2019 AmeriHealth Caritas VIP Care Plus
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ACITRETIN

Products Affected

- *acitretin*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For prophylaxis of skin cancer in patients with previously treated skin cancers who have undergone an organ transplantation the request will be approved. For psoriasis: the patient has documented adequate trials and/or has another documented medical reason for not using at least 2 of the treatment options listed: topical steroids, Tazorac (tazarotene), methotrexate, and cyclosporine.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a dermatologist or an oncologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

ACTEMRA

Products Affected

- ACTEMRA SUBCUTANEOUS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation was submitted indicating that the member was evaluated for active or latent TB infection (i.e. tuberculin skin test).
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	Trial and failure or medical reason for not using Humira (adalimumab) and Enbrel (etanercept) for appropriate indications.

ACTIMMUNE

Products Affected

- ACTIMMUNE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

ADEMPAS

Products Affected

- ADEMPAS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Concomitant use with PDE inhibitor or nitrate therapy
Required Medical Information	Documentation of pulmonary arterial hypertension (PAH) WHO Group classification. For WHO Group I and IV, documentation of PAH Functional Class. Reviewer will verify available patient claim history to confirm patient is not using PDE inhibitors or nitrates.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or cardiologist
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

AFINITOR

Products Affected

- AFINITOR
- AFINITOR DISPERZ

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of members treatment history for relevant disease state. Provider attests that patient's complete blood count with differential, liver function, renal function, blood glucose and lipid profile will be monitored for the duration of therapy as indicated in compendia. Provider also attests that for patients who have subependymal giant cell astrocytoma (SEGA) or tuberous sclerosis complex (TSC)-associated partial seizure, whole blood trough concentration will be routinely monitored as indicated in compendia.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist or neurologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

ALECENSA

Products Affected

- ALECENSA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that patient's liver function tests, heart rate and blood pressure will be monitored for the duration of therapy as indicated in compendia.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

ALPHA-1 PROTEINASE INHIBITORS

Products Affected

- ARALAST NP INTRAVENOUS RECON SOLN 1,000 MG
- GLASSIA
- PROLASTIN-C INTRAVENOUS RECON SOLN
- ZEMAIRA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of hereditary alpha1-antitrypsin deficiency as evident by pretreatment serum AAT levels below 11 micrometer/L and progressive FEV1 or FVC decline demonstrating symptomatic lung disease
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	If the medication request is for an Alpha1-Proteinase Inhibitor (human) product other than Prolastin, the patient has a documented medical reason (such as trial, failure or contraindication) for not using Prolastin to treat their medical condition.

ALUNBRIG

Products Affected

- ALUNBRIG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that blood pressure, heart rate, serum glucose, creatine phosphokinase and lipase & amylase levels will be monitored for the duration of therapy as indicated in compendia.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

AMPYRA

Products Affected

- AMPYRA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	History of seizure.
Required Medical Information	If diagnosis is RRMS, documentation has been provided that member is ambulatory (able to walk at least 25 feet), has a documented walking impairment, and is currently being treated with a disease modifying agent (e.g. immunomodulator, interferon, etc) or has a medical reason why member is unable to use a disease modifying agent for their condition. For all other types of MS, only documentation that member is ambulatory with a documented walking impairment is required.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	For re-authorization, member must experience improvement in walking due to use of Ampyra

ANADROL

Products Affected

- ANADROL-50

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	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

APOKYN

Products Affected

- APOKYN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Apokyn (apomorphine hydrochloride) is contraindicated in concomitant use with serotonin 5-HT3 receptor antagonists.
Required Medical Information	Reviewer will verify available patient claim history to confirm patient is not using 5-HT3 receptor antagonists. If diagnosis is Parkinsons, the patient has a documented trial and failure or intolerance to two formulary alternatives such as entacapone, tolcapone, rasagiline, selegiline, carbidopa/levodopa, bromocriptine, pramipexole or ropinirole.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

ARCALYST

Products Affected

- ARCALYST

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

ARIPIPRAZOLE LONG ACTING

Products Affected

- ABILIFY MAINTENA
- ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 1,064 MG/3.9 ML, 441 MG/1.6 ML, 662 MG/2.4 ML, 882 MG/3.2 ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	The member has a documented history of receiving oral aripiprazole without any clinically significant side effects. Additionally, the member has a documented trial and failure or medical reason (e.g. intolerance, hypersensitivity or contraindication) for not utilizing one of these therapies to manage their medical condition: Invega Sustenna, Invega Trinza or Risperdal Consta.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

BENLYSTA

Products Affected

- BENLYSTA SUBCUTANEOUS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation has been provided indicating the patient has had an adequate trial of two or more of the following agents: glucocorticoids, azathioprine, methotrexate, mycophenolate, or hydroxychloroquine.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a rheumatologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

BENZNIDAZOLE

Products Affected

- *benznidazole*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Patients who have used disulfiram within two weeks of initiation of benznidazole
Required Medical Information	Documentation of a consultation with an infectious disease specialist. Reviewer will verify available patient claim history to confirm that patient has not used disulfiram within two weeks prior to benznidazole initiation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If all conditions are met, the request will be authorized for 60 days of treatment.
Other Criteria	N/A

BOSULIF

Products Affected

- BOSULIF

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that complete blood count, liver function tests and renal function will be monitored for the duration of therapy as indicated in compendia
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

C1 ESTERASE INHIBITOR

Products Affected

- CINRYZE
- HAEGARDA

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	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	Documentation of either trial or a medical reason (e.g. intolerance or hypersensitivity) for not being able to use Danazol to manage their medical condition

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	Provider attests that urine protein levels and blood pressure will be monitored daily for the duration of therapy as indicated in compendia.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	If all conditions are met the request will be approved until the end of contract year.
Other Criteria	N/A

CALQUENCE

Products Affected

- CALQUENCE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that complete blood cell count will be monitored prior to initiation and throughout duration of therapy as indicated in compendia
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a hematologist or an oncologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

CANCIDAS

Products Affected

- *caspofungin*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of a consultation with an infectious disease specialist.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

CARBAGLU

Products Affected

- CARBAGLU

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

CERDELGA

Products Affected

- CERDELGA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	For Cerdelga requests, patients with undetermined CYP2D6 metabolizer status
Required Medical Information	If request is for Cerdelga, patient's CYP2D6 metabolizer status, as determined by an FDA approved test.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	For reauthorization, patient must have continued benefit with the use of agent.

CGRP ANTAGONISTS

Products Affected

- AIMOVIG AUTOINJECTOR (2 PACK)

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that patient has at least 4 migraine days per month or one or more severe migraines lasting for greater than 12 hours despite use of abortive therapy (e.g. triptans or NSAIDs).
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	Initial request will be authorized for 6 months. Reauthorization until end of benefit year.
Other Criteria	For patient newly initiated on CGRP antagonists: Patient must have documented trial and failure, intolerance or a medical reason for not being able to use two medications from the following classes (with each drug belonging to a different class): beta adrenergic blockers, anti-epileptics (topiramate, valproate or divalproex). For reauthorization, patient must have experienced reduction of at least 1 headache day per month within the last month of the initial authorization period.

CHOLBAM

Products Affected

- CHOLBAM

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	Prescriber must be a hepatologist or gastroenterologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year
Other Criteria	N/A

CIMZIA

Products Affected

- CIMZIA
- CIMZIA POWDER FOR RECONST

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation was submitted indicating that the member was evaluated for active or latent TB infection (i.e. tuberculin skin test).
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	Trial and failure or medical reason for not using Humira (adalimumab) and Enbrel (etanercept) for appropriate indications.

COMETRIQ

Products Affected

- COMETRIQ

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that blood pressure and urine protein will be monitored routinely for the duration of therapy as indicated in compendia
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

CORLANOR

Products Affected

- CORLANOR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Blood pressure less than 90/50 mmHg
Required Medical Information	New starts for chronic heart failure must have all of the following: 1) chronic heart failure (NYHA II through IV), have LVEF of 35% or less 2) have sinus rhythm and have resting heart rate greater than or equal to 70 bpm 3) blood pressure greater than or equal to 90/50 mmHg and 4) Tried or is currently receiving beta blocker unless the patient has a contraindication to the use of beta blocker therapy.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a cardiologist
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	Continuation of therapy for chronic heart failure: decreased number of hospitalizations due to acute heart failure while using Corlanor.

COSENTYX

Products Affected

- COSENTYX (2 SYRINGES)
- COSENTYX PEN (2 PENS)

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation was submitted indicating that the member was evaluated for active or latent TB infection (i.e. tuberculin skin test).
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	Trial and failure or medical reason for not using Humira (adalimumab) and Enbrel (etanercept) for appropriate indications.

COTELLIC

Products Affected

- COTELLIC

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that LVEF, SCr, CPK, LFTs have been assessed, and dermatologic and ophthalmologic evaluations have been performed prior to initiation of therapy, and will be routinely assessed throughout the duration of therapy as indicated in compendia. Additionally, for appropriate indications confirmation of BRAF V600K or V600E mutation status with an FDA approved test.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

CUBICIN

Products Affected

- *daptomycin intravenous recon soln 500 mg*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of a consultation with an infectious disease specialist.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

CYSTAGON

Products Affected

- CYSTAGON

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	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

DEFERASIROX

Products Affected

- EXJADE
- JADENU
- JADENU SPRINKLE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Patients with serum creatinine greater than 2 times the age-appropriate upper limit of normal or creatinine clearance less than 40ml/min, patients with platelet counts less than 50,000/mm3
Required Medical Information	For diagnosis of chronic iron overload due to transfusions: laboratory result within 30 days of request for serum ferritin concentration is greater than 1000 mcg/L, platelet count, SCr and CrCl. For diagnosis of chronic iron overload in nontransfusion-dependent thalassemia syndromes: laboratory results with 30 days of request for serum ferritin concentration is greater than 300mcg/L, platelet counts, SCr and CrCl.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

DEMSER

Products Affected

- DEMSER

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of one of the following: 1)Concurrent use of alpha adrenergic blockers 2) medical reason for being unable to use an alpha adrenergic blocker OR 3)patient is not a candidate for surgical resection and requires long term treatment with Demser
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

DEPEN

Products Affected

- DEPEN TITRATABS

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	Specialist for submitted diagnosis.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	Trial and failure or medical reason for not using Humira (adalimumab) and Enbrel (etanercept) for appropriate indications.

