

PA Criteria

Prior Authorization Group

Drug Names

Covered Uses

Exclusion Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

ACITRETIN

ACITRETIN

All FDA-approved indications not otherwise excluded from Part D, Prevention of non-melanoma skin cancers in high risk individuals.

Severely impaired liver function or kidney function. Chronic abnormally elevated blood lipid values. Concomitant use of methotrexate or tetracycline.

Prior Authorization Group

Drug Names

Covered Uses

Exclusion Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

ACTIMMUNE

ACTIMMUNE

All FDA-approved indications not otherwise excluded from Part D, mycosis fungoides, Sezary syndrome, atopic dermatitis.

For chronic granulomatous disease, Actimmune is used for reducing the frequency and severity of serious infections associated with chronic granulomatous disease. For atopic dermatitis, the condition is resistant to conservative treatments (e.g., topical medications, phototherapy).

Prior Authorization Group

Drug Names

Covered Uses

Exclusion Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

ADAGEN

ADAGEN

All FDA-approved indications not otherwise excluded from Part D.

Severe combined immunodeficiency disease (SCID) is due to adenosine deaminase (ADA) deficiency. Condition failed to respond to bone marrow transplantation or patient is not currently a suitable candidate for bone marrow transplantation.

Plan Year

Prior Authorization Group

ADCIRCA - PENDING CMS REVIEW

Drug Names ADCIRCA
Covered Uses
Exclusion Criteria
Required Medical Information
Age Restrictions
Prescriber Restrictions
Coverage Duration
Other Criteria

Prior Authorization Group ADEMPAS - PENDING CMS REVIEW
Drug Names ADEMPAS
Covered Uses
Exclusion Criteria
Required Medical Information
Age Restrictions
Prescriber Restrictions
Coverage Duration
Other Criteria

Prior Authorization Group AFINITOR
Drug Names AFINITOR, AFINITOR DISPERZ
Covered Uses All FDA-approved indications not otherwise excluded from Part D, classical Hodgkin lymphoma, thymomas and thymic carcinomas, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, soft tissue sarcoma subtypes: perivascular epithelioid cell tumors (PEComa), angiomyolipoma, lymphangioleiomyomatosis.
Exclusion Criteria

Required Medical Information

Breast cancer: 1) The patient has advanced hormone receptor positive, HER2 negative disease, AND 2) Afinitor will be used in combination with exemestane, AND 3) The patient's disease a) has progressed within 12 months prior to starting Afinitor, OR b) was previously treated with a nonsteroidal aromatase inhibitor, OR c) was previously treated with tamoxifen. Renal cell carcinoma: 1) The disease is relapsed or medically unresectable, AND 2) Afinitor will be used as a single agent, AND 3) For disease that is of clear cell histology, the patient has previously tried and failed, or had an intolerance or contraindication to pazopanib or sunitinib. Classical Hodgkin lymphoma: 1) The disease is relapsed or refractory AND 2) Afinitor will be used as a single agent. Thymomas and Thymic carcinomas: 1) The disease has progressed on a platinum-based chemotherapy regimen AND 2) Afinitor will be used as a single agent. Soft tissue sarcoma: 1) The patient has one of the following subtypes of STS: a) perivascular epithelioid cell tumors (PEComa), or b) angiomyolipoma, or c) lymphangioleiomyomatosis, AND 2) Afinitor will be used as a single agent. Subependymal giant cell astrocytoma associated with tuberous sclerosis complex (TSC): The patient is not a candidate for curative surgical resection. Renal angiomyolipoma associated with TSC: The patient does not require immediate surgery.

Age Restrictions**Prescriber Restrictions****Coverage Duration****Other Criteria**

Plan Year

Prior Authorization Group**Drug Names****Covered Uses****Exclusion Criteria****Required Medical Information**

ALDURAZYME

ALDURAZYME

All FDA-approved indications not otherwise excluded from Part D

The diagnosis of mucopolysaccharidosis I is confirmed by either an enzyme assay showing a deficiency of alpha-L-iduronidase enzyme activity or by DNA testing. Patients with Scheie syndrome must have moderate to severe symptoms.

Age Restrictions**Prescriber Restrictions****Coverage Duration****Other Criteria**

Plan Year

Prior Authorization Group**Drug Names****Covered Uses****Exclusion Criteria****Required Medical Information****Age Restrictions****Prescriber Restrictions****Coverage Duration**

ALECENSA

ALECENSA

All FDA-approved indications not otherwise excluded from Part D.

Plan Year

Other Criteria

Prior Authorization Group

Drug Names

Covered Uses

Exclusion Criteria

Required Medical Information

ALGLUCOSIDASE

LUMIZYME

All FDA-approved indications not otherwise excluded from Part D.

Diagnosis of Pompe disease was confirmed by an enzyme assay demonstrating a deficiency of acid alpha-glucosidase (GAA) enzyme activity or by DNA testing that identifies mutations in the GAA gene.

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

Plan Year

Prior Authorization Group

Drug Names

Covered Uses

Exclusion Criteria

Required Medical Information

ALOSETRON

ALOSETRON HYDROCHLORIDE

All FDA-approved indications not otherwise excluded from Part D.

Patient has a history of any of the following conditions: Chronic or severe constipation or sequelae from constipation. Intestinal obstruction, stricture, toxic megacolon, gastrointestinal perforation, and/or adhesions. Ischemic colitis. Impaired intestinal circulation, thrombophlebitis or hypercoagulable state. Crohn's disease or ulcerative colitis. Diverticulitis. Severe hepatic impairment.

1) Lotronex is being prescribed for a woman with a diagnosis of severe diarrhea-predominant irritable bowel syndrome (IBS) AND 2) chronic IBS symptoms lasting at least 6 months AND 3) gastrointestinal tract abnormalities have been ruled out AND 4) inadequate response to conventional therapy.

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

Plan Year

Prior Authorization Group

Drug Names

Covered Uses

Exclusion Criteria

Required Medical Information

ALPHA1-PROTEINASE INHIBITOR

ARALAST NP, PROLASTIN-C, ZEMAIRA

All FDA-approved indications not otherwise excluded from Part D

Patients must have clinically evident emphysema. Patients must have a pretreatment serum alpha1-proteinase inhibitor level less than 11 micromoles/L (80 mg/dl). Patients must have a pretreatment post-bronchodilation FEV1 greater than, or equal to, 25 percent and less than, or equal to, 80 percent of predicted.

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

Plan Year

Prior Authorization Group	AMPYRA
Drug Names	AMPYRA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	History of seizures. Creatinine clearance 50 mL/min or less.
Required Medical Information	For new starts: Prior to initiating therapy, patient demonstrates sustained walking impairment and the ability to walk 25 feet (with or without assistance). For continuation of therapy: Patient must have experienced an improvement in walking speed or other objective measure of walking ability since starting Ampyra.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	ANABOLIC STEROIDS
Drug Names	OXANDROLONE
Covered Uses	All FDA approved indications not otherwise excluded from Part D, Cachexia associated with AIDS (HIV-wasting) or due to chronic disease or Turner's syndrome.
Exclusion Criteria	Pregnancy. Known or suspected carcinoma of the prostate or breast in male patients. Carcinoma of the breast in females with hypercalcemia. Nephrosis, the nephrotic phase of nephritis. Hypercalcemia.
Required Medical Information	Patient will be monitored for peliosis hepatis, liver cell tumors and blood lipid changes.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Prior Authorization Group	ANADROL
Drug Names	ANADROL-50
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, Cachexia associated with AIDS (HIV-wasting), Fanconi's anemia.
Exclusion Criteria	Pregnancy. Carcinoma of the prostate or breast in male patients. Carcinoma of the breast in women with hypercalcemia. Nephrosis or the nephrotic phase of nephritis. Severe hepatic dysfunction.
Required Medical Information	Patient will be monitored for peliosis hepatis, liver cell tumors and blood lipid changes.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 Months
Other Criteria	
Prior Authorization Group	APOKYN
Drug Names	APOKYN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria	Concomitant treatment with a serotonin 5HT3 antagonist (e.g., ondansetron, granisetron, dolasetron, palonosetron, and alosetron).
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	ARCALYST
Drug Names	ARCALYST
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Prevention of gout flares in patients initiating or continuing urate-lowering therapy.
Exclusion Criteria	
Required Medical Information	For prevention of gout flares in members initiating or continuing urate-lowering therapy (i.e., allopurinol or febuxostat) (new starts): all of the following criteria must be met: 1) serum uric acid concentration greater than or equal to 445 micromol/L (7.5 mg/dL) prior to initiating Arcalyst, 2) two or more gout flares within the previous 12 months, 3) inadequate response, intolerance or contraindication to maximum tolerated doses of non-steroidal anti-inflammatory drugs and colchicine, and 4) concurrent use with urate-lowering therapy (i.e., allopurinol or febuxostat). For prevention of gout flares in members initiating or continuing urate-lowering therapy (i.e., allopurinol or febuxostat) (continuation): 1) Member must have achieved or maintain a clinical benefit (i.e., a fewer number of gout attacks or fewer flare days) compared to baseline and 2) have continued use of urate-lowering therapy concurrently with Arcalyst.
Age Restrictions	CAPS: 12 years of age or older. Gout: 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	For prevention of gout flares: 4 months. Other: Plan Year
Other Criteria	Abbreviation: CAPS = Cryopyrin-Associated Periodic Syndromes.
Prior Authorization Group	AVASTIN
Drug Names	AVASTIN

Covered Uses

All FDA-approved indications not otherwise excluded from Part D, breast cancer, central nervous system (CNS) tumor types: adult intracranial and spinal ependymoma and anaplastic gliomas, endometrial cancer, ovarian malignant sex cord-stromal tumors, soft tissue sarcoma subtypes: angiosarcoma, solitary fibrous tumor, and hemangiopericytoma, malignant pleural mesothelioma, choroidal neovascularization associated with: ocular histoplasmosis, pathologic myopia, angioid streaks, inflammatory conditions, or of idiopathic etiology, neovascular (wet) age-related macular degeneration including polypoidal choroidopathy and retinal angiomatous proliferation subtypes, macular edema due to retinal vein occlusion, diabetic macular edema, ocular neovascularization of the choroid, retina, or iris associated with proliferative diabetic retinopathy, neovascular glaucoma, and retinopathy of prematurity.

Exclusion Criteria

Required Medical Information

For CRC, Avastin (AV) will be used with a fluoropyrimidine- or irinotecan-based regimen (i.e., capecitabine, CapeOx, FOLFIRI, FOLFOX, FOLFOXIRI, or 5-FU with leucovorin) for: 1) perioperative (neoadjuvant/adjuvant/postoperative) therapy for advanced or metastatic disease or 2) treatment (tx) of unresectable advanced or metastatic disease. For NSCLC, the disease is unresectable, locally advanced, recurrent, or metastatic for patients with tumors of non-squamous cell histology, and no hx of recent hemoptysis and 1) AV will be used as first-line therapy or as subsequent therapy after prior therapy with erlotinib, afatinib, gefitinib or crizotinib a) AV will be used with cisplatin- or carboplatin-based regimens and b) Patient has distant mets or locoregional recurrence with evidence of disseminated disease, OR 2) AV will be used as a continuation maintenance tx (i.e., continuation of AV as first-line therapy beyond 4-6 cycles in the absence of disease progression) for tumor that is negative or unknown for both EGFR and ALK mutations and a) AV will be used alone or in combination with pemetrexed if previously used with a first-line pemetrexed/platinum chemotherapy regimen and b) Patient has achieved tumor response or stable disease following first-line chemotherapy. For epithelial ovarian cancer (CA), fallopian tube CA, or primary peritoneal CA, AV was previously not given for persistent disease or recurrence for patients who have received no more than 2 prior chemotherapy regimens AND is used 1) with liposomal doxorubicin, paclitaxel, or topotecan for platinum-resistant disease OR 2) alone for platinum-sensitive or -resistant disease. For malignant sex cord-stromal tumors, AV is used for clinical relapse in patient with granulosa cell tumors. For breast CA, 1) HER2-negative recurrent or metastatic disease and 2) AV is used with paclitaxel. For endometrial CA, AV is used alone for patients who progressed on prior cytotoxic chemotherapy.

