserpine

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
- 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 Restless Leg Syndrome and insomnia, authorize use. Restless Leg Syndrome, approve clonazepam or temazepam if the patient has tried one other agent for this condition (eg, ropinirole, pramipexole, carbidopa-levodopa [immediate-release or extended-release]). 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
- clorazepate dipotassium
- Diastat
- Diastat AcuDial
- Diazepam Intensol
- diazepam oral solution 5 mg/5 mL
- diazepam oral tablet
- diazepam rectal

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

- estradiol oral
- Surmontil

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

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	N/A
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	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

ILARIS

Products Affected

- Ilaris (PF)

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, or dermatologist. SJIA initial- prescribed by or in consultation with a rheumatologist
Coverage Duration	CAPS/MWS/FCAS-Initial 2 mos, renewal 12 mos. SJIA initial-2 mos, renewal 12 mos
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 diease, 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 limitions 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.

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	History of prior treatment with RCHOP therapy
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

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	N/A
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).

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 pt's 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	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	1 month 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.

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	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

LETAIRIS

Products Affected

- Letairis

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Pregnancy
Required Medical Information	NYHA class II or III symptoms. PAH been confirmed by right heart catheterization.
Age Restrictions	N/A
Prescriber Restrictions	N/A
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 high risk (greater than 20%) or intermediate risk (10-20%) for developing febrile neutropenia. Patients at low risk (less than 10%) for developing febrile neutropenia may also receive Leukine for prophylaxis if there is a significant risk for serious medical consequences due to febrile neutropenia and the intent of chemotherapy is to prolong survival or cure the disease. Leukine is allowable for the treatment of febrile neutropenia in patients who have received prophylaxis with Leukine (or Neupogen) OR in patients at risk for infection-related complications. All patients must receive baseline and regular monitoring of complete blood counts and platelet counts.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

LEUPROLIDE

Products Affected

- Eligard
- 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	N/A

LYNPARZA

Products Affected

- Lynparza

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

NAMENDA

Products Affected

- Namenda
- Namenda Titration Pak
- 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

NEUPOGEN

Products Affected

- Neupogen injection solution 480 mcg/1.6 mL
- Neupogen injection syringe

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 high risk (greater than 20%) or intermediate risk (10-20%) for developing febrile neutropenia. Patients at low risk (less than 10%) for developing febrile neutropenia may receive Neupogen for prophylaxis if there is a significant risk for serious medical consequences due to febrile neutropenia and the intent of chemotherapy is to prolong survival or cure the disease. Neupogen 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. All patients must receive baseline and regular monitoring of complete blood counts and platelet counts.
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

NUVIGIL/PROVIGIL

Products Affected

- modafinil
- Nuvigil

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

- 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

OLYSIO

Products Affected

- Olysio

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	18 years or older
Prescriber Restrictions	Prescribed by or in consultation with a GI, hepatologist, ID, or a liver transplant MD
Coverage Duration	12 weeks
Other Criteria	Genotype 1 - prescribed in combination with PegINF and RBV or in combination with Sovaldi. Has not failed therapy with Olysio or another NS3/4A Protease Inhibitor for HCV (i.e., Incivek or Victrelis). Pts with genotype 1a must NOT have the Q80K polymorphism (unknown Q80K status is not covered).

ONCASPAR

Products Affected

- Oncaspar

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

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	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

PEGINTRON

Products Affected

- PegIntron
- PegIntron Redipen

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Decompensated liver disease. Autoimmune hepatitis. Concomitant administration of didanosine with ribavirin in patients coinfected with HIV.
Required Medical Information	HCV: Prior to initiating therapy, detectable levels of HCV RNA in the serum. For HCV treatment nave, allow PegIntron monotherapy if patient has a contraindication or intolerance to ribavirin. For retreatment, must use in combination with ribavirin and must have nonresponse or relapse with prior HCV therapy. Allow only one time for retreatment with pegylated interferon and ribavirin. For Genotype 1 and 4: undetectable HCV RNA after 12 weeks of treatment OR at least 2 log decrease in HCV RNA after 12 weeks of therapy and undetectable HCV RNA after 24 weeks of treatment.
Age Restrictions	N/A
Prescriber Restrictions	ID specialist, Gastroenterologist, Oncologist
Coverage Duration	12 weeks to a total 72 weeks depending on genotype and initial vs. renewal therapy.
Other Criteria	Monitor for evidence of depression.