DEPO-PROVERA

Products Affected

- DEPO-PROVERA INTRAMUSCULAR SUSPENSION 400 MG/ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a gynecologist, family practice or an oncologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

DIFICID

Products Affected

- DIFICID

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	If all conditions are met, the request will be authorized for 10 days
Other Criteria	Documentation of prior use, or a medical reason for being unable to use oral vancomycin for current infection.

DOPTELET

Products Affected

- DOPTELET

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that complete blood count with differential will be monitored throughout the duration of the therapy as indicated in compendia.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If all conditions are met, the request will be authorized for 5 days.
Other Criteria	N/A

DORIPENEM

Products Affected

- *doripenem intravenous recon soln 500 mg*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If all conditions are met, the request will be authorized for 14 days of treatment.
Other Criteria	N/A

DUPIXENT

Products Affected

- DUPIXENT

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	Prescriber must be a dermatologist, immunologist or an allergist
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	Documented trial and failure or medical reason (e.g. very large surface area affected by atopic dermatitis) for not using the following therapies: 1) topical tacrolimus or Elidel and 2) Eucrisa.

EGRIFTA

Products Affected

- EGRIFTA SUBCUTANEOUS RECON SOLN 1 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of active antiretroviral therapy for at least 8 weeks.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

ENBREL

Products Affected

- ENBREL
- ENBREL SURECLICK

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation was submitted indicating that the member was evaluated for active or latent TB infection (i.e. tuberculin skin test).
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	Trial and failure or medical reason for not using the following if applicable for submitted diagnosis: 1) For Rheumatoid Arthritis, Psoriatic Arthritis, or Juvenile Idiopathic Arthritis: one DMARD (e.g. methotrexate, sulfasalazine, generic leflunomide (Arava), etc.), 2) For Ankylosing Spondylitis: two nonsteroidal anti-inflammatory drugs (NSAIDS), 3) For Plaque Psoriasis one of the following: topical steroids, topical calcipotriene, Tazorac (tazorotene), Methotrexate, UVB phototherapy and/or PUVA therapy.

ENDARI

Products Affected

- ENDARI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation that patient has had two or more painful sickle cell crises within the past 12 months and that they have been taking hydroxyurea for the past three months or longer.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a hematologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

ERAXIS

Products Affected

- ERAXIS(WATER DILUENT)

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	Documentation of a consultation with an infectious disease specialist.
Coverage Duration	If all conditions are met, the request will be approved for up to 42 days of treatment per request.
Other Criteria	N/A

ERIVEDGE

Products Affected

- ERIVEDGE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist or dermatologist
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

ERLEADA

Products Affected

- ERLEADA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For appropriate indication(s) patient must have history of bilateral orchiectomy or must be concurrently using Erleada with gonadotropin-releasing hormone (GnRH).
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

ERYTHROPOETIN STIMULATING AGENTS

Products Affected

- ARANESP (IN POLYSORBATE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 25 MCG/ML, 300 MCG/ML, 40 MCG/ML, 60 MCG/ML
- ARANESP (IN POLYSORBATE) INJECTION SYRINGE
- EPOGEN INJECTION SOLUTION 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML
- PROCRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML, 40,000 UNIT/ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Laboratory results within 30 days of request: Hemoglobin
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If all conditions are met, the request will be authorized for 6 months.
Other Criteria	For initial therapy, the Hgb must be less than 10g/dL for all indications or within compendia range for treatment of the requested medical condition. If the request is for Aranesp, the provider submitted a documented medical reason (i.e. intolerance, contraindication, hypersensitvity) why they are unable to use Epogen or Procrit. For re-authorization, Hgb must not exceed 10g/dL(cancer), 12g/dL(zidovudine-treated HIV patients), 10 to 13g/dL(Elective, noncardiac, nonvascular surgery needing red blood cell allogeneic transfusion reduction).

ESBRIET

Products Affected

- ESBRIET

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	Prescriber must be an pulmonologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

EUCRISA

Products Affected

- EUCRISA

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	Prescriber must be a dermatologist, immunologist or an allergist
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	Documented trial and failure or medical reason (e.g. intolerance or hypersensitivity) for not using the following therapies: Topical tacrolimus or Elidel.

FARESTON

Products Affected

- FARESTON

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that complete blood count, electrolytes levels (including magnesium, potassium and calcium), and liver function tests will be monitored for the duration of therapy as indicated in compendia.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	Patient must have documented trial and failure or intolerance to tamoxifen.

FARYDAK

Products Affected

- FARYDAK

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of prior treatment history for related indications. Provider attests that complete blood count with differential and platelets, serum electrolytes (including potassium, magnesium, and phosphate), liver function tests and ECG monitoring will be completed for the duration of therapy as indicated in compendia.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist or a hematologist
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

FENTANYL CITRATE ORAL TRANSMUCOSAL

Products Affected

- *fentanyl citrate*

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	If all conditions are met, the request will be authorized for 6 months.
Other Criteria	Patient is currently receiving long-acting opioid therapy.

FERRIPROX

Products Affected

- FERRIPROX ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For initial therapy, documentation of the patient's serum ferritin level above 2,500 mcg/L and absolute neutrophil count (ANC) greater than 1.5x10^9/L within 30 days of request.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	For continuation of therapy, approve if the patient is benefiting from therapy as confirmed by the prescribing provider.

FIRAZYR

Products Affected

- FIRAZYR

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	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

FORTEO

Products Affected

- FORTEO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation showing patient falls into one of the following categories:Postmenopausal woman who has a bone mineral density (BMD) value consistent with osteoporosis (i.e., T-scores equal to or less than -2.5) or postmenopausal woman who has had an osteoporotic fracture.Postmenopausal woman who has T-scores from -1.5 to -2.5 and at least one of the following risk factors for fracture: thinness [low body mass index (less than 21 kg/m2)], history of fragility fracture since menopause, or history of hip fracture in a parent. Male greater than or equal to 65 years of age with T-score of -2.5 or less. Male less than 65 years of age with T-score of -2.5 or less and 2 or more risk factors for fractures or previous osteoporotic fracture.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	In addition, the following criteria is also applicable:The patient has a documented treatment failure or has a documented medical reason (intolerance, hypersensitivity, contraindication, etc) for not utilizing an oral bisphosphonate to manage their medical condition AND The therapy does not exceed the therapy maximum of 2 years.

GATTEX

Products Affected

- GATTEX 30-VIAL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation that patient is dependent on parenteral support
Age Restrictions	N/A
Prescriber Restrictions	Provider is a gastroenterologist
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

GILOTRIF

Products Affected

- GILOTRIF

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that liver function monitoring will be completed for the duration of therapy as indicated in compendia. For appropriate indications, documentation of the FDA-approved test results confirming EGFR mutation status were submitted.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

GLEOSTINE

Products Affected

- GLEOSTINE ORAL CAPSULE 10 MG, 100 MG, 40 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that complete blood count with differential, liver function tests, renal function tests and pulmonary function tests will be completed for the duration of therapy as indicated in compendia.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist or hematologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

GNRH AGONISTS

Products Affected

- ELIGARD
- ELIGARD (3 MONTH)
- ELIGARD (4 MONTH)
- ELIGARD (6 MONTH)
- FIRMAGON KIT W DILUENT SYRINGE
- LUPRON DEPOT
- LUPRON DEPOT (3 MONTH)
- LUPRON DEPOT (4 MONTH)
- LUPRON DEPOT (6 MONTH)
- TRELSTAR INTRAMUSCULAR SYRINGE

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	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	If the medication request is for the treatment of prostate cancer and if the request is for any other GnRH agonist other than Eligard, the patient must have a documented treatment failure after receiving an trial of Eligard and/or has another documented medical reason for not utilizing Eligard to treat their prostate cancer.

GOCOVRI

Products Affected

- GOCOVRI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Initial request: documented trial and failure or medical reason for not using generic amantadine.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	Initial request will be authorized for 3 months. Reauthorization until end of contract year.
Other Criteria	Re-authorization: confirmation of improvement in levodopa-induced dyskinesia due to use of Gocovri

GROWTH HORMONES

Products Affected

- GENOTROPIN
- GENOTROPIN MINIQUICK
- HUMATROPE
- NORDITROPIN FLEXPRO
- NUTROPIN AQ NUSPIN
- OMNITROPE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Criteria for new starts for growth hormone deficiency: Growth Hormone Stimulation Test results, Insulin Growth Factor 1 level, bone age testing, MRI of brain to rule out tumor, height, and weight. All other medically accepted uses can be approved.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be Endocrinologist
Coverage Duration	Initial request will be authorized for 6 months. Reauthorization until end of contract year.
Other Criteria	Criteria for continuation of therapy for growth hormone deficiency: medical records showing positive response to treatment.

H. P. ACTHAR

Products Affected

- ACTHAR H.P.