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

Colorectal cancer perioperative therapy: 3 months. Other: Plan Year.

For angiosarcoma, Avastin is used as a single-agent. For solitary fibrous tumor or hemangiopericytoma, Avastin is used with temozolomide. For malignant pleural mesothelioma, Avastin is used with pemetrexed and cisplatin. For RCC, 1) relapsed or for surgically unresectable RCC and 2) Avastin is used as a) first-line tx with interferon alfa-2 for disease with clear cell histology or b) first-line tx as a single-agent for disease with non-clear cell histology, or c) subsequent tx as a single-agent for disease with predominant clear cell histology following prior cytokine tx. Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

Prior Authorization Group

B VS. D

Drug Names

ABELCET, ABRAXANE, ACETYLCYSTEINE, ACYCLOVIR SODIUM, ADRUCIL, ALBUTEROL SULFATE, ALIMTA, AMBISOME, AMIFOSTINE, AMINOSYN, AMINOSYN 7%/ELECTROLYTES, AMINOSYN 8.5%/ELECTROLYTE, AMINOSYN II, AMINOSYN II 8.5%/ELECTROL, AMINOSYN M, AMINOSYN-HBC, AMINOSYN-PF, AMINOSYN-PF 7%, AMINOSYN-RF, AMPHOTERICIN B, AZACITIDINE, AZATHIOPRINE, BENDEKA, BICNU, BLEOMYCIN SULFATE, BUDESONIDE, BUSULFEX, CALCITONIN-SALMON, CALCITRIOL, CARBOPLATIN, CISPLATIN, CLADRIBINE, CLINIMIX 2.75%/DEXTROSE 5, CLINIMIX 4.25%/DEXTROSE 1, CLINIMIX 4.25%/DEXTROSE 2, CLINIMIX 4.25%/DEXTROSE 5, CLINIMIX 5%/DEXTROSE 15%, CLINIMIX 5%/DEXTROSE 20%, CLINIMIX 5%/DEXTROSE 25%, CROMOLYN SODIUM, CYCLOPHOSPHAMIDE, CYCLOSPORINE, CYCLOSPORINE MODIFIED, CYTARABINE AQUEOUS, DACARBAZINE, DAUNORUBICIN HCL, DEPO-PROVERA, DEXRAZOXANE, DIPHTHERIA/TETANUS TOXOID, DOCEFREZ, DOCETAXEL, DOXORUBICIN HCL, DOXORUBICIN HCL LIPOSOME, DRONABINOL, DURAMORPH, ELITEK, EMEND, ENGERIX-B, EPIRUBICIN HCL, ETOPOSIDE, FASLODEX, FLUDARABINE PHOSPHATE, FLUOROURACIL, FORTICAL, FREAMINE HBC 6.9%, FREAMINE III, FUSILEV, GAMASTAN S/D, GANCICLOVIR, GEMCITABINE, GEMCITABINE HCL, GENGRAF, GRANISETRON HCL, HEPARIN SODIUM, HEPATAMINE, HUMULIN R U-500 (CONCENTR, HYDROMORPHONE HCL, HYDROXYPROGESTERONE CAPRO, IDARUBICIN HCL, IFEX, IFOSFAMIDE, INTRALIPID, INTRON A, INTRON A W/DILUENT, IPRATROPIUM BROMIDE, IPRATROPIUM BROMIDE/ALBUT, IRINOTECAN, ISTODAX, KADCYLA, LEUCOVORIN CALCIUM, LEVALBUTEROL, LEVOCARNITINE, LEVOLEUCOVORIN, LEVOLEUCOVORIN CALCIUM, LIDOCAINE HCL, MELPHALAN HYDROCHLORIDE, MESNA, METHOTREXATE SODIUM, METHYLPREDNISOLONE, METHYLPREDNISOLONE ACETAT, METHYLPREDNISOLONE SODIUM, MIACALCIN, MITOMYCIN, MITOXANTRONE HCL, MORPHINE SULFATE, MUSTARGEN, MYCOPHENOLATE MOFETIL, MYCOPHENOLIC ACID DR, NEBUPENT, NEORAL, NEPHRAMINE, NIPENT, NULOJIX, NUTRILIPID, ONDANSETRON HCL, ONDANSETRON ODT, OXALIPLATIN, PACLITAXEL, PAMIDRONATE DISODIUM, PARICALCITOL, PREDNISOLONE, PREDNISOLONE SODIUM PHOSP, PREDNISONE, PREDNISONE INTENSOL, PREMASOL, PROCALAMINE, PROGRAF, PROLEUKIN, PROSOL, RAPAMUNE, RECOMBIVAX HB, SANDIMMUNE, SIROLIMUS, TACROLIMUS, TENIVAC, TETANUS/DIPHTHERIA TOXOID, TOPOSAR, TOPOTECAN HCL, TPN ELECTROLYTES, TRAVASOL, TREANDA, TRISENOX, TROPHAMINE, VINBLASTINE SULFATE, VINCASAR PFS, VINCRISTINE SULFATE, VINORELBINE TARTRATE, ZOLEDRONIC ACID, ZORTRESS

<i>Covered Uses</i>	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.
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	N/A
<i>Other Criteria</i>	
<i>Prior Authorization Group</i>	BANZEL
<i>Drug Names</i>	BANZEL
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D.
<i>Exclusion Criteria</i>	The patient has Familial Short QT Syndrome.
<i>Required Medical Information</i>	
<i>Age Restrictions</i>	1 year of age or older.
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	
<i>Prior Authorization Group</i>	BELEODAQ
<i>Drug Names</i>	BELEODAQ
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D.
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	
<i>Prior Authorization Group</i>	BENLYSTA
<i>Drug Names</i>	BENLYSTA
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D.
<i>Exclusion Criteria</i>	Severe active lupus nephritis. Severe active central nervous system lupus.
<i>Required Medical Information</i>	Diagnosis of active, autoantibody-positive systemic lupus erythematosus (SLE). Member is currently receiving standard therapy for SLE (eg, corticosteroids, azathioprine, leflunomide, methotrexate, mycophenolate mofetil, hydroxychloroquine, non-steroidal anti-inflammatory drugs) or has tried and had an inadequate response or intolerance to standard therapy for SLE.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Initial: 6 months. Renewal: Plan Year.

Other Criteria	For renewals, member is benefiting from Benlysta therapy (eg, reduction of steroid dose, decrease in pain medications).
Prior Authorization Group	BETASERON
Drug Names	BETASERON
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Have a relapsing form of MS (e.g., relapsing-remitting MS, progressive-relapsing MS, or secondary progressive MS with relapses) OR first clinical episode of MS with MRI scan that demonstrated features consistent with a diagnosis of MS.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	BEXAROTENE
Drug Names	BEXAROTENE, TARGRETIN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, mycosis fungoides, Sezary syndrome (capsules only), primary cutaneous CD30-positive T-cell lymphoproliferative disorder types: primary cutaneous anaplastic large cell lymphoma (capsules only) and lymphomatoid papulosis (capsules only), adult T-cell leukemia/lymphoma (gel only), primary cutaneous B-cell lymphoma types: primary cutaneous marginal zone lymphoma (gel only) and primary cutaneous follicle center lymphoma (gel only).
Exclusion Criteria	
Required Medical Information	For capsule formulation: Patient has any of the following types of cutaneous T-cell lymphomas: mycosis fungoides, Sezary syndrome, primary cutaneous anaplastic large cell lymphoma, lymphomatoid papulosis. For primary cutaneous anaplastic large cell lymphoma and lymphomatoid papulosis: 1) The disease is CD30-positive, and 2) bexarotene will be used as a single agent. For gel formulation: For cutaneous T-cell lymphoma, patient has a diagnosis of stage I to III mycosis fungoides. For primary cutaneous B-cell lymphoma, patient has either primary cutaneous marginal zone lymphoma or primary cutaneous follicle center lymphoma.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	BOSULIF - PENDING CMS REVIEW
Drug Names	BOSULIF
Covered Uses	
Exclusion Criteria	

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

Prior Authorization Group

Drug Names

Covered Uses

Exclusion Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

BRIVIACT

BRIVIACT

All FDA-approved indications not otherwise excluded from Part D.

Plan Year

Prior Authorization Group

Drug Names

Covered Uses

Exclusion Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

BUPRENORPHINE - PENDING CMS REVIEW

BUPRENORPHINE HCL

Prior Authorization Group

Drug Names

Covered Uses

Exclusion Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

BUPRENORPHINE-NALOXONE - PENDING CMS REVIEW

BUPRENORPHINE HCL/NALOXON, SUBOXONE

Prior Authorization Group

Drug Names

Covered Uses

Exclusion Criteria

Required Medical Information

Age Restrictions

CABOMETYX

CABOMETYX

All FDA-approved indications not otherwise excluded from Part D

The disease expresses clear cell histology and is advanced or metastatic. The patient has received and progressed on or after prior treatment with a vascular endothelial growth factor receptor targeting tyrosine kinase inhibitor.

Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	CAPRELSA
Drug Names	CAPRELSA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, differentiated thyroid cancer subtypes: papillary, follicular, Hurthle cell.
Exclusion Criteria	
Required Medical Information	For medullary thyroid cancer: 1) disease is symptomatic or progressive and 2) patient has unresectable locoregional or metastatic disease. For differentiated thyroid cancer: 1) histologic subtype is papillary, follicular, or Hurthle cell, 2) disease is symptomatic and/or progressive, 3) disease is iodine-refractory, and 4) patient has unresectable recurrent or persistent locoregional disease OR metastatic disease.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	CARBAGLU
Drug Names	CARBAGLU
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, methylmalonic acidemia, propionic acidemia.
Exclusion Criteria	
Required Medical Information	Diagnosis of NAGS deficiency was confirmed by enzymatic or genetic testing.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	CAYSTON
Drug Names	CAYSTON
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	The diagnosis of cystic fibrosis is confirmed by appropriate diagnostic or genetic testing. Pseudomonas aeruginosa is present in the cultures of the airway.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Prior Authorization Group	CERDELGA
Drug Names	CERDELGA

Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	CYP2D6 extensive metabolizers or intermediate metabolizers taking a strong or moderate CYP2D6 inhibitor (e.g., paroxetine, terbinafine) concomitantly with a strong or moderate CYP3A inhibitor (e.g., ketoconazole, fluconazole). CYP2D6 intermediate metabolizers or poor metabolizers taking a strong CYP3A inhibitor (e.g., ketoconazole). CYP2D6 indeterminate metabolizers (i.e., CYP2D6 genotype cannot be determined). CYP2D6 ultra-rapid metabolizers. Use concomitantly with enzyme replacement therapy.
Required Medical Information	Diagnosis of Gaucher disease was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by DNA testing. The patient's CYP2D6 metabolizer status has been established using an FDA-cleared test. Member is a CYP2D6 extensive metabolizer, an intermediate metabolizer, or a poor metabolizer.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	CEREZYME
Drug Names	CEREZYME
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, type 3 Gaucher disease
Exclusion Criteria	Concomitant therapy with miglustat (Zavesca) or eliglustat (Cerdelga)
Required Medical Information	Diagnosis of Gaucher disease was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by DNA testing. For Type 1 Gaucher disease, the patient has one or more of the following disease complications: anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly. For Type 3 Gaucher disease, the patient has one or more of the following disease complications: anemia, thrombocytopenia, bone disease, hepatomegaly, splenomegaly, developmental delay, or ophthalmoplegia (gaze palsy).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	CHANTIX
Drug Names	CHANTIX, CHANTIX CONTINUING MONTH, CHANTIX STARTING MONTH PA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	The patient has been advised to report any changes to the prescriber such as changes in behavior, hostility, agitation, depressed mood, and suicide related events, including ideation, behavior, and attempted suicide, while taking Chantix.

Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 Months
Other Criteria	
Prior Authorization Group	CINRYZE - PENDING CMS REVIEW
Drug Names	CINRYZE
Covered Uses	
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	
Prior Authorization Group	CLORAZEPATE
Drug Names	CLORAZEPATE DIPOTASSIUM
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	<p>This Prior Authorization requirement only applies to patients 65 years of age or older. The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.1) For the management of anxiety disorders or for the short-term relief of the symptoms of anxiety, the requested drug is being used with a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI) until the antidepressant becomes effective for the symptoms of anxiety OR the patient has experienced an inadequate treatment response, intolerance or contraindication to a selective serotonin reuptake inhibitor (SSRI) (e.g., escitalopram, sertraline) or a serotonin-norepinephrine reuptake inhibitor (SNRI) (e.g., duloxetine, venlafaxine ER) OR 2) For adjunctive therapy in the management of partial seizures OR 3) Symptomatic relief in acute alcohol withdrawal AND 4) The benefit of therapy with the prescribed medication outweighs the potential risk in a patient 65 years of age or older.</p>
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Anxiety Disorders-4 Months, All other Diagnoses-Plan Year
Other Criteria	
Prior Authorization Group	CLOZAPINE ODT
Drug Names	CLOZAPINE ODT
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria	History of clozapine-induced agranulocytosis or severe granulocytopenia. Dementia-related psychosis.
Required Medical Information	The patient is unwilling or unable to take tablets or capsules orally or is at high risk for non-compliance.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	COMETRIQ
Drug Names	COMETRIQ
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Medullary thyroid cancer which meets one of the following: 1) Unresectable locoregional disease that is symptomatic or structurally progressive, 2) Asymptomatic distant metastases if structurally progressive and unresectable, 3) Symptomatic or progressive metastatic disease
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	COTELLIC
Drug Names	COTELLIC
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	CYSTAGON
Drug Names	CYSTAGON
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of nephropathic cystinosis was confirmed by the presence of increased cysteine concentration in leukocytes or by DNA testing.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	CYSTARAN
Drug Names	CYSTARAN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of cystinosis was confirmed by the presence of increased cysteine concentration in leukocytes or by DNA testing. The patient has corneal cystine crystal accumulation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	DAKLINZA
Drug Names	DAKLINZA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, chronic hepatitis C genotype 2 or 4 infection.
Exclusion Criteria	Use with a strong inducer of CYP3A, including phenytoin, carbamazepine, rifampin and St. John's wort
Required Medical Information	Chronic hepatitis C infection confirmed by presence of HCV RNA in serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated variants (eg, NS3 Q80K polymorphism) where applicable, liver transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Criteria will be applied consistent with current AASLD-IDSA guidance
Other Criteria	For HCV/HIV coinfection, patient meets criteria for requested regimen.
Prior Authorization Group	DEFERASIROX
Drug Names	EXJADE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	For chronic iron overload due to blood transfusions: pretreatment serum ferritin level is greater than 1000 mcg/L. For chronic iron overload in patients with non-transfusion dependent thalassemia (NTDT) syndromes: A) For initiation of the deferasirox therapy: Pretreatment liver iron concentration (LIC) is at least 5 mg of iron per gram of liver dry weight (mg Fe/g dw) AND pretreatment serum ferritin levels are greater than 300 mcg/L on 2 consecutive measurements 1 month apart. B) For continuation of the deferasirox therapy: Current LIC is greater than 3 mg Fe/g dw or the deferasirox therapy will be withheld until the LIC reaches above 5 mg Fe/g dw.

Age Restrictions	2 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	DIAZEPAM
Drug Names	DIAZEPAM, DIAZEPAM INTENSOL
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	<p>This Prior Authorization requirement only applies to patients 65 years of age or older. The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.1) For the management of anxiety disorders or for the short-term relief of the symptoms of anxiety, the requested drug is being used with a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI) until the antidepressant becomes effective for the symptoms of anxiety OR the patient has experienced an inadequate treatment response, intolerance or contraindication to a selective serotonin reuptake inhibitor (SSRI) (e.g., escitalopram, sertraline) or a serotonin-norepinephrine reuptake inhibitor (SNRI) (e.g., duloxetine, venlafaxine ER) OR 2) For symptomatic relief in acute alcohol withdrawal OR 3) For use as an adjunct for the relief of skeletal muscle spasms OR 4) For adjunctive therapy in the treatment of convulsive disorders AND 5) The benefit of therapy with the prescribed medication outweighs the potential risk in a patient 65 years of age or older.</p>
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Anxiety Disorders-4 Months, All other Diagnoses-Plan Year
Other Criteria	
Prior Authorization Group	EMSAM - PENDING CMS REVIEW
Drug Names	EMSAM
Covered Uses	
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	
Prior Authorization Group	ENTRESTO
Drug Names	ENTRESTO
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria	History of angioedema related to previous angiotensin-converting enzyme inhibitor (ACE inhibitor) or angiotensin receptor blocker (ARB) therapy. Concomitant use of ACE inhibitors. Concomitant use of aliskiren in a patient with diabetes. Pregnancy.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	Note: Reduced ejection fraction is generally less than or equal to 40 percent
Prior Authorization Group	EPO
Drug Names	PROCRIT
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, anemia due to myelodysplastic syndromes (MDS), anemia in congestive heart failure (CHF), anemia in rheumatoid arthritis (RA), anemia due to hepatitis C treatment (ribavirin in combination with either interferon alfa or peginterferon alfa).
Exclusion Criteria	Patients receiving chemotherapy with curative intent. Patients with myeloid cancer. Use to facilitate preoperative autologous blood donation.
Required Medical Information	For all uses except surgery: 1) Pretreatment (no erythropoietin treatment in previous month) Hgb is less than 10 g/dL (less than 9 g/dL for anemia in CHF only). 2) For reauthorizations (patient received erythropoietin in previous month), an increase in Hgb of at least 1 g/dL after at least 12 weeks of therapy. Additional requirements for anemia due to myelosuppressive cancer chemotherapy: 1) For initial therapy, at least 2 more months of chemotherapy is expected. 2) For reauthorizations, current Hgb is less than 11 g/dL. Additional requirements for CKD not on dialysis reauthorization: 1) Current Hgb is less than or equal to 10 g/dL OR Hgb is greater than 10 but less than or equal to 12 g/dL AND prescriber will reduce or interrupt dose. Additional requirements for MDS: 1) Patient has symptomatic anemia AND 2) Pretreatment serum erythropoietin level is less than or equal to 500 mU/mL. 3) For reauthorizations, current Hgb is less than or equal to 11 g/dL OR Hgb is greater than 11 but less than or equal to 12 g/dL AND prescriber will reduce or interrupt dose. Additional requirements for HIV: 1) Concomitant use of zidovudine at a maximum dose of 4200 mg per week. 2) For initial therapy, pretreatment serum erythropoietin level is less than or equal to 500 mU/mL. 3) For reauthorizations, current Hgb is less than or equal to 11 g/dL OR Hgb is greater than 11 but less than or equal to 12 g/dL AND prescriber will reduce or interrupt dose. Additional requirements for anemia due to CHF, RA, hepatitis C treatment, or patients whose religious beliefs forbid blood transfusions: 1) For reauthorizations, current Hgb is less than or equal to 11 g/dL OR Hgb is greater than 11 but less than or equal to 12 g/dL AND prescriber will reduce or interrupt dose. For surgery: 1) Patient is scheduled for elective, noncardiac, nonvascular surgery. 2) Pretreatment Hgb is greater than 10 but not more than 13 g/dL.

Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 weeks
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual (e.g., used for treatment of anemia for a patient with chronic renal failure who is undergoing dialysis, or furnished from physician's supply incident to a physician service). Coverage includes use in anemia in patients whose religious beliefs forbid blood transfusions. Requirements regarding Hgb values exclude values due to a recent transfusion.
Prior Authorization Group	ERIVEDGE
Drug Names	ERIVEDGE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Patient meets one of the following criteria: 1) patient has nodal or distant metastatic basal cell carcinoma (BCC), OR 2) patient has residual or recurrent disease and further surgery and radiation are contraindicated or not appropriate, OR 3) patient cannot achieve negative margins by Mohs surgery or more extensive surgical procedures.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	ESBRIET
Drug Names	ESBRIET
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Initial Review Only: The patient does not have a known etiology for interstitial lung disease. The patient has completed a high-resolution computed tomography study of the chest which reveals the usual interstitial pneumonia pattern. If the study reveals the possible usual interstitial pneumonia pattern, the diagnosis is supported by surgical lung biopsy. If a surgical lung biopsy has not been conducted, the diagnosis is supported by a multidisciplinary discussion between at least a radiologist and pulmonologist who are experienced in idiopathic pulmonary fibrosis. For initial and continuation: Esbriet will not be used in combination with Ofev.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 6 months, Renewal: Plan Year
Other Criteria	For continuation only: The patient has experienced a reduction in disease progression.
Prior Authorization Group	FABRAZYME
Drug Names	FABRAZYME

Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of Fabry disease was confirmed by an enzyme assay demonstrating a deficiency of alpha-galactosidase enzyme activity or by DNA testing. Patient has clinical signs and symptoms of Fabry disease.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	FARYDAK
Drug Names	FARYDAK
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	The patient has received at least two prior regimens, including bortezomib and an immunomodulatory agent (eg, lenalidomide, thalidomide, pomalidomide). Farydak will be used in combination with bortezomib and dexamethasone. The patient does not have a baseline QTc interval greater than, or equal to, 450 ms. The patient will be monitored for severe diarrhea.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	FENTANYL PATCH
Drug Names	FENTANYL
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Significant respiratory depression. Known or suspected paralytic ileus.
Required Medical Information	1) The patient has been evaluated and will be monitored regularly for the development of addiction, abuse, or misuse of fentanyl patch AND 2) The patient can safely take the requested dose based on their current opioid use history. [Note: Fentanyl patch is indicated for use in opioid-tolerant patients. Patients considered opioid-tolerant are those who are taking, for one week or longer, at least 60mg of morphine daily, or at least 30mg of oral oxycodone daily, or at least 8mg of oral hydromorphone daily, or an equianalgesic dose of another opioid.] AND 3) Fentanyl patch is being prescribed for pain severe enough to require daily, around-the-clock, long-term treatment in a patient who has been taking an opioid.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	FERRIPROX
Drug Names	FERRIPROX
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	FILGRASTIM
Drug Names	GRANIX, NEUPOGEN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, treatment of chemotherapy-induced febrile neutropenia (FN), following chemotherapy for acute lymphocytic leukemia (ALL), leukemic relapse following allogeneic stem cell transplantation, myelodysplastic syndromes (MDS), agranulocytosis, aplastic anemia, HIV-related neutropenia.
Exclusion Criteria	Use of a G-CSF product within 24 hours prior to or following chemotherapy or radiotherapy. For treatment of chemotherapy-induced FN, patient received prophylactic pegylated G-CSF (e.g., Neulasta) during the current chemotherapy cycle.
Required Medical Information	For prophylaxis of myelosuppressive chemotherapy-induced FN patients must meet all of the following: 1) Patient has a non-myeloid cancer, 2) Patient is currently receiving or will be receiving treatment with myelosuppressive anti-cancer therapy. For treatment of myelosuppressive chemotherapy-induced FN patients must meet all of the following: 1) Patient has a non-myeloid cancer, 2) Patient is currently receiving or has received treatment with myelosuppressive anti-cancer therapy. For the treatment of anemia in MDS patients must meet all of the following: 1) Patient has symptomatic anemia, 2) The requested G-CSF product will be used in combination with epoetin or darbepoetin, 3) Patient has MDS with a low or intermediate-1 risk stratification, 4) The serum erythropoietin level is less than, or equal to, 500 mU/ml. For neutropenia in MDS: 1) Member is neutropenic, 2) Patient experiences recurrent or resistant infections.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	For prevention of neutropenia: Patient will not receive chemotherapy and radiotherapy concurrently
Prior Authorization Group	FIRAZYR
Drug Names	FIRAZYR
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, ACE inhibitor-induced angioedema.
Exclusion Criteria	