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

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	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 Pomalyst use. Patients should be monitored for signs and symptoms of thromboembolism.

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 (in combination with interferon or pegylated interferon alfa 2a/2b products with or without the direct-acting antiviral agents Victrelis or Incivek), and Anemia in HIV-infected patients.
Exclusion Criteria	N/A
Required Medical Information	Confirmation of adequate iron stores (eg, prescribing information recommends supplemental iron therapy when serum ferritin is less than 100 mcg/L or when serum transferrin saturation is less than 20%).CRF anemia in patients on and not on dialysis.Hemoglobin (Hb) of less than 10.0 g/dL for adults or less than or equal to 11 g/dL for children to start.Hb less than or equal to 11.5 g/dL for adults or 12 g/dL or less for children. Anemia w/myelosuppressive chemotx.pt must be currently receiving myelosuppressive chemo and Hb 10.0 g/dL or less to start.Hb less than or equal to 12.0 g/dL .MDS, approve if Hb is 10 g/dL or less or serum erythropoietin level is 500 mU/mL or less to start. 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 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
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.

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. Thrombocytopenia due to HCV-related cirrhosis, platelet counts.
Age Restrictions	Adults
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 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

REBIF

Products Affected

- Rebif (with albumin)
- 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 at least 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. Psoriatic arthritis with predominantly axial symptoms and ankylosing spondylitis - Must have an inadequate response or intolerance/contraindication to at least 2 non-steroidal anti-inflammatory drugs (NSAIDs). 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	N/A

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.

REVATIO

Products Affected

- sildenafil

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. If patient is an infant, PAH diagnosed by Doppler echocardiogram.
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 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) Revlimid is used after at least one prior therapy or as salvage therapy. 2) Revlimid is used with dexamethasone as primary induction therapy or in combination with melphalan and prednisone in nontransplant candidates. 3) Revlimid is used as maintenance monotherapy following response to either stem cell transplant or primary induction therapy. 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	Hemoglobin less than 8.5 g/dL. Hemoglobinopathy. History of unstable 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 interferon. For retreatment: patient must have nonresponse or relapse with prior HCV therapy. Allow only one time retreatment with pegylated interferon and ribavirin OR Infergen and ribavirin. For Genotype 1 and 4: undetectable HCV RNA after 12 weeks of treatment OR at least 2 log decrease in HCV RNA after 12 weeks of therapy and undetectable HCV RNA after 24 weeks of treatment.
Age Restrictions	N/A
Prescriber Restrictions	ID specialist, gastroenterologist, or oncologist
Coverage Duration	12 weeks to the end of the plan year depending on genotype and initial vs. renewal therapy.
Other Criteria	Patient has been instructed to practice effective contraception during therapy and for six months after stopping ribavirin therapy.

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,1mo. 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.

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	Initial treatment infantile spasms, 1 month to 2 years. Initial treatment CPS, 16 years or older.
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

SANDOSTATIN LAR

Products Affected

- Sandostatin LAR Depot intramuscular kit

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Patient received initial treatment with Sandostatin Injection (not the Depot form) for at least 2 weeks and treatment with Sandostatin Injection was effective and tolerable.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
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	prior treatment with Sovaldi
Required Medical Information	Will not be used in combination use with NS3/4A Protease Inhibitor (i.e., telaprevir, boceprevir)
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by or in consultation w/ GI, hepatologist, ID, or a liver transplant MD
Coverage Duration	12wk-geno1 triple tx,other.24 wk-geno1 dual tx,geno3/4 rbv only.48 wk geno1,2,3,4 liver trans
Other Criteria	Geno 1 - prescribed in combination with PegINF and RBV (PR), unless pt can't take INF based on a documented comorbid medical condition (e.g., autoimmune disorder, significant psychiatric disease, seizure disorder) then must be used in combo with RBV OR in combination with Olysio. Geno 2/3 - prescribed in combo with RBV. Geno 4 - prescribed in combo with PegINF/RBV. Geno 1, 2, 3, or 4 awaiting liver transplant - has HCC and prescribed in combination with RBV.