PA Criteria	Criteria Details
Covered Uses	All medically-accepted indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	For initial MS exacerbation, rheumatic disorders, collagen diseases, dermatologic diseases, serum sickness, ophthalmic disease and respiratory diseases, documentation was submitted indicating trials and/or a documented medical reason (e.g. intolerance, hypersensitivity or contraindication) for not utilizing high-dose parenteral corticosteroids to manage their medical condition.
Age Restrictions	N/A
Prescriber Restrictions	For Infantile spasms and MS exacerbation: neurologist. For Rheumatic Disorders and Collagen Diseases: rheumatologist. For Dermatologic: dermatologist. For Allergic state: allergist, immunologist. For Ophthalmic disease: optometrist, ophthalmologist. Respiratory diseases: pulmonologist. For Edematous state: nephrologist, rheumatologist.
Coverage Duration	MS exacerbation: 1 month. Other conditions: initial for 3 months and reauth end of contract year.
Other Criteria	Reauthorization Criteria: 1) For continuation of therapy for MS exacerbation, documentation of symptom improvement and confirmation that member is currently maintained on multiple sclerosis drugs such as Copaxone, Avonex, or Aubagio. 2) For all other conditions, documented evidence of disease response to treatment as indicated by improvement in symptoms.

HEPSERA

Products Affected

- *adefovir*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For the diagnosis of hepatitis B:Submitted current (within 30 days of request) laboratory values indicating evidence of active viral replication. Submitted current laboratory values indicating persistent elevations in ALT or AST or histologically active disease. Clinical evidence of Lamivudine-resistant hepatitis B virus or documented treatment failure with Lamivudine therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

HETLIOZ

Products Affected

- HETLIOZ

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Provider is a sleep specialist or neurologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

HEXALEN

Products Affected

- HEXALEN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that complete blood count with differential and neurologic examination will be completed for the duration of therapy as indicated in compendia.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

HIGH DOSE OPIOID

Products Affected

- *fentanyl transdermal patch 72 hour 100 mcg/hr*
- *methadone oral tablet 10 mg*
- *morphine oral tablet extended release 100 mg, 200 mg*
- *oxycodone oral tablet,oral only,ext.rel.12 hr*

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	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	NEW START: ONE of the following (A) pain associated with cancer or sickle cell disease OR (B) chronic non-cancer pain and member has ALL of the following: (1) documented trial and failure and/or intolerance to two non-opioid containing pain medications (ex. NSAIDs, antidepressants, etc.) (2)current regimen is the lowest possible effective dose of opioid therapy (3) member is not being treated for substance abuse (4) if member is on concurrent benzodiazepines and/or muscle relaxant therapy, the prescriber should provide attestation of an intent to monitor side effects AND provide documentation that patient counseling has and will continue to take place outlining the risks and potential side effects of concurrent use of benzodiazepines, opioids and/or muscle relaxants. CONTINUING THERAPY: ONE of the following: (A) pain associated with cancer or sickle cell disease OR (B) chronic non-cancer pain and ALL of the following: (1) member's pain has been assessed within the last 6 months (2) member is not being treated for substance abuse (3) if member is on concurrent benzodiazepines and/or muscle relaxant therapy, the prescriber provides attestation of an intent to monitor

PA Criteria	Criteria Details
	side effects AND provide documentation that patient counseling has and will continue to take place outlining the risks and potential side effects of concurrent use.

HIGH RISK MEDICATION

Products Affected

- *amitriptyline*
- *benztropine oral*
- *chlorzoxazone oral tablet 500 mg*
- *clemastine oral tablet 2.68 mg*
- *clomipramine*
- *cyproheptadine*
- *dexmethylphenidate*
- *dextroamphetamine oral capsule, extended release 10 mg, 15 mg, 5 mg*
- *dextroamphetamine oral tablet 10 mg, 5 mg*
- *dextroamphetamine-amphetamine oral capsule,extended release 24hr*
- *dextroamphetamine-amphetamine oral tablet 10 mg, 12.5 mg, 15 mg, 20 mg, 30 mg, 5 mg, 7.5 mg*
- *dipyridamole oral*
- *disopyramide phosphate oral capsule*
- *doxepin oral*
- *ergoloid*
- *estropipate oral tablet 0.75 mg*
- *glyburide micronized oral tablet 1.5 mg, 3 mg, 6 mg*
- *glyburide oral tablet 1.25 mg, 2.5 mg, 5 mg*
- *glyburide-metformin oral tablet 1.25-250 mg, 2.5-500 mg, 5-500 mg*
- *guanfacine oral tablet*
- *hydroxyzine hcl oral solution 10 mg/5 ml*
- *hydroxyzine hcl oral tablet*
- *hydroxyzine pamoate*
- *imipramine hcl*
- *imipramine pamoate*
- *indomethacin oral*
- *ketorolac oral*
- *megestrol oral suspension 400 mg/10 ml (40 mg/ml), 625 mg/5 ml*
- *megestrol oral tablet*
- MENEST ORAL TABLET 0.3 MG, 0.625 MG, 1.25 MG
- *meperidine oral solution*
- *meperidine oral tablet*
- *methocarbamol oral*
- *methyldopa*
- *methyldopa-hydrochlorothiazide*
- *methylphenidate hcl oral capsule, er biphasic 30-70*
- *methylphenidate hcl oral capsule,er biphasic 50-50 20 mg, 30 mg, 40 mg, 60 mg*
- *methylphenidate hcl oral solution*
- *methylphenidate hcl oral tablet*
- *methylphenidate hcl oral tablet extended release 10 mg, 20 mg*
- *methylphenidate hcl oral tablet extended release 24hr 18 mg, 27 mg, 36 mg, 54 mg*
- *methylphenidate hcl oral tablet,chewable*
- *nifedipine oral capsule*
- NORPACE CR
- *orphenadrine citrate oral*
- *pentazocine-naloxone*
- *perphenazine-amitriptyline*
- *promethazine oral*
- *promethazine rectal suppository 12.5 mg, 25 mg*
- PROMETHAZINE VC
- PROMETHEGAN RECTAL SUPPOSITORY 50 MG
- *thioridazine*
- *trihexyphenidyl*
- *trimethobenzamide oral*
- *trimipramine*

PA Criteria	Criteria Details

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For patients 65 years old and older: The prescriber has documented the indication for the use of the high risk medication with an explanation of the specific benefit with the medication, and how that benefit outweighs the potential risk. The prescriber provides attestation of an intent to monitor side effects AND The prescriber must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.
Age Restrictions	If the patient is 64 years old or younger, the request will be approved. If the patient is 65 years old or older, the patient will require prior authorization for the drug.
Prescriber Restrictions	N/A
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

HIGH RISK MEDICATION, BUTALBITAL

Products Affected

- ASCOMP WITH CODEINE
- BUTALBITAL COMPOUND W/CODEINE
- *butalbital-acetaminop-caf-cod oral capsule 50-325-40-30 mg*
- *butalbital-acetaminophen oral tablet 50-325 mg*
- *butalbital-acetaminophen-caff oral capsule 50-325-40 mg*
- *butalbital-acetaminophen-caff oral tablet 50-325-40 mg*
- *butalbital-aspirin-caffeine oral capsule*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For patients 65 years old and older: The prescriber has documented the indication for the use of the high risk medication with an explanation of the specific benefit with the medication, and how that benefit outweighs the potential risk. The prescriber provides attestation of an intent to monitor side effects AND The prescriber must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication. Additionally, documentation was submitted of adequate trials and/or medical reason (e.g. intolerance or hypersensitivity) for not utilizing this therapy to manage their medical condition: one formulary oral NSAID
Age Restrictions	If the patient is 64 years old or younger, the request will be approved. If the patient is 65 years old or older, the patient will require prior authorization for the drug.
Prescriber Restrictions	N/A
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

HIGH RISK MEDICATION, DIGOXIN

Products Affected

- DIGITEK ORAL TABLET 250 MCG
- DIGOX ORAL TABLET 250 MCG
- *digoxin oral solution 50 mcg/ml*
- *digoxin oral tablet 250 mcg*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For patients 65 years old and older: Patient must have documented trial and failure to doses up to 0.125mg per day OR the prescriber has documented the indication for the use of doses greater than 0.125mg per day. The prescriber provides attestation of an intent to monitor side effects AND The prescriber must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.
Age Restrictions	If the patient is 64 years old or younger, the request will be approved. If the patient is 65 years old or older, the patient will require prior authorization for the drug.
Prescriber Restrictions	N/A
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

HIGH RISK MEDICATION, SHORT TERM MUSCLE RELAXANT

Products Affected

- *carisoprodol*
- *carisoprodol-asa-codeine*
- *carisoprodol-aspirin*
- *cyclobenzaprine oral tablet 10 mg, 5 mg*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For patients 65 years old and older: The prescriber has documented the indication for the use of the high risk medication with an explanation of the specific benefit with the medication, and how that benefit outweighs the potential risk. The prescriber provides attestation of an intent to monitor side effects AND The prescriber must document that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.
Age Restrictions	If the patient is 64 years old or younger, the request will be approved. If the patient is 65 years old or older, the patient will require prior authorization for the drug.
Prescriber Restrictions	N/A
Coverage Duration	If all conditions are met, the request will be authorized for 30 days.
Other Criteria	N/A

HUMIRA

Products Affected

- HUMIRA
- HUMIRA PEDIATRIC CROHN'S START
- HUMIRA PEN
- HUMIRA PEN CROHN'S-UC-HS START
- HUMIRA PEN PSORIASIS-UVEITIS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation was submitted indicating that the member was evaluated for active or latent TB infection (i.e. tuberculin skin test).
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	For Hidradenitis suppurativa: confirmation of Hurley Stage II or III disease. Trial and failure or medical reason for not using the following if applicable for submitted diagnosis: 1) For Rheumatoid Arthritis, Psoriatic Arthritis, or Juvenile Idiopathic Arthritis: one DMARD (e.g. methotrexate, sulfasalazine, generic leflunomide (Arava), etc.), 2) For Ankylosing Spondylitis: two nonsteroidal anti-inflammatory drugs (NSAIDS), 3) For Plaque Psoriasis: one of the following: moderate to high potency topical steroids, topical calcipotriene, Tazorac (tazorotene), Methotrexate, UVB phototherapy and/or PUVA therapy. 4) For Crohns Disease and Ulcerative Colitis: one conventional oral therapy (e.g. azathioprine, sulfasalazine, prednisone, mesalamine products). 5) For Non-infectious Uveitis: one ophthalmic corticosteroid.