Required Medical Information	For hereditary angioedema (HAE): Diagnostic laboratory testing for HAE has been performed (eg, C4, C1 inhibitor functional, and C1 inhibitor antigenic protein levels). For patients with HAE with C1 inhibitor deficiency, C1 inhibitor antigenic protein level and/or C1 inhibitor functional level is below the lower limit of normal as defined by the laboratory performing the test. For patients with HAE with normal C1 inhibitor: Other causes of angioedema have been ruled out (eg, drug induced) and EITHER 1) Patient tested positive for the F12 gene mutation OR 2) Patient has a family history of angioedema.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	For HAE, Firazyr is being requested for the treatment of acute HAE attacks.
Prior Authorization Group	FORTEO
Drug Names	FORTEO
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For all indications: patient has had an oral bisphosphonate trial of at least 1-year duration unless contraindicated or intolerant to an oral bisphosphonate. For primary or hypogonadal osteoporosis and postmenopausal osteoporosis: Patient has a) a history of an osteoporotic vertebral or hip fracture OR b) a pre-treatment T-score of less than or equal to -2.5 OR c) a pre-treatment T-score of less than or equal to -1 but greater than -2.5 AND a pre-treatment FRAX score of either greater than or equal to 20 percent for any major osteoporotic fracture or greater than or equal to 3 percent for hip fracture. For glucocorticoid-induced osteoporosis in postmenopausal women and men 50 years of age or older: 1) Patient is currently receiving or will be initiating glucocorticoid therapy, and 2) Patient has a) a history of fragility fracture OR b) a pre-treatment T-score of less than or equal to -2.5 OR c) a pre-treatment FRAX score of either greater than or equal to 20 percent for any major osteoporotic fracture or greater than or equal to 3 percent for hip fracture. For glucocorticoid-induced osteoporosis in premenopausal women and men less than 50 years of age: 1) Patient is currently receiving or will be initiating glucocorticoid therapy, and 2) The anticipated glucocorticoid length of therapy is at least 3 months, and 3) Patient has a history of a fragility fracture.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 months (lifetime)
Other Criteria	
Prior Authorization Group	FYCOMPA
Drug Names	FYCOMPA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria	
Required Medical Information	The patient and caregivers will be advised to contact the healthcare provider immediately if any serious psychiatric or behavioral reactions are observed.
Age Restrictions	12 years of age or older.
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	GATTEX
Drug Names	GATTEX
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Patient was dependent on parenteral support for at least 12 months prior to initiation of therapy with Gattex. For continuation: requirement for parenteral support has decreased from baseline while on Gattex therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	GILENYA
Drug Names	GILENYA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Have a relapsing form of MS (e.g., relapsing-remitting MS, progressive-relapsing MS, or secondary progressive MS with relapses).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	GILOTRIF
Drug Names	GILOTRIF
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For non-small cell lung cancer (NSCLC), patient meets either of the following: 1) Patient has metastatic squamous NSCLC that progressed after platinum-based chemotherapy, OR 2) Patient had EGFR mutation testing and is positive for exon 19 deletions or exon 21 (L858R) substitution mutations AND Gilotrif is prescribed for use as any of the following: a) First-line therapy as a single agent for recurrent or metastatic disease (EGFR mutation discovered prior to first-line chemotherapy or during first-line chemotherapy), or b) Subsequent therapy as a single agent for recurrent or metastatic disease following disease progression on afatinib or erlotinib.

Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	GLATIRAMER
Drug Names	COPAXONE, GLATOPA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, first clinical episode of MS.
Exclusion Criteria	
Required Medical Information	Have a relapsing form of MS (e.g., relapsing-remitting MS, progressive-relapsing MS, or secondary progressive MS with relapses) OR first clinical episode of MS with MRI scan that demonstrated features consistent with a diagnosis of MS.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	GROWTH HORMONE - PENDING CMS REVIEW
Drug Names	NORDITROPIN FLEXPOR
Covered Uses	
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	
Prior Authorization Group	HERCEPTIN
Drug Names	HERCEPTIN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, esophageal and esophagogastric junction cancer, leptomeningeal metastases from HER2-positive breast cancer
Exclusion Criteria	

Required Medical Information	For HER2-positive breast cancer, Herceptin is used either: 1) For neoadjuvant treatment in combination with chemotherapy, OR 2) For adjuvant treatment in combination with chemotherapy for tumors at least 0.6cm or node positive, OR 3) For recurrent or metastatic disease in combination with aromatase inhibition for hormone-receptor positive disease, OR 4) For recurrent or metastatic disease in patients without previous treatment with Herceptin for recurrent or metastatic disease who meet 4a or 4b. 4a) Patients are hormone-receptor negative or are hormone-receptor positive and endocrine refractory, have symptomatic visceral disease, or visceral crisis. 4b) Patients use Herceptin as a single agent, in combination with chemotherapy, in combination with pertuzumab and docetaxel or paclitaxel, OR 5) For recurrent or metastatic disease in patient with previous treatment with Herceptin for recurrent or metastatic disease who meet 5a or 5b. 5a) Patients are hormone-receptor negative or are hormone-receptor positive and endocrine refractory, have symptomatic visceral disease, or visceral crisis, OR 5b) Patients use Herceptin in combination with capecitabine, in combination with lapatinib without chemotherapy, in combination with pertuzumab with or without chemotherapy and the patient previous received chemotherapy and Herceptin in the absence of pertuzumab. For esophageal, gastric, or esophagogastric junction cancer: 1) The disease is locally advanced or metastatic, AND 2) Herceptin is used with cisplatin and fluorouracil or cisplatin and capecitabine.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prior Authorization Group	HETLIOZ
Drug Names	HETLIOZ
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For initial therapy and continuation of HetlioZ therapy: 1) diagnosis of Non-24 Hour Sleep-Wake Disorder, AND 2) diagnosis of total blindness in both eyes (e.g., nonfunctioning retinas), AND 3) unable to perceive light in both eyes. For patients currently on HetlioZ therapy, must meet at least one of the following: 1) increased total nighttime sleep OR 2) decreased daytime nap duration
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initiation: 3 Months, Renewal: Plan Year
Other Criteria	
Prior Authorization Group	HIGH RISK MEDICATION

Drug Names	CYPROHEPTADINE HCL, DISOPYRAMIDE PHOSPHATE, GUANFACINE ER, NORPACE CR, TRANSDERM-SCOP
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.
Prior Authorization Group	HRM-ANTICONVULSANTS
Drug Names	PHENOBARBITAL, PHENOBARBITAL SODIUM
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) 1) Two non-HRM alternative formulary drugs carbamazepine, lamotrigine, levetiracetam, topiramate, or valproic acid have not been tried. AND 2) The patient has a contraindication to two non-HRM alternative formulary drugs carbamazepine, lamotrigine, levetiracetam, topiramate, or valproic acid AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. OR 4) Two non-HRM alternative formulary drugs carbamazepine, lamotrigine, levetiracetam, topiramate, or valproic acid have been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to two non-HRM alternative formulary drugs carbamazepine, lamotrigine, levetiracetam, topiramate, or valproic acid AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.
Prior Authorization Group	HRM-ANTIDEPRESSANTS TCA - PENDING CMS REVIEW
Drug Names	AMITRIPTYLINE HCL, DOXEPIN HCL, IMIPRAMINE HCL, TRIMIPRAMINE MALEATE
Covered Uses	
Exclusion Criteria	
Required Medical Information	

Age Restrictions
Prescriber Restrictions
Coverage Duration
Other Criteria

Prior Authorization Group

HRM-ANTIPARKINSON

Drug Names

BENZTROPINE MESYLATE

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

Plan Year

This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) EPS: 1) One non-HRM alternative formulary drug amantadine has not been tried. AND 2) The patient has a contraindication to one non-HRM alternative formulary drug amantadine AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. OR 4) One non-HRM alternative formulary drug amantadine has been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to one non-HRM alternative formulary drug amantadine AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. Parkinson's: Two non-HRM formulary drugs amantadine, carbidopa, carbidopa/levodopa, pramipexole, or ropinirole have not been tried. AND 2) The patient has a contraindication to two non-HRM formulary drugs amantadine, carbidopa, carbidopa/levodopa, pramipexole, or ropinirole AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. OR 4) Two non-HRM formulary drugs amantadine, carbidopa, carbidopa/levodopa, pramipexole, or ropinirole have been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to two non-HRM formulary drugs amantadine, carbidopa, carbidopa/levodopa, pramipexole, or ropinirole AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.

Prior Authorization Group

HRM-ANTIPSYCHOTICS

Drug Names

THIORIDAZINE HCL

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions
Coverage Duration
Other Criteria

Plan Year

This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) 1) Two non-HRM alternative formulary drugs aripiprazole, asenapine, iloperidone, lurasidone, quetiapine, risperidone, or ziprasidone have not been tried. AND 2) The patient has a contraindication to two non-HRM alternative formulary drugs aripiprazole, asenapine, iloperidone, lurasidone, quetiapine, risperidone, or ziprasidone. AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. OR 4) Two non-HRM alternative formulary drugs aripiprazole, asenapine, iloperidone, lurasidone, quetiapine, risperidone, or ziprasidone have been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to two non-HRM alternative formulary drugs aripiprazole, asenapine, iloperidone, lurasidone, quetiapine, risperidone, or ziprasidone. AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.

Prior Authorization Group
Drug Names
Covered Uses
Exclusion Criteria
Required Medical Information
Age Restrictions
Prescriber Restrictions
Coverage Duration

HRM-CLOMIPRAMINE

CLOMIPRAMINE HCL

All FDA-approved indications not otherwise excluded from Part D.

Plan Year

Other Criteria

This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) 1) Two non-HRM alternative formulary drugs escitalopram, fluoxetine, fluvoxamine, fluvoxamine ER, sertraline, venlafaxine or venlafaxine ER have not been tried. AND 2) The patient has a contraindication to two non-HRM alternative formulary drugs escitalopram, fluoxetine, fluvoxamine, fluvoxamine ER, sertraline, venlafaxine or venlafaxine ER AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. OR 4) Two non-HRM alternative formulary drugs escitalopram, fluoxetine, fluvoxamine, fluvoxamine ER, sertraline, venlafaxine or venlafaxine ER have been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to two non-HRM alternative formulary drugs escitalopram, fluoxetine, fluvoxamine, fluvoxamine ER, sertraline, venlafaxine or venlafaxine ER AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.

Prior Authorization Group**Drug Names**

HRM-DIGOXIN

Covered Uses

DIGITEK, DIGOX, DIGOXIN

Exclusion Criteria

All FDA-approved indications not otherwise excluded from Part D.

Required Medical Information**Age Restrictions****Prescriber Restrictions****Coverage Duration**

Plan Year

Other Criteria

This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) 1) Reduction in dose is inappropriate AND 2) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.

Prior Authorization Group**Drug Names**

HRM-ESTROGENS

Covered Uses

ESTRADIOL, FYAVOLV, JINTELI, NORETHINDRONE ACETATE/ETH

Exclusion Criteria

All FDA-approved indications not otherwise excluded from Part D.