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, patient meets one of the following: 1) ALL is newly diagnosed and Sprycel is used in combination with chemotherapy, or 2) 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	N/A
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
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 mutation
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	N/A

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 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

- Targretin oral

PA Criteria	Criteria Details
Covered Uses	All FDA approved 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	N/A
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.

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

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	Authorization will be for the plan year, unless otherwise specified.
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).

TRACLEER

Products Affected

- Tracleer

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	AST/ALT level greater than 3 times upper limit of normal (ULN). Pregnancy. Concomitant use of cyclosporine A or glyburide.
Required Medical Information	PAH confirmed by right heart catheterization. NYHA Class II-IV symptoms.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	Female patients of childbearing potential must use more than one method of contraception concurrently.

TRETINOIN

Products Affected

- adapalene topical cream
- adapalene topical gel 0.1 %
- tretinoin microspheres topical gel with pump
- tretinoin topical

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

VIEKIRA

Products Affected

- Viekira Pak

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrent treatment with interferon, Sovaldi, Olysio, or Harvoni
Required Medical Information	Genotype and subtype
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by or in consultation w/ GI, hepatologist, ID, or a liver transplant MD
Coverage Duration	12WK: Gen-1a-no cirr+rbv, Gen-1b-no cirr, Gen-1b/cirr+rbv. 24WK: Gen-1a/cirr+rb, Liver tran+rbv.
Other Criteria	Geno 1a w/ or w/o cirrhosis-prescribed in combination with RBV. Geno 1b w/ cirrhosis-prescribed in combination with RBV.Liver transplant recipients with normal hepatic function and metavir score less than 2-prescribed in combination with RBV.

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	A. The patient will receive Vimpat as an adjunctive anticonvulsant for the treatment of partial onset seizures. B. The patient had a previous or present trial/failure/contraindication to two or more of the following: carbamazepine, divalproex, ethosuximide, ethotoin, gabapentin, lamotrigine, levetiracetam, methsuximide, oxcarbazepine, phenytoin, phenobarbital, pregabalin, rufinamide, tiagabine, topiramate, valproic acid or zonisamide.
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.
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.

XENAZINE

Products Affected

- Xenazine

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, Xenazine must be prescribed by or after consultation with a neurologist. For TD, Xenazine must be prescribed by or after consultation with a neurologist or psychiatrist.
Coverage Duration	Plan Year
Other Criteria	N/A

XOLAIR

Products Affected

- Xolair

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	12 years of age and older
Prescriber Restrictions	Pulmonologist, allergist or immunologist
Coverage Duration	Plan Year
Other Criteria	To continue therapy, patients must demonstrate an improvement in asthma control with use of Xolair.

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	N/A
Required Medical Information	Diagnosis for which Xtandi is being used. For metastatic castration-resistant prostate cancer, prior therapies tried.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Plan Year
Other Criteria	For prostate cancer, patient must have metastatic, castration-resistant prostate cancer for approval. For metastatic, castration-resistant prostate cancer, patient must have previously received therapy with docetaxel for approval.

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.

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.

ZYVOX

Products Affected

- linezolid
- Zyvox intravenous parenteral solution 600 mg/300 mL
- Zyvox oral

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	Up to 28 days
Other Criteria	N/A