IBRANCE

Products Affected

- IBRANCE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For diagnosis of breast cancer, documentation of specific type of cancer (e.g. HR-positive, HER2-negative). Provider attests that complete blood count with differential test will be completed for the duration of therapy as indicated in compendia.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

ICLUSIG

Products Affected

- ICLUSIG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that complete blood count with differential, liver function tests, serum lipase, cardiac function and blood pressure will be monitored for the duration of therapy as indicated in compendia.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist or hematologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

IDHIFA

Products Affected

- IDHIFA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that complete blood count and serum potassium, phosphate, calcium and uric acid levels will be monitored throughout the duration of the therapy as indicated in compendia. For appropriate indications, confirmation of IDH2 mutation status prior to treatment initiation.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist or hematologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

IMATINIB

Products Affected

- *imatinib*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that complete blood count with differential and liver function tests will be completed for the duration of therapy as indicated in compendia.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist or hematologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

IMBRUVICA

Products Affected

- IMBRUVICA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that complete blood count with differential will be completed for the duration of therapy as indicated in compendia.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist, hematologist or transplant specialist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

INCRELEX

Products Affected

- INCRELEX

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	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

INLYTA

Products Affected

- INLYTA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that liver function tests, thyroid function, blood pressure and urinalysis will be completed for the duration of therapy as indicated in compendia.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

INTRON-A

Products Affected

- INTRON A INJECTION

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	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

INVANZ

Products Affected

- INVANZ INJECTION

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	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

IRESSA

Products Affected

- IRESSA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that liver function monitoring will be completed for the duration of therapy as indicated in compendia. For appropriate indications, documentation of the FDA-approved test results confirming mutation were submitted.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

JAKAFI

Products Affected

- JAKAFI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that complete blood count and lipid profile monitoring will be completed for the duration of therapy as indicated in compendia.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist or a hematologist
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

JUXTAPID

Products Affected

- JUXTAPID

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Patients with moderate or severe hepatic impairment (Child- Pugh B or C) or active liver disease.
Required Medical Information	Documentation of treatment history, trial and failure after three months with Repatha AND THEN Kynamro (mipomersen), or has a documented medical reason (e.g. intolerance, hypersensitivity or contraindication) for not utilizing these therapies to manage their condition. In addition, a fasting lipid panel report with abnormal LDL cholesterol results (over 70mg/dL) and baseline LFTs and bilirubin, along with patient's Child Pugh Score are required within 90 days of request.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a cardiologist, specialist in treatment of lipid disorders or endocrinologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

JYNARQUE

Products Affected

- JYNARQUE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that transaminases and bilirubin will be monitored prior to initiation and throughout duration of therapy as indicated in compendia.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a nephrologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

KALYDECO

Products Affected

- KALYDECO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Combination use with Orkambi
Required Medical Information	Documentation of cystic fibrosis mutation.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

KEVEYIS

Products Affected

- KEVEYIS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Initial request: 1) Provider attests that serum potassium and serum bicarbonate will be monitored for the duration of therapy as indicated in compendia 2) Documentation has been provided that the patient has tried and failed or has a documented medical reason for not utilizing acetazolamide.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a geneticist, neurologist, or endocrinologist.
Coverage Duration	Initial request will be authorize for 2 months. Reauthorization until end of contract year.
Other Criteria	Reauthorization requires documentation of clinical improvement with therapy. Provider attests that serum potassium and serum bicarbonate will be monitored for the duration of therapy as indicated in compendia

KINERET

Products Affected

- KINERET

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	Specialist for submitted diagnosis.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	Trial and failure or medical reason for not using Humira (adalimumab) and Enbrel (etanercept) for appropriate indications.

KISQALI

Products Affected

- KISQALI
- KISQALI FEMARA CO-PACK

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that complete blood count with differential, liver function test, serum electrolytes and ECG monitoring will be completed for the duration of therapy as indicated in compendia.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

KORLYM

Products Affected

- KORLYM

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	For all members patient must not be currently on simvastatin, lovastatin, cyclosporine, dihydroergotamine, ergotamine, fentanyl, pimozide, quididine, sirolimus, and tacrolimus.
Required Medical Information	Reviewer will verify available claim history to confirm member is not taking simvastatin, lovastatin, cyclosporine, dihydroergotamine, ergotamine, fentanyl, pimozide, quididine, sirolimus or tacrolimus concurrently with Korylm.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

KUVAN

Products Affected

- KUVAN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For initial therapy, documentation of elevated baseline phenylalanine levels
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial request will be authorized for 3 months. Reauthorization until end of contract year
Other Criteria	Reauthorization criteria: prescriber has confirmed improvement in phenylalanine levels from baseline

KYNAMRO

Products Affected

- KYNAMRO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Patients with moderate or severe hepatic impairment (Child- Pugh B or C) or active liver disease
Required Medical Information	Documentation of treatment history, trial and failure after three months with Repatha or has a documented medical reason (e.g. intolerance, hypersensitivity or contraindication) for not utilizing Repatha to manage their condition. In addition, a fasting lipid panel report with abnormal LDL cholesterol results (over 70mg/dL) and baseline ALT/AST and bilirubin results, along with patient's Child Pugh Score are required within 90 days of request.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a cardiologist or specialist in treatment of lipid disorders.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

LAZANDA

Products Affected

- LAZANDA NASAL SPRAY,NON-AEROSOL 100 MCG/SPRAY, 300 MCG/SPRAY, 400 MCG/SPRAY

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	This product must not be used in opioid intolerant patients and contraindicated in the management of acute or postoperative pain.
Required Medical Information	The patient is currently receiving and tolerant to opioid therapy for chronic pain. Patient is unable to swallow, has dysphagia, esophagitis, mucositis, or uncontrolled nausea/vomiting. Patient must have documented trial and failure or intolerance to fentanyl citrate oral transmucosal.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

LENVIMA

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that liver function, renal function, thyroid function will be monitored for the duration of therapy as indicated in compendia.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

LETAIRIS

Products Affected

- LETAIRIS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of pulmonary arterial hypertension (PAH) WHO Group classification and PAH Functional Class.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or cardiologist
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

LIDOCAINE PATCH

Products Affected

- *lidocaine topical adhesive patch,medicated*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

LONSURF

Products Affected

- LONSURF

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that complete blood count including differential and absolute neutrophil count will be monitored for the duration of therapy as indicated in compendia.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

LUCEMYRA

Products Affected

- LUCEMYRA

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	If all conditions are met, the request will be authorized for 14 days.
Other Criteria	Patient must have documented trial and failure or intolerance to clonidine. Reauthorization criteria: chart notes that show positive response to prior treatment.

LYNPARZA

Products Affected

- LYNPARZA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that CBC and renal function will be monitored for the duration of therapy as indicated in compendia. For appropriate indications, documentation FDA approved test confirming BRCA mutation. Documentation of patient's treatment history for related conditions.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

MAVYRET

Products Affected

- MAVYRET

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Labs within 3 months of request: ALT/AST, detectable HCV RNA viral load. In addition, documentation of genotype, treatment history, and if cirrhotic, documentation of compensated or decompensated cirrhosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a hepatologist, gastroenterologist, infectious disease specialist, nephrologist or transplant specialist.
Coverage Duration	If all conditions are met, request will be authorized for 8-16 weeks as per AASLD-IDSA guidance.
Other Criteria	N/A

MEKINIST

Products Affected

- MEKINIST

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that CBC, liver function and LVEF will be monitored for the duration of therapy as indicated in compendia. For appropriate indications, documentation of FDA approved mutation testing was submitted confirming the presence of BRAF V600E or V600K mutations.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

METHYLTESTOSTERONE

Products Affected

- *methyltestosterone oral capsule*

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	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

MULTIPLE SCLEROSIS AGENTS

Products Affected

- AUBAGIO
- BETASERON SUBCUTANEOUS KIT
- GILENYA ORAL CAPSULE 0.5 MG
- *glatiramer*
- GLATOPA
- REBIF (WITH ALBUMIN)
- REBIF REBIDOSE
- REBIF TITRATION PACK
- TECFIDERA

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	Prescriber must be a neurologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	If the medication request is for glatiramer or Aubagio, the request will be approved. If the medication is not for glatiramer or Aubagio, will require documentation showing trial of two of the following agents: Aubagio and glatiramer OR the patient has another documented medical reason (intolerance, hypersensitivity, etc) for not taking any of these therapies to manage their medical condition.

MYCAMINE

Products Affected

- MYCAMINE

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	If all conditions are met, the request will be approved for 12 weeks
Other Criteria	N/A

NATPARA

Products Affected

- NATPARA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of serum calcium greater than 7.5 mg/dL and vitamin D level (within 30 days of request).
Age Restrictions	N/A
Prescriber Restrictions	Provider is an endocrinologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

NERLYNX

Products Affected

- NERLYNX

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Prescriber attests that liver function tests will be assessed prior to initiation and throughout the duration of therapy as indicated in compendia.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

NEXAVAR

Products Affected

- NEXAVAR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Provider attests that liver function and blood pressure will be monitored for the duration of therapy as indicated in compendia.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

NINLARO

Products Affected

- NINLARO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that liver function and platelet counts will be monitored for the duration of therapy as indicated in compendia.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist or a hematologist
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

NITISINONE

Products Affected

- ORFADIN

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	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

NOCTIVA

Products Affected

- NOCTIVA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that eGFR and serum sodium will be monitored throughout the duration of the therapy, and that the patient does not have baseline hyponatremia or primary nocturnal enuresis.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a urologist
Coverage Duration	If all conditions are met, the request will be authorized for the contract year
Other Criteria	For patients newly starting on Noctiva: For respective indications, patient must have shown either a lack of benefit during trial of one of the following medications, or is experiencing nocturia unrelated to any of the following etiologies. Nocturia secondary to lower urinary tract symptoms or benign prostate enlargement: trial of alpha adrenergic antagonists (e.g. tamsulosin, alfuzosin). Nocturia secondary to benign prostate hyperplasia: trial of alpha adrenergic antagonist and 5-alpha reductase inhibitor (e.g. finasteride). Nocturia due to nocturnal polyuria: trial of bumetanide during daytime. Nocturia secondary to overactive bladder: trial of an antimuscarinic agent (e.g. oxybutynin).