Required Medical Information**Age Restrictions****Prescriber Restrictions****Coverage Duration**

Plan Year

Other Criteria

This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Vaginal dryness, vaginal atrophy, dyspareunia: 1) One non-HRM alternative formulary drug Estrace Vaginal Cream has not been tried. AND 2) The patient has a contraindication to one non-HRM alternative formulary drug Estrace Vaginal Cream AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient OR 4) One non-HRM alternative formulary drug Estrace Vaginal Cream has been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to one non-HRM alternative formulary drug Estrace Vaginal Cream AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. Hot Flashes: Two non-HRM formulary drugs citalopram, venlafaxine ER, desvenlafaxine succinate, or gabapentin have not been tried. AND 2) The patient has a contraindication to two non-HRM formulary drugs citalopram, venlafaxine ER, desvenlafaxine succinate, or gabapentin AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. OR 4) Two non-HRM formulary drugs citalopram, venlafaxine ER, desvenlafaxine succinate, or gabapentin have been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to two non-HRM formulary drugs citalopram, venlafaxine ER, desvenlafaxine succinate, or gabapentin AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. Post-Menopausal Osteoporosis: Two non-HRM formulary drugs alendronate, risedronate, or raloxifene have not been tried. AND 2) The patient has a contraindication to two non-HRM formulary drugs alendronate, risedronate, or raloxifene AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. OR 4) Two non-HRM formulary drugs alendronate, risedronate, or raloxifene have been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to two non-HRM formulary drugs alendronate, risedronate, or raloxifene AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.

Prior Authorization Group

Drug Names

Covered Uses

Exclusion Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

HRM-HYDROXYZINE

HYDROXYZINE HCL, HYDROXYZINE PAMOATE

All FDA-approved indications not otherwise excluded from Part D.

Plan Year

Other Criteria

This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) For pruritus 1) A non-HRM alternative formulary drug levocetirizine has not been tried. AND 2) The patient has a contraindication to a non-HRM alternative formulary drug levocetirizine AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. OR 4) A non-HRM alternative formulary drug levocetirizine has been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to a non-HRM alternative formulary drug levocetirizine AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. For anxiety 1) Two non-HRM alternative formulary drugs buspirone, duloxetine, escitalopram, sertraline, or venlafaxine ER have not been tried. AND 2) The patient has a contraindication to two non-HRM alternative formulary drugs buspirone, duloxetine, escitalopram, sertraline, or venlafaxine ER) AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. OR 4) Two non-HRM alternative formulary drugs buspirone, duloxetine, escitalopram, sertraline, or venlafaxine ER have been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to two non-HRM alternative formulary drugs buspirone, duloxetine, escitalopram, sertraline, or venlafaxine ER AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.

Prior Authorization Group**Drug Names****Covered Uses****Exclusion Criteria****Required Medical Information****Age Restrictions****Prescriber Restrictions****Coverage Duration**

HRM-HYDROXYZINE INJ

HYDROXYZINE HCL

All FDA-approved indications not otherwise excluded from Part D.

Plan Year

Other Criteria

This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Alcohol Withdrawal Syndrome: 1) One non-HRM alternative formulary drug clorazepate or lorazepam have not been tried AND 2) The patient has a contraindication to one non-HRM alternative formulary drug clorazepate or lorazepam AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient OR 4) One non-HRM alternative formulary drug clorazepate or lorazepam have been tried AND 5) The patient experienced an inadequate treatment response OR intolerance to one non-HRM alternative formulary drug clorazepate or lorazepam AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient Anxiety: 1) Two non-HRM alternative formulary drugs buspirone, duloxetine, escitalopram, sertraline or venlafaxine ER have not been tried AND 2) The patient has a contraindication to two non-HRM alternative formulary drugs buspirone, duloxetine, escitalopram, sertraline or venlafaxine ER AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient OR 4) Two non-HRM alternative formulary drugs buspirone, duloxetine, escitalopram, sertraline or venlafaxine ER have been tried AND 5) The patient experienced an inadequate treatment response OR intolerance to two non-HRM alternative formulary drugs buspirone, duloxetine, escitalopram, sertraline or venlafaxine ER AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient OR 7) If being requested for nausea/vomiting, prescriber must acknowledge that medication benefits outweigh potential risks for this patient.

Prior Authorization Group

Drug Names

Covered Uses

Exclusion Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

HRM-HYPNOTICS

ZOLPIDEM TARTRATE

All FDA-approved indications not otherwise excluded from Part D.

Plan Year

Other Criteria

This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) 1) Two non-HRM alternative formulary drugs Silenor (3mg or 6mg), Rozerem, or trazodone have not been tried. AND 2) The patient has a contraindication to two non-HRM alternative formulary drugs Silenor (3mg or 6mg), Rozerem or trazodone. AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient OR 4) Two non-HRM alternative formulary drugs Silenor (3mg or 6mg), Rozerem, or trazodone have been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to two non-HRM alternative formulary drugs Silenor (3mg or 6mg), Rozerem, or trazodone. AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. APPLIES TO GREATER THAN CUMULATIVE 90 DAYS OF THERAPY PER YEAR.

Prior Authorization Group**Drug Names**

HRM-MEGESTROL AC
MEGESTROL ACETATE

Covered Uses

All FDA-approved indications not otherwise excluded from Part D, oral suspension - palliative treatment of advanced carcinoma of the breast or endometrium (i.e., recurrent, inoperable, or metastatic disease).

Exclusion Criteria**Required Medical Information****Age Restrictions****Prescriber Restrictions****Coverage Duration**

Plan Year

Other Criteria

This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.

Prior Authorization Group**Drug Names**

HRM-NITROFURANTOIN
NITROFURANTOIN MACROCRYST, NITROFURANTOIN MONOHYDRAT

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria**Required Medical Information****Age Restrictions****Prescriber Restrictions****Coverage Duration**

Plan Year

Other Criteria

This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) 1) Two non-HRM alternative formulary drugs cephalexin, ciprofloxacin, levofloxacin, sulfamethoxazole/trimethoprim, or trimethoprim have not been tried. AND 2) The patient has a contraindication to two non-HRM alternative formulary drugs cephalexin, ciprofloxacin, levofloxacin, sulfamethoxazole/trimethoprim, or trimethoprim AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. OR 4) Two non-HRM alternative formulary drugs cephalexin, ciprofloxacin, levofloxacin, sulfamethoxazole/trimethoprim, or trimethoprim have been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to two non-HRM alternative formulary drugs cephalexin, ciprofloxacin, levofloxacin, sulfamethoxazole/trimethoprim, or trimethoprim) AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. APPLIES TO GREATER THAN CUMULATIVE 90 DAYS OF THERAPY PER YEAR.

Prior Authorization Group**Drug Names****Covered Uses****Exclusion Criteria****Required Medical Information****Age Restrictions****Prescriber Restrictions****Coverage Duration**

HRM-PROMETHAZINE

PHENADOZ, PHENERGAN, PROMETHAZINE HCL, PROMETHEGAN

All FDA-approved indications not otherwise excluded from Part D.

Plan Year

Other Criteria

This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Rhinitis: 1) One non-HRM alternative formulary drug levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal have not been tried. AND 2) The patient has a contraindication to one non-HRM alternative formulary drug levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. OR 4) One non-HRM alternative formulary drug levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal have been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to one non-HRM alternative formulary drug levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient Urticaria: 1) One non-HRM alternative formulary drug levocetirizine have not been tried. AND 2) The patient has a contraindication to one non-HRM alternative formulary drug levocetirizine AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. OR 4) One non-HRM alternative formulary drug levocetirizine have been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to one non-HRM alternative formulary drug levocetirizine AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient OR 7) The drug is being requested for antiemetic therapy in postoperative patients or motion sickness AND 8) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient

Prior Authorization Group

Drug Names

Covered Uses

Exclusion Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

HRM-SKELETAL MUSCLE RELAXANTS

CYCLOBENZAPRINE HCL

All FDA-approved indications not otherwise excluded from Part D.

Plan Year

This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.

Prior Authorization Group

HUMIRA

Drug Names	HUMIRA, HUMIRA PEDIATRIC CROHNS D, HUMIRA PEN, HUMIRA PEN-CROHNS DISEASE, HUMIRA PEN-PSORIASIS STAR
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, axial spondyloarthritis, uveitis.
Exclusion Criteria	
Required Medical Information	Latent TB screening with either a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB) prior to initiating Humira (or other biologic). For moderately to severely active rheumatoid arthritis (new starts only): Patient meets at least one of the following criteria: 1) Inadequate response to at least a 3-month trial of methotrexate (MTX) despite adequate dosing (i.e., titrated to 25 mg/week), 2) Intolerance or contraindication to MTX, 3) Inadequate response to at least a 3-month trial of a prior biologic DMARD or a targeted synthetic DMARD (e.g., Xeljanz), 4) Intolerance to a prior biologic DMARD or a targeted synthetic DMARD, 5) Severely active RA. For moderately to severely active polyarticular juvenile idiopathic arthritis (new starts only): Patient meets ANY of the following criteria: 1) Inadequate response to at least a 3-month trial of MTX, 2) Intolerance or contraindication to MTX, 3) Inadequate response to at least a 3-month trial of a prior biologic DMARD, 4) Intolerance to a prior biologic DMARD. For active ankylosing spondylitis and axial spondyloarthritis (new starts only): Inadequate response to at least a 4-week NSAID trial at maximum recommended or tolerated dose OR intolerance and/or contraindication to NSAIDs. For moderate to severe chronic plaque psoriasis (new starts only): 1) At least 5% of BSA is affected or crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis, AND 2) Patient meets any of the following: a) Patient has experienced an inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) Pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated, c) Patient has severe psoriasis that warrants a biologic DMARD as first-line therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year

Other Criteria

For moderately to severely active Crohn's disease (new starts only): 1) Inadequate response to at least one conventional therapy (e.g., corticosteroids, sulfasalazine, azathioprine, mesalamine), OR 2) Intolerance or contraindication to conventional therapy. For moderately to severely active ulcerative colitis (new starts only): 1) Inadequate response to immunosuppressant therapy (e.g., corticosteroids, azathioprine, mercaptopurine) or intolerance or contraindication to immunosuppressant therapy, AND 2) Patient is naive to TNF inhibitor therapy or patient lost response to previous TNF inhibitor therapy due to antibody formation. For active psoriatic arthritis (PsA) (new starts only): Patient meets ANY of the following: 1) Inadequate response to at least a 3-month trial of MTX, sulfasalazine, or leflunomide, 2) Intolerance or contraindication to MTX, sulfasalazine, or leflunomide, 3) Inadequate response to at least a 3-month trial of a prior biologic DMARD, 4) Intolerance to a prior biologic DMARD, 5) Severely active PsA as evidenced by ANY of the following: a) multiple swollen joints, b) structural damage in the presence of inflammation, c) clinically relevant extra-articular manifestations (e.g., extensive skin, bowel, ocular, cardiovascular, urogenital, or pulmonary involvement), 6) Active enthesitis and/or dactylitis (i.e., sausage finger), 7) Predominant axial disease (i.e., extensive spinal involvement). For uveitis (new starts only): Patient has experienced an inadequate response or intolerance or has a contraindication to a trial of immunosuppressive therapy for uveitis (e.g., methotrexate, azathioprine, or mycophenolate mofetil).

Prior Authorization Group

Drug Names

Covered Uses

Exclusion Criteria

Required Medical Information

HYPNOTIC BENZODIAZEPINES

TEMAZEPAM

All FDA-approved indications not otherwise excluded from Part D.

This Prior Authorization requirement only applies to patients 65 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) 1) Two non-HRM alternative formulary drugs Silenor (3mg or 6mg), Rozerem, or trazodone have not been tried. AND 2) The patient has a contraindication to two non-HRM alternative formulary drugs Silenor (3mg or 6mg), Rozerem or trazodone. AND 3) Prescriber must acknowledge that medication benefits outweigh potential risk in a patient 65 years of age or older. OR 4) Two non-HRM alternative formulary drugs Silenor (3mg or 6mg), Rozerem, or trazodone have been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to two non-HRM alternative formulary drugs Silenor (3mg or 6mg), Rozerem, or trazodone. AND 6) Prescriber must acknowledge that medication benefits outweigh potential risk in a patient 65 years of age or older. APPLIES TO GREATER THAN CUMULATIVE 90 DAYS OF THERAPY PER YEAR.