PART B VERSUS PART D

Products Affected

- Abelcet
- Abilify intramuscular
- Abilify Maintena intramuscular suspension,extended rel recon 300 mg
- Abilify Maintena intramuscular suspension,extended rel syring
- acetylcysteine solution
- Actemra intravenous solution 200 mg/10 mL (20 mg/mL)
- acyclovir sodium intravenous solution
- Adagen
- Adrucil intravenous solution 500 mg/10 mL
- A-Hydrocort
- 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
- Alimta intravenous recon soln 500 mg
- AmBisome
- amifostine crystalline
- amikacin injection solution 500 mg/2 mL
- aminophylline intravenous solution 250 mg/10 mL
- Aminosyn 8.5 %-electrolytes
- Aminosyn II 10 %
- Aminosyn II 15 %
- Aminosyn II 7 %
- Aminosyn II 8.5 %
- Aminosyn II 8.5 %-electrolytes
- Aminosyn M 3.5 %
- Aminosyn-HBC 7%
- Aminosyn-PF 10 %
- Aminosyn-PF 7 % (sulfite-free)
- Aminosyn-RF 5.2 %
- amiodarone intravenous solution
- amphotericin B
- ampicillin sodium injection recon soln 1 gram, 10 gram, 125 mg
- ampicillin-sulbactam injection recon soln 15 gram, 3 gram
- ampicillin-sulbactam intravenous recon soln 1.5 gram
- Aralast NP intravenous recon soln 500 mg
- Astagraf XL
- Avastin
- Avelox in NaCl (iso-osmotic)
- Azasan
- azathioprine
- azithromycin intravenous
- BACiiM
- bacitracin intramuscular
- BCG vaccine, live (PF)
- Beleodaq
- Benlysta intravenous recon soln 120 mg
- benztropine injection
- Bicillin C-R
- BiCNU
- bleomycin injection recon soln 30 unit
- budesonide inhalation
- buprenorphine HCl injection syringe
- Busulfex
- calcitriol intravenous solution 1 mcg/mL
- calcitriol oral
- Cancidas
- Capastat
- carboplatin intravenous solution
- cefazolin in dextrose (iso-os) intravenous piggyback 1 gram/50 mL
- cefazolin injection recon soln 1 gram, 10 gram, 500 mg
- cefepime
- cefotaxime injection recon soln 1 gram, 2 gram, 500 mg
- cefoxitin
- cefoxitin in dextrose, iso-osm
- ceftazidime injection recon soln 1 gram, 2 gram
- ceftriaxone injection recon soln 10 gram, 250 mg, 500 mg
- ceftriaxone intravenous recon soln
- cefuroxime sodium injection recon soln 1.5 gram, 750 mg

- cefuroxime sodium intravenous
- CellCept Intravenous
- CellCept oral suspension for reconstitution
- Cerebyx injection solution 500 mg PE/10 mL
- Cerezyme intravenous recon soln 400 unit
- chloramphenicol sod succinate
- cidofovir
- Cimzia Powder for Reconst
- ciprofloxacin lactate intravenous solution 400 mg/40 mL
- cisplatin
- cladribine
- clindamycin phosphate intravenous solution 600 mg/4 mL
- Clinimix 5%/D15W Sulfite Free
- Clinimix 5%/D25W sulfite-free
- Clinimix 2.75%/D5W Sulfit Free
- Clinimix 4.25%/D10W Sulf Free
- Clinimix 4.25%/D5W Sulfit Free
- Clinimix 4.25%-D20W sulf-free
- Clinimix 4.25%-D25W sulf-free
- Clinimix 5%-D20W(sulfite-free)
- Clinimix E 2.75%/D10W Sul Free
- Clinimix E 2.75%/D5W Sulf Free
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- Clinimix E 4.25%/D25W Sul Free
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- Clinimix E 5%/D15W Sulfit Free
- Clinimix E 5%/D20W Sulfit Free
- Clinimix E 5%/D25W Sulfit Free
- Clinisol SF 15 %
- colistin (colistimethate Na)
- Cosmegen
- cromolyn inhalation
- Cubicin
- cyclophosphamide oral capsule
- cyclosporine intravenous
- cyclosporine modified
- cyclosporine oral capsule
- cytarabine
- D2.5 %-0.45 % sodium chloride
- D5 % and 0.9 % sodium chloride
- D5 %-0.45 % sodium chloride
- dacarbazine intravenous recon soln 200 mg
- daunorubicin intravenous solution
- decitabine
- Delestrogen
- Depo-Provera intramuscular solution
- dexamethasone sodium phosphate injection
- dexrazoxane HCl intravenous recon soln 250 mg
- dextrose 10 % and 0.2 % NaCl
- dextrose 10 % in water (D10W) intravenous parenteral solution
- dextrose 5 % in water (D5W) intravenous parenteral solution
- dextrose 5 %-lactated ringers
- dextrose 5%-0.2 % sod chloride
- dextrose 5%-0.3 % sod.chloride
- Dextrose With Sodium Chloride
- Dextrose-KCl-NaCl
- diltiazem HCl intravenous
- diphenhydramine HCl injection solution 50 mg/mL
- Doxil
- doxorubicin intravenous solution 50 mg/25 mL
- Doxy-100
- doxycycline hyclate intravenous
- dronabinol
- Duramorph (PF) injection solution 0.5 mg/mL, 1 mg/mL
- Elaprase
- Elelyso
- Elitek intravenous recon soln 1.5 mg
- Emend oral capsule 125 mg, 40 mg, 80 mg
- Emend oral capsule,dose pack
- Engerix-B (PF) intramuscular syringe
- Engerix-B Pediatric (PF)
- epirubicin intravenous solution 50 mg/25 mL
- Erythrocin intravenous recon soln 500 mg
- esomeprazole sodium
- estradiol valerate intramuscular oil 20 mg/mL
- etoposide intravenous
- Fabrazyme intravenous recon soln 35 mg
- famotidine (PF)
- famotidine (PF)-NaCl (iso-os)
- Faslodex