NON-AMPHETAMINE CENTRAL NERVOUS SYSTEM AGENTS

Products Affected

- *armodafinil*
- *modafinil*

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	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

NOXAFIL

Products Affected

- NOXAFIL ORAL

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	Documentation of a consultation with an infectious disease specialist.
Coverage Duration	28 days for oropharyngeal candidiasis, end of contract year for other indications
Other Criteria	For treatment of oropharyngeal candidiasis, there must be documentation of either at least a one week trial or a medical reason (e.g. intolerance, known resistance, hypersensitivity) for not being able to use one of the following agents: fluconazole or itraconazole

NUEDEXTA

Products Affected

- NUEDEXTA

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	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

NUPLAZID

Products Affected

- NUPLAZID ORAL TABLET 17 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

OCALIVA

Products Affected

- OCALIVA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Members with complete biliary obstruction.
Required Medical Information	Initial for primary biliary cholagnitis (PBC): 1) member has failed at least a 12 month trial of ursodiol, or a medical reason was submitted (e.g. intolerance, hypersensitivity) that the member is unable to tolerate ursodiol, 2) lab results for baseline ALT/AST, alkaline phosphatase (ALP), bilirubin, and lipid profile within 90 days of request. Reauthorization for primary biliary cholangitis (PBC): repeat ALT/AST, ALP, bilirubin and lipid profile within 30 days of request with improvement in at least ALP and/or bilirubin values.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a gastroenterologist, hepatologist, or transplant specialist.
Coverage Duration	Initial request will be authorized for 4 months. Reauthorization until end of contract year.
Other Criteria	N/A

OCTREOTIDE ACETATE

Products Affected

- *octreotide acetate injection solution*
- SOMATULINE DEPOT SUBCUTANEOUS SYRINGE 120 MG/0.5 ML, 60 MG/0.2 ML, 90 MG/0.3 ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	If criteria are met, a prior authorization for the generic octreotide will be approved. Otherwise, documentation showing an adverse event or inadequate response associated with use of the generic agent must be submitted for review.

ODOMZO

Products Affected

- ODOMZO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that serum creatine kinase levels and renal function will be monitored for the duration of therapy as indicated in compendia.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

OFEV

Products Affected

- OFEV

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation was provided including ALT/AST and bilirubin within 30 days of request. If diagnosis is idiopathic pulmonary fibrosis, member must have documented trial of Esbriet or provide medical justification (e.g. intolerance or hypersensitivity) for not utilizing Esbriet.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

ORAL ANTIPSYCHOTICS

Products Affected

- FANAPT ORAL TABLET
- FANAPT ORAL TABLETS,DOSE PACK
- LATUDA ORAL TABLET 120 MG, 20 MG, 40 MG, 60 MG, 80 MG
- VRAYLAR ORAL CAPSULE
- VRAYLAR ORAL CAPSULE,DOSE PACK

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For a diagnosis of schizophrenia and manic or mixed episodes associated with bipolar l disorder, the patient must have documented trial and failure or intolerance to two formulary generic antipsychotics (aripiprazole, risperidone, olanzapine, quetiapine, or ziprasidone) and Saphris. For major depressive disorder associated with bipolar l disorder, the patient must have documented trial and failure or intolerance to two formulary generic antipsychotics (aripiprazole, risperidone, olanzapine, quetiapine, or ziprasidone).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

ORENCIA

Products Affected

- ORENCIA
- ORENCIA CLICKJECT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation was submitted indicating that the member was evaluated for active or latent TB infection (i.e. tuberculin skin test).
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	Trial and failure or medical reason for not using Humira (adalimumab) and Enbrel (etanercept) for appropriate indications.

ORKAMBI

Products Affected

- ORKAMBI ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Combination use with Kalydeco
Required Medical Information	Documentation of cystic fibrosis mutation.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an pulmonologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

OTEZLA

Products Affected

- OTEZLA
- OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)-20 MG (4)-30 MG (47)

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Trial and failure or medical reason for not using Humira (adalimumab) and Enbrel (etanercept) for appropriate indications.
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

OXSORALEN ULTRA

Products Affected

- *methoxsalen*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	Patient must have documented trial and failure or intolerance to methotrexate.

OXYCODONE ER

Products Affected

- *oxycodone oral tablet,oral only,ext.rel.12 hr*

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	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	NEW START: Patient must meet ALL of the following criteria: (1) patient has a documented trial and failure or intolerance to two formulary long-acting pain medications (2) member is not being treated for substance abuse (3) if member is on concurrent benzodiazepines and/or muscle relaxant therapy, the prescriber should provide attestation of an intent to monitor side effects AND provide documentation that patient counseling has and will continue to take place outlining the risks and potential side effects of concurrent use of benzodiazepines, opioids and/or muscle relaxants AND (4) member has documented history of receiving a non-opioid analgesic or immediate-release opioid. CONTINUING THERAPY: Documentation of ALL of the following : (1)member's pain has been assessed within the last 3 months (2) member has demonstrated improved functioning on current medication regimen (3) member is not being treated for substance abuse AND (4) if member is on concurrent benzodiazepines and/or muscle relaxant therapy, the prescriber should provide attestation of an intent to monitor side effects AND provide documentation that patient counseling has and will continue to take place outlining the risks and potential side effects of concurrent use of benzodiazepines, opioids and/or muscle relaxants.

PALIPERIDONE

Products Affected

- *paliperidone oral tablet extended release 24hr 1.5 mg, 3 mg, 6 mg, 9 mg*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	For the diagnosis of schizophrenia: the patient must have documented failure or intolerance to a formulary second generation atypical antipsychotic

PALIPERIDONE LONG ACTING

Products Affected

- INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 117 MG/0.75 ML, 156 MG/ML, 234 MG/1.5 ML, 39 MG/0.25 ML, 78 MG/0.5 ML
- INVEGA TRINZA INTRAMUSCULAR SYRINGE 273 MG/0.875 ML, 410 MG/1.315 ML, 546 MG/1.75 ML, 819 MG/2.625 ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	The member has a documented history of receiving oral risperidone or oral paliperidone without any clinically significant side effects. For requests for Invega Trinza, the member has documented treatment with Invega Sustenna for at least 4 months.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

PEGINTERFERON

Products Affected

- PEGASYS
- PEGASYS PROCLICK SUBCUTANEOUS PEN INJECTOR 180 MCG/0.5 ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For Hepatitis C: Labs within 3 months of request: ALT/AST, and detectable HCV RNA viral load. In addition, documentation of genotype, treatment history, and if cirrhotic, documentation of compensated or decompensated cirrhosis. For Hepatitis B: Labs within 3 months of request: ALT/AST. In addition, documentation of HBeAg status is required.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a gastroenterologist, hepatologist, infectious disease doctor or transplant specialist.
Coverage Duration	If all conditions are met request will be authorized for up to 48 weeks as defined by compendia
Other Criteria	N/A

PENTAM 300

Products Affected

- PENTAM

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	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

PHENOXYBENZAMINE

Products Affected

- *phenoxybenzamine*

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	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

POMALYST

Products Affected

- POMALYST

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that CBC with differential and liver function test will be completed for the duration of therapy as indicated in compendia. Documentation of trial of Revlimid and a proteosome inhibitor prior to initiating Pomalyst.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist or a hematologist
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

PREVYMIS

Products Affected

- PREVYMIS ORAL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that serum creatinine and renal function will be monitored prior to initiation and throughout duration of therapy as indicated in compendia
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a hematologist, oncologist or infectious disease specialist.
Coverage Duration	If all conditions are met, the request will be authorized for 6 months
Other Criteria	N/A

PROLIA

Products Affected

- PROLIA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For a diagnosis of osteoporosis: Documentation showing patient falls into one of the following categories: Postmenopausal woman or a male patient who has a bone mineral density (BMD) value consistent with osteoporosis (i.e., T-scores equal to or less than - 2.5) or who has had an osteoporotic fracture. Postmenopausal woman or man with a T-score between -1 and -2.5 at the femoral neck or spine and a 10 year hip fracture probability greater than 3% or a 10 year major osteoporosis-related fracture probability greater than 20% based on the US-adapted WHO absolute fracture risk model.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	In addition, the following criteria is also applicable: The patient has a documented treatment failure after receiving a trial (including dates of treatment at maximum recommended doses of therapy) or has a documented medical reason (intolerance, hypersensitivity, contraindication, etc) for not utilizing an oral bisphosphonate to manage their medical condition.

PROMACTA

Products Affected

- PROMACTA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that all liver function tests, as well as CBC with differential will be monitored prior to initiation and throughout the therapy as indicated in compendia.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If all conditions are met, the request will be authorized for the contract year
Other Criteria	N/A

RAVICTI

Products Affected

- RAVICTI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Provider is a geneticist, metabolic specialist, gastroenterologist, hepatologist, or liver transplant specialist
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

REGRANEX

Products Affected

- REGRANEX

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	If all conditions are met, the request will be authorized for 20 weeks.
Other Criteria	N/A

RELISTOR

Products Affected

- RELISTOR ORAL
- RELISTOR SUBCUTANEOUS SOLUTION
- RELISTOR SUBCUTANEOUS SYRINGE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of opioid use leading to constipation
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	Patient must have documented trial and failure or intolerance to 1) Amitiza, and 2) lactulose or polyethylene glycol. Additionally, for constipation caused by opioids that are used for chronic, non-cancer pain, patient must have a medical reason for not being able to use oral Relistor in order to receive Relistor injection.