Age Restrictions

Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	IBRANCE
Drug Names	IBRANCE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Single-agent therapy for the treatment of well-differentiated/dedifferentiated liposarcoma for retroperitoneal sarcomas.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	ICLUSIG
Drug Names	ICLUSIG
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For CML or Ph+ ALL, diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	IMATINIB
Drug Names	IMATINIB MESYLATE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, Ph+ lymphoblastic lymphoma, desmoid tumors, pigmented villonodular synovitis/tenosynovial giant cell tumor (PVNS/TGCT), chordoma, and melanoma.
Exclusion Criteria	
Required Medical Information	For CML or Ph+ ALL/lymphoblastic lymphoma, diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, patient did not fail (excluding failure due to intolerance) prior therapy with a tyrosine kinase inhibitor (eg, dasatinib, nilotinib, bosutinib, ponatinib). For melanoma, c-Kit mutation is positive.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	IMBRUVICA

Drug Names	IMBRUVICA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, small lymphocytic lymphoma, lymphoplasmacytic lymphoma.
Exclusion Criteria	
Required Medical Information	For Waldenstrom's macroglobulinemia and lymphoplasmacytic lymphoma (WM/LPL): Imbruvica is used as a single agent.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	INCRELEX - PENDING CMS REVIEW
Drug Names	INCRELEX
Covered Uses	
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	
Prior Authorization Group	INLYTA
Drug Names	INLYTA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, papillary, Hurthle cell, or follicular thyroid carcinoma.
Exclusion Criteria	
Required Medical Information	For renal cell carcinoma: 1) Inlyta will be used as a single agent and 2) the disease is relapsed or medically unresectable. For disease that is of clear cell histology, the patient has previously tried and failed, or had an intolerance or contraindication to pazopanib or sunitinib. For thyroid carcinoma: 1) The disease has papillary, Hurthle cell, or follicular histology, 2) Nexavar is not an appropriate option for the patient, 3) the disease is unresectable or metastatic, 4) the disease is radioiodine refractory, and 5) the disease is progressive or symptomatic.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	IRESSA
Drug Names	IRESSA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	

Age Restrictions
Prescriber Restrictions
Coverage Duration
Other Criteria

Plan Year

Prior Authorization Group
Drug Names
Covered Uses

ISOTRETINOIN
CLARAVIS, MYORISAN, ZENATANE
All FDA-approved indications not otherwise excluded from Part D, Cutaneous T-cell Lymphoma (CTCL) (e.g., mycosis fungoides, Sezary syndrome), Keratosis follicularis (Darier Disease), Lamellar ichthyosis, Neuroblastoma, Pityriasis rubra pilaris, Transient acantholytic dermatosis (Grover Disease), severe refractory Rosacea, refractory Acne, Reduction of the development of skin cancer (squamous cell cancers) in high risk patients.

Exclusion Criteria
Required Medical Information

1) For acne (severe recalcitrant nodular or refractory) or severe refractory rosacea and patient had inadequate treatment responses to any topical acne product and an oral antibiotic [Note: topical products include salicylic acid, benzoyl peroxide, azelaic acid, adapalene, tretinoin, tazarotene, clindamycin, erythromycin, or metronidazole for rosacea] [Note: oral antibiotics include minocycline, doxycycline, tetracycline, erythromycin, trimethoprim-sulfamethoxazole, trimethoprim, azithromycin]. OR 2) For transient acantholytic dermatosis (Grover Disease), keratosis follicularis (Darier Disease), lamellar ichthyosis, or pityriasis rubra pilaris and patient had inadequate response to another treatment.

Age Restrictions
Prescriber Restrictions
Coverage Duration
Other Criteria

Plan Year

For acne (severe recalcitrant nodular or refractory) or severe refractory rosacea treatment will be limited to 40 weeks (2 courses) or less AND with at least 8 weeks between each course.

Prior Authorization Group
Drug Names
Covered Uses

ITRACONAZOLE
ITRACONAZOLE
All FDA-approved indications not otherwise excluded from Part D, Coccidioidomycosis, Cryptococcosis, Sporotrichosis, Penicilliosis, Microsporidiosis, Pityriasis versicolor/Tinea versicolor, Tinea corporis/Tinea cruris, Tinea manuum/Tinea pedis. Current use of certain drugs metabolized by CYP3A4. If the patient has the diagnosis of onychomycosis, evidence of ventricular dysfunction, such as congestive heart failure (CHF).

Exclusion Criteria

Required Medical Information	1) If for the treatment of onychomycosis due to tinea, the diagnosis has been confirmed with a fungal diagnostic test OR 2) Pityriasis versicolor or Tinea versicolor OR 3) If for the treatment of tinea corporis, tinea cruris, tinea manuum, tinea pedis, the patient has experienced either an inadequate treatment response, adverse event, intolerance, or contraindication to griseofulvin OR 4) Diagnosis of blastomycosis, histoplasmosis, aspergillosis, coccidioidomycosis, cryptococcosis, sporotrichosis, penicilliosis, microsporidiosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Onychomycosis, Versicolor (pityriasis or tinea), Tinea-3mo, Systemic infection-6mo
Other Criteria	Criteria apply to capsule dosage form only.
Prior Authorization Group	IVIG
Drug Names	BIVIGAM, CARIMUNE NANOFILTERED, FLEBOGAMMA DIF, GAMMAGARD LIQUID, GAMMAGARD S/D IGA LESS TH, GAMMAKED, GAMMAPLEX, GAMUNEX-C, OCTAGAM
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, primary immunodeficiency, chronic inflammatory demyelinating polyneuropathy, multifocal motor neuropathy, dermatomyositis, polymyositis, Guillain-Barre syndrome (GBS), myasthenia gravis, Lambert-Eaton myasthenic syndrome, Kawasaki syndrome, idiopathic thrombocytopenic purpura, pure red cell aplasia (PRCA), fetal/neonatal alloimmune thrombocytopenia, and prophylaxis of bacterial infections in B-cell chronic lymphocytic leukemia (CLL), bone marrow/hematopoietic stem cell transplant (BMT/HSCT) recipients, and pediatric HIV infection.
Exclusion Criteria	IgA deficiency with antibodies to IgA and a history of hypersensitivity. History of anaphylaxis or severe systemic reaction to human immune globulin or product components.
Required Medical Information	For CLL: serum IgG less than 500 mg/dL OR a history of recurrent bacterial infections. For BMT/HSCT: IVIG is requested within the first 100 days post-transplant OR serum IgG less than 400 mg/dL. For pediatric HIV infection: 1) Serum IgG less than 400 mg/dL OR 2) History of recurrent bacterial infections, patient is not able to take combination antiretroviral therapy, and antibiotic prophylaxis was not effective. For dermatomyositis and polymyositis: standard first-line treatments (corticosteroids or immunosuppressants) have been tried but were unsuccessful or not tolerated OR patient is unable to receive standard therapy because of a contraindication or other clinical reason. For GBS: physical mobility must be severely affected such that the patient requires an aid to walk AND IVIG therapy must be initiated within 2 weeks of symptom onset. For myasthenia gravis: IVIG is requested for worsening weakness, acute exacerbation or use in preparation for surgery. PRCA is secondary to parvovirus B19 infection.

Age Restrictions	For pediatric HIV infection: age 12 years or younger
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prior Authorization Group	JAKAFI
Drug Names	JAKAFI
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For polycythemia vera, patient has had an inadequate response to or is intolerant of hydroxyurea.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	JUXTAPID - PENDING CMS REVIEW
Drug Names	JUXTAPID
Covered Uses	
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	
Prior Authorization Group	KALYDECO
Drug Names	KALYDECO
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Use in combination with Orkambi
Required Medical Information	The patient has a diagnosis of cystic fibrosis. The patient has one of the following documented mutations to the CFTR gene that was confirmed by genetic testing: G551D, G1244E, G1349D, G178R, G551S, S1251N, S1255P, S549N, S549R, or R117H.
Age Restrictions	Granules: 2 years of age and older, Tablets: 6 years of age and older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	KETOCONAZOLE
Drug Names	KETOCONAZOLE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, Cushing's syndrome

Exclusion Criteria	Acute or chronic liver disease. Current use with dofetilide, quinidine, pimozide, cisapride, methadone, disopyramide, dronedarone, ranolazine.
Required Medical Information	The patient's liver status will be assessed prior to therapy and as needed during therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	1) Patient has one of the following diagnoses: blastomycosis, coccidioidomycosis, histoplasmosis, chromomycosis, and paracoccidioidomycosis AND other antifungal therapies are ineffective, unavailable, or not tolerated OR 2) Ketoconazole (Nizoral) is being prescribed for a patient with Cushing's syndrome who cannot tolerate surgery or surgery has not been curative.
Prior Authorization Group	KEYTRUDA - PENDING CMS REVIEW
Drug Names	KEYTRUDA
Covered Uses	
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	
Prior Authorization Group	KORLYM
Drug Names	KORLYM
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Korlym is being used to control hyperglycemia secondary to hypercortisolism in a patient with endogenous Cushing's syndrome who has type 2 diabetes mellitus or glucose intolerance. Patient has had surgery that was not curative or the patient is not a candidate for surgery.
Age Restrictions	
Prescriber Restrictions	Endocrinologist
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	KUVAN - PENDING CMS REVIEW
Drug Names	KUVAN
Covered Uses	
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	

Coverage Duration
Other Criteria

Prior Authorization Group KYNAMRO - PENDING CMS REVIEW
Drug Names KYNAMRO
Covered Uses
Exclusion Criteria
Required Medical Information
Age Restrictions
Prescriber Restrictions
Coverage Duration
Other Criteria

Prior Authorization Group LENVIMA
Drug Names LENVIMA 10 MG DAILY DOSE, LENVIMA 14 MG DAILY DOSE, LENVIMA 18 MG DAILY DOSE, LENVIMA 20 MG DAILY DOSE, LENVIMA 24 MG DAILY DOSE, LENVIMA 8 MG DAILY DOSE
Covered Uses All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria
Required Medical Information For differentiated thyroid cancer: 1) histologic subtype is papillary, follicular, or Hurthle cell, 2) disease is symptomatic and/or progressive, 3) disease is iodine-refractory, and 4) patient has unresectable recurrent or persistent locoregional disease OR metastatic disease.
Age Restrictions
Prescriber Restrictions
Coverage Duration Plan Year
Other Criteria

Prior Authorization Group LETAIRIS - PENDING CMS REVIEW
Drug Names LETAIRIS
Covered Uses
Exclusion Criteria
Required Medical Information
Age Restrictions
Prescriber Restrictions
Coverage Duration
Other Criteria

Prior Authorization Group LEUKINE
Drug Names LEUKINE

<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D, prevention and treatment of chemotherapy-induced febrile neutropenia (FN), following chemotherapy for acute lymphocytic leukemia (ALL) or acute myeloid leukemia (AML), neutropenia in myelodysplastic syndromes (MDS), agranulocytosis, aplastic anemia, HIV-related neutropenia.
<i>Exclusion Criteria</i>	Use of Leukine within 24 hours prior to or following chemotherapy or radiotherapy. For treatment of chemotherapy-induced FN, patient received prophylactic pegylated G-CSF (eg, Neulasta) during the current chemotherapy cycle.
<i>Required Medical Information</i>	For prophylaxis of myelosuppressive chemotherapy-induced FN the patient must meet all of the following: 1) Patient has a non-myeloid cancer, 2) Patient is currently receiving or will be receiving treatment with myelosuppressive anti-cancer therapy. For treatment of myelosuppressive chemotherapy-induced FN the patient must meet all of the following: 1) Patient has a non-myeloid cancer, 2) Patient is currently receiving or has received treatment with myelosuppressive anti-cancer therapy. For MDS: Patient has neutropenia and experiences recurrent or resistant infections.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	6 months
<i>Other Criteria</i>	For prevention of neutropenia: Patient will not receive chemotherapy and radiotherapy concurrently
<i>Prior Authorization Group</i>	LIDOCAINE PATCHES
<i>Drug Names</i>	LIDOCAINE
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D, pain associated with diabetic neuropathy, pain associated with cancer-related neuropathy (including treatment-related neuropathy [e.g. neuropathy associated with radiation treatment or chemotherapy]).
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	Plan Year
<i>Other Criteria</i>	
<i>Prior Authorization Group</i>	LONSURF
<i>Drug Names</i>	LONSURF
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D.
<i>Exclusion Criteria</i>	

Required Medical Information	For metastatic colorectal cancer, KRAS (with or without NRAS) mutation testing is performed on either the primary tumor or metastases to confirm RAS mutation status. The patient must have been previously treated with fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy, an anti-VEGF therapy, and, if KRAS or NRAS wild type, an anti-EGFR therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	LUPRON - PENDING CMS REVIEW
Drug Names	LEUPROLIDE ACETATE, LUPRON DEPOT, LUPRON DEPOT-PED
Covered Uses	
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	
Prior Authorization Group	LYNPARZA
Drug Names	LYNPARZA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	MEGESTROL
Drug Names	MEGESTROL ACETATE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Pregnancy
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	MEKINIST - PENDING CMS REVIEW
Drug Names	MEKINIST
Covered Uses	
Exclusion Criteria	

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

Prior Authorization Group

Drug Names

MEMANTINE

MEMANTINE HCL, MEMANTINE HYDROCHLORIDE, NAMENDA XR, NAMENDA XR
TITRATION PACK

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Required Medical Information

The drug is being prescribed for the treatment of moderate to severe dementia of the
Alzheimer's type.