- fluconazole in dextrose(iso-o) intravenous piggyback 400 mg/200 mL
- fludarabine intravenous recon soln
- fluorouracil intravenous solution 2.5 gram/50 mL
- fluphenazine decanoate
- fluphenazine HCl injection
- fomepizole
- fosphenytoin injection solution 100 mg PE/2 mL
- furosemide injection
- ganciclovir sodium
- gemcitabine intravenous recon soln 1 gram
- Gemzar intravenous recon soln 1 gram
- Gengraf
- gentamicin in NaCl (iso-osm) intravenous piggyback 100 mg/100 mL
- gentamicin in NaCl (iso-osm) intravenous piggyback 80 mg/100 mL
- gentamicin injection solution 40 mg/mL
- gentamicin sulfate (PF) intravenous solution 80 mg/8 mL
- Geodon intramuscular
- granisetron (PF) intravenous solution 100 mcg/mL
- granisetron HCl intravenous solution 1 mg/mL (1 mL)
- granisetron HCl oral
- haloperidol decanoate
- haloperidol lactate injection
- Havrix (PF) intramuscular suspension 1,440 Elisa unit/mL
- Havrix (PF) intramuscular syringe 720 Elisa unit/0.5 mL
- 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%
- Herceptin
- hydralazine injection
- hydromorphone (PF) injection solution 10 mg/mL
- hydroxyzine HCl intramuscular
- idarubicin
- Ifex intravenous recon soln 1 gram
- ifosfamide intravenous recon soln 1 gram
- imipenem-cilastatin
- Increlex
- Intralipid intravenous emulsion 20 %, 30 %
- Intron A injection recon soln
- Intron A injection solution 6 million unit/mL
- Invanz injection
- Invega Sustenna
- Ionosol-B in D5W
- Ionosol-MB in D5W
- ipratropium bromide inhalation
- ipratropium-albuterol
- irinotecan intravenous solution 100 mg/5 mL
- Istodax
- Kadcyla intravenous recon soln 100 mg
- Keytruda 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
- levetiracetam in NaCl (iso-os)
- levetiracetam intravenous
- levocarnitine (with sugar)
- levocarnitine intravenous
- levocarnitine oral tablet
- levofloxacin intravenous
- levoleucovorin calcium
- levothyroxine intravenous recon soln 100 mcg
- lidocaine (PF) injection solution 5 mg/mL (0.5 %)
- lidocaine HCl injection solution 20 mg/mL (2 %)
- Liposyn III intravenous emulsion 10 %, 20 %
- magnesium sulfate injection
- melphalan HCl
- meropenem intravenous recon soln 500 mg
- mesna
- methadone injection
- methotrexate sodium (PF)
- methotrexate sodium oral