REPATHA

Products Affected

- REPATHA PUSHTRONEX
- REPATHA SURECLICK
- REPATHA SYRINGE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a cardiologist or a specialist in treatment of lipid disorders.
Coverage Duration	Initial request will be authorized for 4 months. Reauthorization until end of contract year.
Other Criteria	For ALL diagnoses for initial approval:documentation (copy of dated lab results required) of two fasting lipid panel reports within the past 12 months with abnormal LDL cholesterol results (above 70mg/dL) after treatment for a minimum of 3 months with two high potency statins (atorvastatin and rosuvastatin) or a medical reason (contraindication or intolerance) has been provided as to why the patient is unable to use these therapies. Intolerance requires chart notes or supporting labs that confirm intolerable statin related adverse effects including elevated LFTs, rhabdomyolysis, intolerable myalgia or myopathy or myositis. If patient experiences intolerance, patient has undergone a trial of statin re-challenge with maximally tolerated dose of statins for a minimum of 3 months with continued abnormal LDL cholesterol results (above 70mg/dL) or with documented return of side effects. If diagnosis is familial hypercholesterolemia (FH), additional documentation has been provided including TWO of the following: 1) genetic testing (copy of dated lab results required) confirming FH diagnosis OR 2) evidence of FH in first or second degree relatives with history of high levels of total cholesterol, tendon xanthoma, or sudden cardiac death or premature

PA Criteria	Criteria Details
	clinical atherosclerotic cardiovascular disease (ASCVD) before 55 years in men and 60 years in women OR 3) clinical manifestations of FH such as xanthomas or inflamed tendons OR 4) a clinical diagnosis of FH using the Dutch Lipid Clinic Diagnostic criteria (total score greater than 8 points), OR Simon-Broome Diagnostic criteria (total cholesterol greater than 290 mg/dL or LDL-C greater than 190 mg/dL, plus tendon xanthoma in patient, first-degree parent, sibling or child) or second-degree relative (grandparent, uncle or aunt). If diagnosis is ASCVD, additional documentation has been provided that includes history of acute coronary syndromes, history of MI, stable or unstable angina, coronary or other arterial revascularization, stroke, TIA, or peripheral arterial disease presumed to be of atherosclerotic origin. For ALL diagnoses for initial reauthorization: patient has had consistent monthly fills and repeat LDL cholesterol lab (copy of dated lab result required) showing improvement in LDL from initial request. For all other reauthorization requests patient had consistent monthly fills and repeat LDL cholesterol lab (copy of dated lab result required) was submitted with request.

REVATIO ORAL

Products Affected

- REVATIO ORAL SUSPENSION FOR RECONSTITUTION
- *sildenafil (antihypertensive) oral*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Documentation of concurrent nitrate or Adempas use.
Required Medical Information	Documentation of pulmonary arterial hypertension (PAH) WHO Group and PAH Functional Class. Reviewer will verify available patient claim history to confirm patient is not using nitrates or Adempas.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or cardiologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	For Revatio Suspension: Documentation was submitted documenting trial with sildenafil tablet OR the patient has another documented medical reason for not taking sildenafil tablet to manage their medical condition.

REVLIMID

Products Affected

- REVLIMID

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that CBC with differential, liver function tests and thyroid function tests will be completed for the duration of therapy as indicated in compendia.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist or a hematologist
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

REXULTI

Products Affected

- REXULTI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For a diagnosis of schizophrenia the patient must HAVE documented trial and failure or intolerance to two of the following: aripiprazole, risperidone, olanzapine, quetiapine, or ziprasidone. For major depressive disorder, the patient must have documented trial and failure or intolerance to two of the following: escitalopram, sertraline, fluoxetine, paroxetine, venlafaxine, venlafaxine ER, citalopram, mirtazapine, desvenlafaxine or duloxetine.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

RISPERDAL CONSTA

Products Affected

- RISPERDAL CONSTA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	The member has a documented history of receiving oral risperidone without any clinically significant side effects.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

RUBRACA

Products Affected

- RUBRACA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that CBC will be monitored for the duration of therapy as indicated in compendia. For appropriate indications, documentation of FDA approved test confirming mutation. Documentation of patient's treatment history for related conditions.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

RYDAPT

Products Affected

- RYDAPT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that Complete Blood Count (CBC with differential) will be monitored for the duration of therapy as indicated in compendia.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist or a hematologist
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

SEIZURES, BENZODIAZEPINES AND BARBITURATES

Products Affected

- *clonazepam oral tablet 0.5 mg, 1 mg, 2 mg*
- *clonazepam oral tablet,disintegrating 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg*
- *clorazepate dipotassium oral tablet 15 mg, 3.75 mg, 7.5 mg*
- DIAZEPAM INTENSOL
- *diazepam oral solution 5 mg/5 ml (1 mg/ml)*
- *diazepam oral tablet*
- *phenobarbital*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For use in patients with panic disorders or anxiety disorders, the patient must have a documented trial and failure or intolerance to one formulary antidepressant.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

SEIZURES, OTHER

Products Affected

- BANZEL ORAL SUSPENSION
- BANZEL ORAL TABLET
- ONFI ORAL SUSPENSION
- ONFI ORAL TABLET 10 MG, 20 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For treatment of Lennox Gastaut Syndrome, patient must have documented trial and failure or intolerance to one formulary anticonvulsant agent that is indicated for Lennox-Gastaut Syndrome. For use in patients with anxiety disorders, the patient must have documented trial and failure or intolerance to one formulary antidepressant (eg SNRI or SSRI).
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

SEROSTIM

Products Affected

- SEROSTIM SUBCUTANEOUS RECON SOLN 4 MG, 5 MG, 6 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If all conditions are met, the request will be authorized for 12 weeks.
Other Criteria	N/A

SIGNIFOR

Products Affected

- SIGNIFOR

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	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

SIMPONI

Products Affected

- SIMPONI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation was submitted indicating that the member was evaluated for active or latent TB infection (i.e. tuberculin skin test).
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	Trial and failure or medical reason for not using Humira (adalimumab) and Enbrel (etanercept) for appropriate indications.

SIRTURO

Products Affected

- SIRTURO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of prior trial and failure of first-line TB regimen containing isoniazid and rifampin. Provider attests that baseline LFT and EKG will be obtained prior to initiation of therapy and throughout the duration of treatment with Sirturo
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If all conditions are met, the request will be authorized for up to 24 weeks.
Other Criteria	Documentation was submitted (consistent with pharmacy claims data, OR for new members to the health plan consistent with medical chart history) that the member is currently taking three additional antimycobacterial drugs in combination to treat MDR-TB.

SODIUM PHENYLBUTYRATE

Products Affected

- *sodium phenylbutyrate*

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	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

SOMAVERT

Products Affected

- SOMAVERT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

SPRYCEL

Products Affected

- SPRYCEL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that CBC with differential and electrolyte levels will be monitored for the duration of therapy as indicated in compendia.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist or a hematologist
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

STELARA

Products Affected

- STELARA SUBCUTANEOUS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation was submitted indicating that the member was evaluated for active or latent TB infection (i.e. tuberculin skin test).
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	Trial and failure or medical reason for not using Humira (adalimumab) and Enbrel (etanercept) for appropriate indications.

STIVARGA

Products Affected

- STIVARGA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that liver function test and blood pressure will be monitored for the duration of therapy as indicated in compendia. Documentation of patient's treatment history for related conditions.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

SUCRAID

Products Affected

- SUCRAID

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	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

SUTENT

Products Affected

- SUTENT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that CBC with differential, liver function, blood glucose levels and blood pressure will be monitored for the duration of therapy as indicated in compendia.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

SYLATRON

Products Affected

- SYLATRON

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	A history of anaphylaxis to peginterferon alfa-2b or interferon alfa-2b, autoimmune hepatitis, or hepatic decompensation (Child-Pugh greater than 6[class B and C]).
Required Medical Information	For appropriate indication, documentation of definitive surgical resection including complete lymphadenectomy within 84 days of initiating treatment.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

SYMDEKO

Products Affected

- SYMDEKO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that AST, ALT and bilirubin will be monitored prior to treatment initiation and throughout the duration of therapy as indicated in compendia.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or an expert in treatment of cystic fibrosis.
Coverage Duration	If all conditions are met, the request will be authorized for the contract year
Other Criteria	N/A

SYMLIN

Products Affected

- SYMLINPEN 120
- SYMLINPEN 60

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For new starts HbA1C values within 90 days of request should be provided showing the following: 1) for patients with type 2 diabetes HbA1C is greater than or equal to 8% despite receiving insulin therapy or 2) for pateints with type 1 diabetes, HbA1C is greater than or equal to 7% despite receiving insulin therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	Patient must have documented trial or intolerance to two formulary anti-diabetic agents.