Age Restrictions

Prescriber Restrictions

Coverage Duration

Plan Year

Other Criteria

This edit only applies to patients less than 30 years of age.

Prior Authorization Group

Drug Names

MOZOBIL

MOZOBIL

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Required Medical Information

Age Restrictions

Prescriber Restrictions

Coverage Duration

6 months

Other Criteria

Prior Authorization Group

Drug Names

NAGLAZYME

NAGLAZYME

Covered Uses

All FDA-approved indications not otherwise excluded from Part D

Exclusion Criteria

Required Medical Information

Diagnosis of mucopolysaccharidosis VI (MPS VI) disease was confirmed by an enzyme
assay demonstrating a deficiency of N-acetylgalactosamine 4-sulfatase (arylsulfatase
B) enzyme activity or by DNA testing

Age Restrictions

Prescriber Restrictions

Coverage Duration

Plan Year

Other Criteria

Prior Authorization Group

Drug Names

NATPARA

NATPARA

Covered Uses

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Acute postsurgical hypoparathyroidism (within 6 months of surgery).

Hypoparathyroidism due to calcium-sensing receptor mutations. Any of the following risk factors for osteosarcoma: Paget's disease of bone, unexplained elevations of alkaline phosphatase, open epiphyses (ie, children or young adults), hereditary disorder that predisposes to osteosarcoma, history of external beam or implant radiation therapy involving the skeleton.

Required Medical Information

Natpara is prescribed to control hypocalcemia associated with hypoparathyroidism.

Natpara will be used in conjunction with calcium supplements with or without calcitriol (activated vitamin D). For initial therapy only: 1) total serum calcium levels are inadequately controlled despite treatment with optimized doses of calcium supplements and calcitriol, 2) total serum calcium level (albumin-corrected) is above 7.5 mg/dL, 3) serum 25-hydroxyvitamin D level is within the normal range, and 4) serum magnesium level is within the normal range. For continuation of therapy only: 1) total serum calcium level (albumin-corrected) is within the low-normal range (generally between 8 mg/dL and 9 mg/dL) OR the dose of Natpara, calcitriol, or calcium supplement is being adjusted to achieve total serum calcium levels within the low-normal range, and 2) serum 25-hydroxyvitamin D level is within the normal range.

Age Restrictions**Prescriber Restrictions****Coverage Duration**

Initial: 6 months Renewal: Plan Year

Other Criteria**Prior Authorization Group**

NEXAVAR

Drug Names

NEXAVAR

Covered Uses

All FDA-approved indications not otherwise excluded from Part D, osteosarcoma, soft tissue sarcoma subtypes: angiosarcoma, desmoid tumors (aggressive fibromatosis), gastrointestinal stromal tumor (GIST), medullary thyroid carcinoma, acute myeloid leukemia.

Exclusion Criteria

Required Medical Information

For hepatocellular carcinoma: 1) Nexavar will be used as a single agent and 2) the disease is a) metastatic, OR b) unresectable and the patient is not a candidate for liver transplantation, OR c) the patient is not a candidate for surgery due to performance status or comorbidities. For renal cell carcinoma: 1) The patient has relapsed or medically unresectable disease, 2) Nexavar will be used as a single agent, and 3) for disease that is of clear cell histology, the patient has previously tried and failed, or had an intolerance or contraindication to pazopanib or sunitinib. For follicular, papillary, or Hurthle cell thyroid carcinoma: 1) The disease is unresectable or metastatic, 2) the disease is radioiodine-refractory, and 3) the disease is progressive or symptomatic. For medullary thyroid carcinoma: 1) The patient has progressive disease or symptomatic distant metastatic disease and 2) the disease has progressed on vandetanib or cabozantinib OR vandetanib or cabozantinib are not appropriate options for the patient. For osteosarcoma: Nexavar will be used as a single agent. For gastrointestinal stromal tumor: The disease has progressed after treatment with imatinib, sunitinib, or regorafenib. For acute myeloid leukemia: 1) The disease is relapsed or refractory, 2) the patient has FLT3-ITD mutation-positive disease, 3) the patient cannot tolerate more aggressive regimens, and 4) Nexavar will be used in combination with azacitidine or decitabine.

Age Restrictions**Prescriber Restrictions****Coverage Duration****Other Criteria**

Plan Year

Prior Authorization Group**Drug Names****Covered Uses****Exclusion Criteria****Required Medical Information****Age Restrictions****Prescriber Restrictions****Coverage Duration****Other Criteria**

NINLARO

NINLARO

All FDA-approved indications not otherwise excluded from Part D

Plan Year

Prior Authorization Group**Drug Names****Covered Uses****Exclusion Criteria****Required Medical Information****Age Restrictions****Prescriber Restrictions****Coverage Duration****Other Criteria**

NORTHERA - PENDING CMS REVIEW

NORTHERA

Prior Authorization Group	NUEDEXTA
Drug Names	NUEDEXTA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient is currently using quinidine, quinine, mefloquine, monoamine oxidase inhibitors (MAOIs), or drugs that both prolong the QT interval and are metabolized by CYP2D6 (examples: thioridazine and pimozide). Patient has a prolonged QT interval or congenital long QT syndrome (LQTS), or heart failure or a history suggestive of torsades de pointes (TdP). Patient has complete atrioventricular (AV) block without an implanted pacemaker or is at high risk of complete AV block.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	NUPLAZID
Drug Names	NUPLAZID
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Dementia-related psychosis that is unrelated to the hallucinations and delusions associated with Parkinson's disease psychosis.
Required Medical Information	The diagnosis of Parkinson's disease was made prior to the onset of psychotic symptoms. Member has a baseline mini-mental status examination (MMSE) score of at least 21 points.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	NUVIGIL
Drug Names	ARMODAFINIL
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	1) Diagnosis is narcolepsy confirmed by sleep lab evaluation OR 2) Diagnosis is obstructive sleep apnea (OSA) confirmed by polysomnography OR 3) Diagnosis is Shift Work Disorder (SWD).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	OCTREOTIDE
Drug Names	OCTREOTIDE ACETATE, SANDOSTATIN LAR DEPOT

Covered Uses

All FDA-approved indication not otherwise covered under Part D, meningiomas, thymomas and thymic carcinomas, adrenal gland neuroendocrine tumors (NETs), NETs of the gastrointestinal (GI) tract, thymus, and lung, pancreatic NETs, and poorly differentiated (high-grade)/large or small cell NETs.

Exclusion Criteria**Required Medical Information**

Meningiomas: 1) Patient has recurrent or progressive disease (dx), 2) Dx is unresectable, 3) Dx is refractory to radiation therapy, and 4) Somatostatin receptor status (SRS) is positive. Thymomas and thymic carcinomas: 1) Patient has locally advanced, advanced, or recurrent dx, 2) Dx is unresectable OR patient has residual dx following resection, 3) Patient has progressed on at least one prior chemotherapy regimen, and 4) SRS is positive OR patient has symptoms of carcinoid syndrome. NETs of GI tract: Patient has 1) distant metastases OR 2) unresectable dx, OR 3) primary site of tumor is gastric, tumor is less than or equal to 2 cm, AND patient has hypersecretion of gastrin. NETs of thymus: Patient has distant metastases OR unresectable dx. NETs of lung: 1) Patient has distant metastases OR 2) Patient has a) NET that is low-grade (typical carcinoid) or intermediate-grade (atypical carcinoid), AND b) Stage IIIB dx that is T4 due to multiple lung nodules or Stage IV dx, AND c) SRS is positive or patient has symptoms of carcinoid syndrome. Pancreatic NETs: 1) For gastrinoma, glucagonoma, and VIPoma, patient's SRS is positive OR patient has hormone-related symptoms, OR 2) For insulinoma, non-functioning pancreatic tumor, somatostatinoma, pancreatic polypeptidoma, cholecystikininoma, ACTH-secreting pancreatic NET, and parathyroid hormone-related protein-secreting pancreatic NET, patient has a) distant metastases or unresectable dx AND b) SRS is positive OR patient has hormone-related symptoms. Adrenal gland NETs: 1) Patient has a diagnosis of non-ACTH dependent Cushing's syndrome, and 2) Cortisol production is symmetric, and 3) Tumors are less than 4 cm, and 4) SRS is positive. Poorly differentiated (high-grade)/large or small cell NETs (excluding lung): 1) Patient has metastatic or unresectable dx, 2) SRS is positive, and 3) Patient has hormone-related symptoms.

Age Restrictions**Prescriber Restrictions****Coverage Duration****Other Criteria**

Plan Year

Acromegaly: Patient has 1) clinical evidence of acromegaly, 2) a high pre-treatment IGF-1 level for age and/or gender, and 3) an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why patient has not had surgery or radiotherapy. For acromegaly continuation of therapy: patient's IGF-1 level has decreased or normalized since initiation of therapy.

Prior Authorization Group

ODOMZO

Drug Names

ODOMZO

Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Pregnancy
Required Medical Information	Member has a diagnosis of locally advanced basal cell carcinoma (BCC). Member experienced disease recurrence following surgery or radiation therapy OR member is not a candidate for surgery or radiation therapy. For females of reproductive potential, pregnancy has been ruled out with a negative pregnancy test result.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	OFEV
Drug Names	OFEV
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Initial Review Only: The patient does not have a known etiology for interstitial lung disease. The patient has completed a high-resolution computed tomography study of the chest which reveals the usual interstitial pneumonia pattern. If the study reveals the possible usual interstitial pneumonia pattern, the diagnosis is supported by surgical lung biopsy. If a surgical lung biopsy has not been previously conducted, the diagnosis is supported by a multidisciplinary discussion between a radiologist and pulmonologist who are experienced in idiopathic pulmonary fibrosis. For initial and continuation: Ofev will not be used in combination with Esbriet.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 6 months, Renewal: Plan Year
Other Criteria	For continuation only: The patient has experienced a reduction in disease progression.
Prior Authorization Group	ONFI
Drug Names	ONFI
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	2 years of age or older.
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	OPSUMIT - PENDING CMS REVIEW
Drug Names	OPSUMIT
Covered Uses	
Exclusion Criteria	
Required Medical Information	

Age Restrictions
Prescriber Restrictions
Coverage Duration
Other Criteria

Prior Authorization Group
Drug Names
Covered Uses
Exclusion Criteria
Required Medical Information

ORAL-INTRANASAL FENTANYL
 FENTANYL CITRATE ORAL TRA, FENTORA
 All FDA-approved indications not otherwise excluded from Part D.
 Significant respiratory depression. Known or suspected paralytic ileus.
 1) The patient has CANCER related pain AND 2) The ICD diagnosis code provided supports the CANCER RELATED diagnosis [Note: For drug coverage approval, ICD diagnosis code provided MUST support the CANCER RELATED diagnosis.] AND 3) The drug is being prescribed for the management of breakthrough pain in a CANCER patient who is currently receiving around-the-clock opioid therapy for underlying CANCER pain AND 4) The patient can safely take the requested dose based on their current opioid use history. [Note: The TIRF (Transmucosal Immediate-Release Fentanyl) products (Abstral, Actiq, Fentora, Lazanda, Onsolis, and Subsys) are indicated for opioid- tolerant patients. Patients considered opioid tolerant are those who are taking at least: 60 mg of oral morphine/day, 25 mcg of transdermal fentanyl/hour, 30 mg oral oxycodone/day, 8 mg oral hydromorphone/day, 25 mg oral oxymorphone/day, or an equianalgesic dose of another opioid for a week or longer.]