- methylprednisolone acetate
- methylprednisolone sodium succ injection recon soln 125 mg, 40 mg
- metoclopramide HCl injection solution
- metoprolol tartrate intravenous solution
- Miacalcin injection
- mitomycin intravenous recon soln 20 mg
- mitoxantrone
- morphine intravenous syringe 10 mg/mL, 8 mg/mL
- Mozobil
- Mustargen
- mycophenolate mofetil
- mycophenolate sodium
- Myozyme
- nafcillin in dextrose iso-osm intravenous piggyback 1 gram/50 mL
- nafcillin injection recon soln 1 gram
- nafcillin injection recon soln 10 gram
- Naglazyme
- nalbuphine injection solution 10 mg/mL, 20 mg/mL
- Nebupent
- Neoral
- Nephramine 5.4 %
- Neumega
- Nexium IV
- nitroglycerin intravenous
- Normosol-M in 5 % dextrose
- Normosol-R in 5 % dextrose
- Normosol-R pH 7.4
- Nulojix
- ondansetron
- ondansetron HCl (PF)
- ondansetron HCl oral solution
- ondansetron HCl oral tablet 24 mg, 4 mg, 8 mg
- oxacillin in dextrose(iso-osm)
- oxacillin injection recon soln 10 gram
- oxacillin intravenous recon soln 2 gram
- oxaliplatin intravenous solution 100 mg/20 mL
- paclitaxel
- pamidronate intravenous solution
- paricalcitol oral
- penicillin G potassium injection recon soln 5 million unit
- penicillin G procaine intramuscular syringe 1.2 million unit/2 mL
- penicillin G sodium
- Pentam
- Perforomist
- Perjeta
- phenytoin sodium intravenous solution
- piperacillin-tazobactam intravenous recon soln 3.375 gram, 4.5 gram
- Plasma-Lyte 148
- Plasma-Lyte A
- Plasma-Lyte-56 in 5 % dextrose
- potassium chlorid-D5-0.45%NaCl
- 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
- Premarin injection
- Premasol 10 %
- Premasol 6 %
- Procalamine 3%
- Proleukin
- Prolia
- propranolol intravenous
- Prosol 20 %
- Pulmozyme
- ranitidine HCl injection solution 25 mg/mL
- Rapamune
- Recombivax HB (PF) intramuscular suspension 10 mcg/mL, 40 mcg/mL
- Recombivax HB (PF) intramuscular syringe
- Remodulin
- Rheumatrex
- rifampin intravenous
- ringers intravenous

- Risperdal Consta
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- Simulect intravenous recon soln 20 mg
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- Somatuline Depot
- Somavert
- streptomycin intramuscular
- sulfamethoxazole-trimethoprim intravenous
- Synercid
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- tacrolimus oral
- tacrolimus oral
- Teflaro
- terbutaline subcutaneous
- testosterone cypionate intramuscular oil 200 mg/mL
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- tetanus toxoid,adsorbed (PF)
- tetanus-diphtheria toxoids-Td
- tobramycin in 0.225 % NaCl
- tobramycin sulfate injection solution
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- topotecan intravenous recon soln
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- tranexamic acid intravenous
- Travasol 10 %
- Treanda intravenous recon soln 100 mg
- Treanda intravenous solution 45 mg/0.5 mL
- Trelstar intramuscular suspension for reconstitution
- Trelstar intramuscular syringe 11.25 mg/2 mL, 3.75 mg/2 mL
- Trisenox
- TrophAmine 10 %
- Trophamine 6%
- Twinrix (PF) intramuscular suspension
- valproate sodium
- vancomycin intravenous recon soln 1,000 mg, 10 gram, 500 mg
- Vaqta (PF) intramuscular suspension 25 unit/0.5 mL
- Velcade
- 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
- Virazole
- voriconazole intravenous
- VPRIV
- Xgeva
- Zaltrap intravenous solution 100 mg/4 mL (25 mg/mL)
- Zemplar intravenous
- zoledronic acid intravenous solution
- zoledronic acid-mannitol-water intravenous solution
- Zometa intravenous solution 4 mg/100 mL
- Zortress
- 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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GuildNet Gold Plus FIDA Plan is an MMP-POS plan with a Medicare and New York State Medicaid contract. Enrollment in GuildNet Gold Plus FIDA Plan depends on contract renewal.

Beneficiaries must use network pharmacies to access their premium and/or copayment/coinsurance may change on January 1, 2016.

This document includes GuildNet Gold Plus FIDA Plan's partial formulary as of July 1, 2015. For a complete, updated formulary, please visit our website at www.guildnetny.org or call 1-800-815-0000 (TTY 1-800-662-1220).

For alternative formats or language, please call Participant Services toll free at: 1-800-815-0000, Monday through Sunday from 8am to 8pm. TTY/TDD users should call 1-800-662-1220.

You can get this information for free in other languages. Call 1-800-815-0000 and TTY/TDD 1-800-662-1220 during 8am to 8pm. The call is free.

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The State of New York has created a participant ombudsman program called the Independent Consumer Advocacy Network (ICAN) to provide Participants free, confidential assistance on any services offered by GuildNet Gold Plus FIDA Plan. ICAN may be reached toll-free at 1-844-614-8800 or online at icannys.org.

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