SYNAREL

Products Affected

- SYNAREL

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	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

SYNDROS

Products Affected

- SYNDROS

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	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	Documentation of either trial/failure or a medical reason (e.g. intolerance or hypersensitivity) for not being able to use dronabinol capsules

SYNRIBO

Products Affected

- SYNRIBO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that CBC with differential will be completed for the duration of therapy as indicated in compendia.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist or a hematologist
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

TABLOID

Products Affected

- TABLOID

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that CBC with differential and liver function test will be completed for the duration of therapy as indicated in compendia.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist or a hematologist
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

TAFINLAR

Products Affected

- TAFINLAR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For appropriate indications, confirmation of mutation as detected by an FDA-approved test.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

TAGRISSO

Products Affected

- TAGRISSO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of prior treatment history for related condition. For appropriate indications, confirmation of mutation as detected by an FDA-approved test.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

TARCEVA

Products Affected

- TARCEVA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that liver function tests and renal function test will be completed for the duration of therapy as indicated in compendia. For appropriate indications, confirmation of mutation as detected by an FDA-approved test.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

TASIGNA

Products Affected

- TASIGNA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that CBC with differential, liver function, electrolytes, lipid profile and glucose will be monitored for the duration of therapy as indicated in compendia. Documentation of prior treatment history for related condition.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist or a hematologist
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

TEFLARO

Products Affected

- TEFLARO

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	If all conditions are met, the request will be approved for 14 days of treatment.
Other Criteria	N/A

THIOLA

Products Affected

- THIOLA

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	If all conditions are met, the request will be authorized for the contract year
Other Criteria	N/A

TOPICAL ANTINEOPLASTIC RETINOIDS

Products Affected

- PANRETIN
- TARGRETIN TOPICAL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

TOPICAL TESTOSTERONE

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Patient initiating topical testosterone therapy for hypogonadism must have both of the following characteristics of hypogonadism: 1) symptoms associated with hypogonadism (e.g. unexplained mild anemia, low libido, decreased energy, etc.) 2) Two instances of low serum total or free testosterone, as defined by the reference range by the lab. For all patients, provider attests that PSA levels, hemoglobin, hematocrit and testosterone levels will be monitored periodically throughout the treatment as indicated in compendia.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If all conditions are met, the request will be authorized for the contract year
Other Criteria	N/A

TREMFYA

Products Affected

- TREMFYA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation was submitted indicating that the member was evaluated for active or latent TB infection (i.e. tuberculin skin test).
Age Restrictions	N/A
Prescriber Restrictions	Specialist for submitted diagnosis.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	Trial and failure or medical reason for not using Humira (adalimumab) and Enbrel (etanercept) for appropriate indications.

TRIENTINE

Products Affected

- *trientine*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documented penicillamine intolerance.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

TYKERB

Products Affected

- TYKERB

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that liver function and left ventricular ejection fraction will be monitored for the duration of therapy as indicated in compendia.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	For patients with advanced or metastatic breast cancer who are HER2 positive and has had a trial at therapeutic doses with an anthracycline (i.e. Doxorubicin or Epirubicin) a taxane (i.e. Docetaxel or Paclitaxel) and Herceptin (trastuzumab) then documentation of concurrent use of Xeloda (capecitabine). For patients who are postmemopausal with hormone receptor positive and HER2 positive then documentation of concurrent use of Femara (letrozole).

TYMLOS

Products Affected

- TYMLOS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation showing patient falls into one of the following categories: Postmenopausal woman who has a bone mineral density (BMD) value consistent with osteoporosis (i.e., T-scores equal to or less than -2.5) or postmenopausal woman who has had an osteoporotic fracture. Postmenopausal woman who has T-scores from -1.5 to -2.5 and at least one of the following risk factors for fracture: thinness [low body mass index (less than 21 kg/m2)], history of fragility fracture since menopause, or history of hip fracture in a parent.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	In addition, the following criteria is also applicable: The patient has a documented treatment failure or has a documented medical reason (intolerance, hypersensitivity, contraindication, etc) for not utilizing an oral bisphosphonate to manage their medical condition AND The therapy does not exceed the therapy maximum of 2 years.

VABOMERE

Products Affected

- VABOMERE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of a consultation with an infectious disease specialist.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If all conditions are met, the request will be authorized for 14 days of treatment.
Other Criteria	N/A

VANDETANIB

Products Affected

- CAPRELSA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that serum electrolytes, TSH, ECG and blood pressure will be monitored prior to initiation and throughout the duration of therapy as indicated in compendia.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist or endocrinologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

VENCLEXTA

Products Affected

- VENCLEXTA
- VENCLEXTA STARTING PACK

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that CBC with differential will be completed for the duration of therapy as indicated in compendia. For appropriate indications, documentation of 17p deletion, as detected by an FDA-approved test.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of contract year.
Other Criteria	N/A

VENTAVIS

Products Affected

- VENTAVIS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of pulmonary arterial hypertension (PAH) WHO Group classification and PAH Functional Class.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a pulmonologist or cardiologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

VERZENIO

Products Affected

- VERZENIO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that liver function tests and complete blood cell count will be assessed prior to initiation and throughout the duration of therapy as indicated in compendia.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a hematologist or an oncologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

VIGABATRIN

Products Affected

- SABRIL ORAL TABLET
- *vigabatrin*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	If the patient has a diagnosis of infantile spasms or West syndrome, the request will be approved. Patient must have a diagnosis of refractory complex partial seizures who is currently receiving another antiepileptic drug and the patient has experienced treatment failure from two previous formulary antiepileptic agents (lamotrigine, gabapentin, carbamazepine, topiramate, tiagabine, oxcarbazepine, levetiracetam, phenytoin, zonisamide, divalproex).
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year
Other Criteria	N/A

VMAT-2 INHIBITORS

Products Affected

- AUSTEDO
- INGREZZA
- *tetrabenazine*

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	Prescriber must be a neurologist, clinical geneticist, or psychiatrist
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	If the request is for tetrabenazine, request will be approved. For Ingrezza, trial and failure or medical reason for not using the tetrabenazine for tardive dyskinesia. For Austedo, trial and failure or medical reason for not using the following if applicable for submitted diagnosis 1) Chorea associated with Huntington disease- trial of tetrabenazine. 2) Tardive dyskinesia -trial of tetrabenazine and Ingrezza. Reauthorization: Confirmation of improvement in tardive dyskinesia symptoms or chorea associated with Huntington disease symptoms.

VOSEVI

Products Affected

- VOSEVI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Labs within 3 months of request: ALT or AST, detectable HCV RNA viral load. In addition, documentation of genotype, treatment history, and if cirrhotic, documentation of compensated or decompensated cirrhosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a hepatologist, gastroenterologist, infectious disease specialist, or transplant specialist.
Coverage Duration	If all conditions are met, the request will be authorized for 12 weeks
Other Criteria	Criteria will be applied consistent with current AASLD-IDSA guidance.

VOTRIENT

Products Affected

- VOTRIENT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that liver function, serum electrolytes, blood pressure, thyroid function and ECG will be monitored for the duration of therapy as indicated in compendia.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

WHITE BLOOD CELL STIMULATORS

Products Affected

- GRANIX
- LEUKINE INJECTION RECON SOLN
- NEULASTA SUBCUTANEOUS SYRINGE
- NEUPOGEN
- ZARXIO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For treatment or prophylaxis of febrile neutropenia, provider attests that ANC and temperature will be regularly monitored throughout the duration of therapy
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist or an infectious disease specialist.
Coverage Duration	For new starts only, 4 months. All others, until end of the year
Other Criteria	For Neupogen, Granix and Neulasta requests, documentation of trial of, or a medical reason for not being able to use Zarxio (including inability to administer or comply with Zarxio, or known intolerance to filgrastim products). Re-authorization criteria: diagnosis of chronic neutropenia or a medical reason for continued need for GCSF. Reauthorization will be approved until end of the year

XALKORI

Products Affected

- XALKORI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that CBC with differential and liver function tests will be completed for the duration of therapy as indicated in compendia.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

XATMEP

Products Affected

- XATMEP

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	Prescriber must be an oncologist or rheumatologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

XERMELO

Products Affected

- XERMELO

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	If all conditions are met, the request will be authorized until end of contract year
Other Criteria	N/A

XGEVA

Products Affected

- XGEVA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Patients with baseline hypocalcemia
Required Medical Information	Criteria for new starts: Serum calcium levels for all indications
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Skeletal related events and giant cell bone tumor:contract year. Malignant hypercalcemia: 4months
Other Criteria	Reauthorization criterion for skeletal related events or giant cell bone tumor:statement of continued need for use of Xgeva. Reauthorization criteria for malignant hypercalcemia: albumin-adjusted serum calcium level below 12.5mg/dl within 30 days of request and statement of continued need for Xgeva.

XIFAXAN

Products Affected

- XIFAXAN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For diagnosis of hepatic encephalopathy: patient must have documentation of trial and failure, intolerance, or contraindication to lactulose. For diagnosis of irritable bowel syndrome with diarrhea (IBS D), the patient has a documentation of trial, intolerance, or contraindication to loperamide and dicyclomine. For diagnosis of travelers diarrhea caused by noninvasive strains of E. Coli (with no bloody stools or fever), patient must be intolerant to or must have had trial of at least 3 days of one of the following agents: ciprofloxacin, ofloxacin, levofloxacin or azithromycin.
Age Restrictions	N/A
Prescriber Restrictions	For hepatic encephalopathy, gastroenterologist, hepatologist. For IBS-D, gastroenterologist
Coverage Duration	For hepatic encephalopathy:end of contract year. For IBS D: 8 weeks. For travelers diarrhea: 3 days
Other Criteria	N/A

XOLAIR

Products Affected

- XOLAIR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Criteria for new starts for the diagnosis of moderate to severe persistent allergic asthma: 1) evidence of specific allergic sensitivity confirmed by positive skin test (i.e. prick/puncture test) or blood test (i.e. radioallergosorbent test) for a specific IgE or in vitro reactivity to a perennial aeroallergen, AND 2) pretreatment serum IgE levels greater than 30 and less than 1300 IU/mL, AND 3) symptoms are not adequately controlled with high-dose inhaled corticosteroid (ICS) plus long-acting beta2-agonist (LABA) for at least 3 months, or medical justification has been provided indicating why a patient is not able to utilize a high-dose inhaled corticosteroid (ICS) plus long-acting beta2-agonist (LABA) to treat their medical condition. Criteria for new starts for the diagnosis of chronic idiopathic urticaria include: 1) Patient must have inadequate symptomatic relief despite trial of two weeks of two different oral antihistamine therapies (unless contraindicated) and 2) Patient's disease must be severe enough to warrant short term systemic corticosteroid therapy for management of urticaria.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial authorization: 6 months. Reauthorization until end of contract year.
Other Criteria	For asthma patients, one of the following must be met during Xolair use for continuation of therapy: 1) reduction in asthma exacerbation resulting in systemic steroid use and/or hospitalization, 2) reduction of rescue inhaler use, or 3) documentation of improvement in pulmonary function tests since baseline (prior to initiation of Xolair). Criteria for continuation of therapy for chronic idiopathic urticaria: continued improvement of symptoms associated with urticaria within 6 months of Xolair use.

XTANDI

Products Affected

- XTANDI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

XURIDEN

Products Affected

- XURIDEN

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	Prescriber must be an endocrinologist, metabolic specialist, clinical geneticist or hematologist
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

XYREM

Products Affected

- XYREM

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a sleep specialist or a neurologist
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	For treatment of somnolence associated with narcolepsy, patient must have documentation of either trial of or a medical reason for being unable to use an approved formulary CNS stimulant (e.g. methylphenidate, modafinil, armodafinil, etc.)

YONSA

Products Affected

- YONSA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that liver function test will be completed for the duration of therapy as indicated in compendia.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

ZEJULA

Products Affected

- ZEJULA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that that Complete Blood Count (CBC with differential), blood pressure, and heart rate will be monitored for the duration of therapy as indicated in compendia.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

ZELBORAF

Products Affected

- ZELBORAF

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that liver function, ECG and electrolyte will be monitored for the duration of therapy as indicated in compendia. For appropriate indication, documentation that patient has a BRAF V600E or V600K mutation as detected by an FDA-approved test.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist or a hematologist
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

ZOLINZA

Products Affected

- ZOLINZA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that CBC, electrolytes, serum glucose, and serum creatinine will be monitored for the duration of therapy as indicated in compendia
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

ZYDELIG

Products Affected

- ZYDELIG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that CBC with differential and liver function test will be completed for the duration of therapy as indicated in compendia. Documentation of prior treatment history for related conditions.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

ZYKADIA

Products Affected

- ZYKADIA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that liver function, heart rate and blood pressure will be monitored for the duration of therapy as indicated in compendia.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

ZYPREXA RELPREVV

Products Affected

- ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 210 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	The member has a documented history of receiving oral olanzapine without any clinically significant side effects. Additionally, the member has a documented trial and failure or medical reason (e.g. intolerance, hypersensitivity or contraindication) for not utilizing one of these therapies to manage their medical condition: Invega Sustenna, Invega Trinza or Risperdal Consta
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

ZYTIGA

Products Affected

- ZYTIGA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Provider attests that liver function tests, blood pressure and electrolytes will be monitored for the duration of therapy as indicated in compendia.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	N/A

PART B VERSUS PART D

Products Affected

- ABELCET INTRAVENOUS SUSPENSION 5 MG/ML
- *acetylcysteine solution 100 mg/ml (10 %), 200 mg/ml (20 %)*
- *acyclovir sodium intravenous solution 50 mg/ml*
- *albuterol sulfate inhalation solution for nebulization 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg /3 ml (0.083 %), 5 mg/ml*
- AMBISOME INTRAVENOUS SUSPENSION FOR RECONSTITUTION 50 MG
- AMINOSYN 7 % WITH ELECTROLYTES INTRAVENOUS PARENTERAL SOLUTION 7 %
- AMINOSYN 8.5 %-ELECTROLYTES INTRAVENOUS PARENTERAL SOLUTION 8.5 %
- AMINOSYN II 10 % INTRAVENOUS PARENTERAL SOLUTION 10 %
- AMINOSYN II 15 % INTRAVENOUS PARENTERAL SOLUTION 15 %
- AMINOSYN II 8.5 % INTRAVENOUS PARENTERAL SOLUTION 8.5 %
- AMINOSYN II 8.5 %-ELECTROLYTES INTRAVENOUS PARENTERAL SOLUTION 8.5 %
- AMINOSYN-HBC 7% INTRAVENOUS PARENTERAL SOLUTION 7 %
- AMINOSYN-PF 10 % INTRAVENOUS PARENTERAL SOLUTION 10 %
- AMINOSYN-PF 7 % (SULFITE-FREE) INTRAVENOUS PARENTERAL SOLUTION 7 %
- AMINOSYN-RF 5.2 % INTRAVENOUS PARENTERAL SOLUTION 5.2 %
- *amphotericin b injection recon soln 50 mg*
- *aprepitant oral capsule 125 mg, 40 mg, 80 mg*
- *aprepitant oral capsule,dose pack 125 mg (1)-80 mg (2)*
- ASTAGRAF XL ORAL CAPSULE,EXTENDED RELEASE 24HR 0.5 MG, 1 MG, 5 MG
- *azathioprine oral tablet 50 mg*
- BIVIGAM INTRAVENOUS SOLUTION 10 %
- *budesonide inhalation suspension for nebulization 0.25 mg/2 ml, 0.5 mg/2 ml, 1 mg/2 ml*
- CARIMUNE NF NANOFILTERED INTRAVENOUS RECON SOLN 6 GRAM
- CLINIMIX 4.25%/D10W SULF FREE INTRAVENOUS PARENTERAL SOLUTION 4.25 %
- CLINIMIX 4.25%-D20W SULF-FREE INTRAVENOUS PARENTERAL SOLUTION 4.25 %
- CLINIMIX 4.25%-D25W SULF-FREE INTRAVENOUS PARENTERAL SOLUTION 4.25 %
- CLINISOL SF 15 % INTRAVENOUS PARENTERAL SOLUTION 15 %
- *cromolyn inhalation solution for nebulization 20 mg/2 ml*
- *cyclophosphamide oral capsule 25 mg, 50 mg*
- *cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg*
- *cyclosporine modified oral solution 100 mg/ml*
- *cyclosporine oral capsule 100 mg, 25 mg*
- *dronabinol oral capsule 10 mg, 2.5 mg, 5 mg*
- DURAMORPH (PF) INJECTION SOLUTION 0.5 MG/ML, 1 MG/ML
- EMEND ORAL SUSPENSION FOR RECONSTITUTION 125 MG (25 MG/ ML FINAL CONC.)
- ENGERIX-B (PF) INTRAMUSCULAR SYRINGE 20 MCG/ML
- ENGERIX-B PEDIATRIC (PF) INTRAMUSCULAR SYRINGE 10 MCG/0.5 ML
- ENVARSUS XR ORAL TABLET EXTENDED RELEASE 24 HR 0.75 MG, 1 MG, 4 MG
- FLEBOGAMMA DIF INTRAVENOUS SOLUTION 10 %
- GAMMAGARD LIQUID INJECTION SOLUTION 10 %

- GAMMAGARD S-D (IGA < 1 MCG/ML) INTRAVENOUS RECON SOLN 10 GRAM, 5 GRAM
- GAMMAKED INJECTION SOLUTION 1 GRAM/10 ML (10 %)
- GAMMAPLEX (WITH SORBITOL) INTRAVENOUS SOLUTION 5 %
- GAMMAPLEX INTRAVENOUS SOLUTION 10 %, 10 % (100 ML), 10 % (200 ML)
- GAMUNEX-C INJECTION SOLUTION 1 GRAM/10 ML (10 %)
- GENGRAF ORAL CAPSULE 100 MG, 25 MG
- GENGRAF ORAL SOLUTION 100 MG/ML
- GEODON INTRAMUSCULAR RECON SOLN 20 MG/ML (FINAL CONC.)
- *granisetron hcl oral tablet 1 mg*
- *heparin (porcine) injection solution 10,000 unit/ml, 5,000 unit/ml*
- *imipenem-cilastatin intravenous recon soln 250 mg, 500 mg*
- INTRALIPID INTRAVENOUS EMULSION 20 %, 30 %
- *ipratropium bromide inhalation solution 0.02 %*
- *ipratropium-albuterol inhalation solution for nebulization 0.5 mg-3 mg(2.5 mg base)/3 ml*
- *levalbuterol hcl inhalation solution for nebulization 0.31 mg/3 ml, 0.63 mg/3 ml, 1.25 mg/3 ml*
- *linezolid in dextrose 5% intravenous piggyback 600 mg/300 ml*
- *mycophenolate mofetil oral capsule 250 mg*
- *mycophenolate mofetil oral suspension for reconstitution 200 mg/ml*
- *mycophenolate mofetil oral tablet 500 mg*
- *mycophenolate sodium oral tablet,delayed release (dr/ec) 180 mg, 360 mg*
- NEBUPENT INHALATION RECON SOLN 300 MG
- *ondansetron hcl oral solution 4 mg/5 ml*
- *ondansetron hcl oral tablet 24 mg, 4 mg, 8 mg*
- *ondansetron oral tablet,disintegrating 4 mg, 8 mg*
- PLENAMINE INTRAVENOUS PARENTERAL SOLUTION 15 %
- PRIVIGEN INTRAVENOUS SOLUTION 10 %
- PULMOZYME INHALATION SOLUTION 1 MG/ML
- RAPAMUNE ORAL SOLUTION 1 MG/ML
- RECOMBIVAX HB (PF) INTRAMUSCULAR SUSPENSION 10 MCG/ML, 40 MCG/ML
- RECOMBIVAX HB (PF) INTRAMUSCULAR SYRINGE 10 MCG/ML, 5 MCG/0.5 ML
- SANDIMMUNE ORAL SOLUTION 100 MG/ML
- *sirolimus oral tablet 0.5 mg, 1 mg, 2 mg*
- *sodium chloride intravenous parenteral solution 2.5 meq/ml*
- *tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg*
- *tobramycin in 0.225 % nacl inhalation solution for nebulization 300 mg/5 ml*
- *vancomycin intravenous recon soln 1,000 mg, 10 gram, 500 mg*
- ZORTRESS ORAL TABLET 0.25 MG, 0.5 MG, 0.75 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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