Age Restrictions
Prescriber Restrictions
Coverage Duration
Other Criteria

Plan Year

Prior Authorization Group
Drug Names
Covered Uses
Exclusion Criteria
Required Medical Information

ORFADIN - PENDING CMS REVIEW
 ORFADIN

Age Restrictions
Prescriber Restrictions
Coverage Duration
Other Criteria

Prior Authorization Group
Drug Names
Covered Uses
Exclusion Criteria
Required Medical Information
Age Restrictions
Prescriber Restrictions

ORKAMBI
 ORKAMBI
 All FDA-approved indications not otherwise excluded from Part D.
 Use in combination with Kalydeco
 The patient is positive for the F508del mutation on both alleles of the CFTR gene.
 12 years of age or older

Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	PEGASYS - PENDING CMS REVIEW
Drug Names	PEGASYS, PEGASYS PROCLICK
Covered Uses	
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	
Prior Authorization Group	PHENYLBUTYRATE - PENDING CMS REVIEW
Drug Names	BUPHENYL, SODIUM PHENYLBUTYRATE
Covered Uses	
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	
Prior Authorization Group	POMALYST
Drug Names	POMALYST
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, systemic light chain amyloidosis.
Exclusion Criteria	
Required Medical Information	For multiple myeloma: 1) The patient has previously received at least two prior therapies for multiple myeloma, including an immunomodulatory agent (ie, thalidomide, lenalidomide) AND a proteasome inhibitor (ie, bortezomib, carfilzomib), 2) Pomalyst will be used as a single agent or in combination with dexamethasone, and 3) the patient will be monitored for thromboembolism. For systemic light chain amyloidosis: 1) Pomalyst will be used in combination with dexamethasone and 2) the patient will be monitored for thromboembolism.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	PRALUENT
Drug Names	PRALUENT
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Required Medical Information

Member must have one of the following conditions (new starts and continuation): 1) Prior clinical atherosclerotic cardiovascular disease (ASCVD) or cardiovascular event (see Other Criteria), or 2) Heterozygous familial hypercholesterolemia (HeFH): Definite diagnosis of FH (See Other Criteria). For new starts: For members with prior clinical ASCVD or cardiovascular event, at least one of the following requirements is met: 1) Current LDL-C level 70 mg/dL or greater after treatment with a high-intensity statin (eg, atorvastatin, rosuvastatin), 2) Current LDL-C level 70 mg/dL or greater with intolerance to a high-intensity statin AND is taking a maximally tolerated dose of any statin, 3) Current LDL-C level 70 mg/dL or greater with contraindication to statin (see Other Criteria) OR intolerance to any dose of two statins, or 4) Recent treatment (ie, within the last 120 days) with another PCSK9 inhibitor. For members with HeFH, at least one of the following requirements is met: 1) With ASCVD: See requirements for members with prior ASCVD above, 2) Current LDL-C level 100 mg/dL or greater after treatment with a high-intensity statin (eg, atorvastatin, rosuvastatin), 3) Current LDL-C level 100 mg/dL or greater with intolerance to a high-intensity statin AND is taking a maximally tolerated dose of any statin, 4) Current LDL-C level 100 mg/dL or greater with contraindication to statin (see Other Criteria) OR intolerance to any dose of two statins, or 5) Recent treatment (ie, within the last 120 days) with another PCSK9 inhibitor. For continuation: Response to therapy as demonstrated by a reduction in LDL-C. 18 years of age or older

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

Plan Year

Clinical ASCVD or cardiovascular event defined as acute coronary syndromes, myocardial infarction, stable or unstable angina, coronary or other arterial revascularization procedure [eg, PTCA, CABG], stroke of presumed atherosclerotic origin, transient ischemic attack, peripheral arterial disease of presumed atherosclerotic origin, findings from CT angiogram or catheterization consistent with clinical ASCVD). Diagnosis of FH must be confirmed by one of the following: 1) Genetic confirmation: An LDL-receptor mutation, familial defective apo B-100, or a PCSK9 gain-of-function mutation, 2) Simon-Broome Diagnostic Criteria for definite FH: 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), or 3) Dutch Lipid Clinic Network Criteria for definite FH: Total score greater than 8 points. Contraindication to statin must be due to one of the following: 1) Active liver disease, including unexplained persistent elevations in hepatic transaminase levels (eg, ALT level at least 3 times ULN), 2) Women who are pregnant or may become pregnant, or 3) Nursing mothers.

Prior Authorization Group

PRIVIGEN

Drug Names	PRIVIGEN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, chronic inflammatory demyelinating polyneuropathy, multifocal motor neuropathy, dermatomyositis, polymyositis, Guillain-Barre syndrome (GBS), myasthenia gravis, Lambert-Eaton myasthenic syndrome, Kawasaki syndrome, pure red cell aplasia (PRCA), fetal/neonatal alloimmune thrombocytopenia, and prophylaxis of bacterial infections in B-cell chronic lymphocytic leukemia (CLL), bone marrow/hematopoietic stem cell transplant (BMT/HSCT) recipients, and pediatric HIV infection.
Exclusion Criteria	IgA deficiency with antibodies to IgA and a history of hypersensitivity. History of anaphylaxis or severe systemic reaction to human immune globulin or product components. Hyperprolinemia.
Required Medical Information	For CLL: serum IgG less than 500 mg/dL OR a history of recurrent bacterial infections. For BMT/HSCT: IVIG is requested within the first 100 days post-transplant OR serum IgG less than 400 mg/dL. For pediatric HIV infection: 1) Serum IgG less than 400 mg/dL, OR 2) History of recurrent bacterial infections, patient is not able to take combination antiretroviral therapy, and antibiotic prophylaxis was not effective. For dermatomyositis and polymyositis: standard first-line treatments (corticosteroids or immunosuppressants) have been tried but were unsuccessful or not tolerated OR patient is unable to receive standard therapy because of a contraindication or other clinical reason. For GBS: physical mobility must be severely affected such that the patient requires an aid to walk AND IVIG therapy must be initiated within 2 weeks of symptom onset. For myasthenia gravis: IVIG is requested for worsening weakness, acute exacerbation or use in preparation for surgery. PRCA is secondary to parvovirus B19 infection.
Age Restrictions	For pediatric HIV infection: age 12 years or younger
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prior Authorization Group	PROMACTA
Drug Names	PROMACTA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	

Required Medical Information

For chronic or persistent immune thrombocytopenia (ITP): For new starts: a) Patient has had an inadequate response or is intolerant to corticosteroids, immunoglobulins or splenectomy, AND b) Untransfused platelet count at time of diagnosis is less than 30,000/mcL OR 30,000-50,000/mcL with symptomatic bleeding or risk factor(s) for bleeding. For continuation of therapy, platelet (plt) count response to Promacta: a) Current plt count is 50,000-200,000/mcL OR b) Current plt count is less than 50,000/mcL and sufficient to avoid clinically important bleeding OR c) Current plt count is less than 50,000/mcL and patient has not received a maximal dose of Promacta for at least 4 weeks OR d) Current plt count is greater than 200,000/mcL and dosing will be adjusted to a plt count sufficient to avoid clinically important bleeding. For thrombocytopenia associated with chronic hepatitis C: For new starts: a) Promacta is used for initiation and maintenance of interferon-based therapy, AND b) Untransfused platelet count at time of diagnosis is less than 75,000/mcL. For continuation of therapy: patient is receiving interferon-based therapy. For severe aplastic anemia (AA): For new starts: a) Patient has had an inadequate response to immunosuppressive therapy, AND b) Untransfused platelet count at time of diagnosis is less than or equal to 30,000/mcL. For continuation of therapy, plt count response to Promacta: a) Current plt count is 50,000-200,000/mcL OR b) Current plt count is less than 50,000/mcL and patient has not received appropriately titrated therapy for at least 16 weeks OR c) Current plt count is greater than 200,000/mcL and dosing will be adjusted to achieve and maintain an appropriate target plt count. Adequate platelet response = APR. Inadequate platelet response = IRP

Age Restrictions**Prescriber Restrictions****Coverage Duration**

HCV:6mo, ITP/AA initial:6mo, ITP/AA APR reauth: Plan Yr, ITP IPR reauth:3mo, AA IPR reauth:16wks

Other Criteria**Prior Authorization Group****Drug Names****Covered Uses****Exclusion Criteria****Required Medical Information****Age Restrictions****Prescriber Restrictions****Coverage Duration****Other Criteria**

PULMOZYME - PENDING CMS REVIEW
PULMOZYME

Prior Authorization Group**Drug Names**

QUININE SULFATE
QUININE SULFATE

<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D, Babesiosis, uncomplicated Plasmodium vivax malaria
<i>Exclusion Criteria</i>	Prolonged QT interval. Glucose-6-phosphate dehydrogenase (G6PD) deficiency. Myasthenia gravis. Optic neuritis.
<i>Required Medical Information</i>	
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	1 month
<i>Other Criteria</i>	
<i>Prior Authorization Group</i>	RAVICTI - PENDING CMS REVIEW
<i>Drug Names</i>	RAVICTI
<i>Covered Uses</i>	
<i>Exclusion Criteria</i>	
<i>Required Medical Information</i>	
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	
<i>Other Criteria</i>	
<i>Prior Authorization Group</i>	REGRANEX
<i>Drug Names</i>	REGRANEX
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D.
<i>Exclusion Criteria</i>	Neoplasm(s) at site(s) of application.
<i>Required Medical Information</i>	1) For the treatment of lower extremity diabetic ulcers that extend into the subcutaneous tissue or beyond and have an adequate blood supply AND 2) Good ulcer care practices including initial sharp debridement, pressure relief, and infection control will be performed.
<i>Age Restrictions</i>	
<i>Prescriber Restrictions</i>	
<i>Coverage Duration</i>	20 weeks
<i>Other Criteria</i>	
<i>Prior Authorization Group</i>	RELISTOR
<i>Drug Names</i>	RELISTOR
<i>Covered Uses</i>	All FDA-approved indications not otherwise excluded from Part D.
<i>Exclusion Criteria</i>	Known or suspected mechanical gastrointestinal obstruction. At increased risk of recurrent obstruction due to the potential for gastrointestinal perforation.

Required Medical Information

1) Relistor is being prescribed for opioid-induced constipation in an adult patient with advanced illness who is receiving palliative care when response to laxative therapy has not been sufficient OR 2) Relistor is being prescribed for opioid-induced constipation in an adult patient with chronic non-cancer pain AND 3) The patient is unable to tolerate oral medications OR 4) An oral drug indicated for opioid-induced constipation in an adult patient with chronic non-cancer pain has been tried. (Note: Examples are Amitiza or Movantik) AND 5) The patient experienced an inadequate treatment response or intolerance to an oral drug indicated for opioid-induced constipation in an adult patient with chronic non-cancer pain. (Note: Examples are Amitiza or Movantik) OR 6) The patient has a contraindication to an oral drug indicated for opioid-induced constipation in an adult patient with chronic non-cancer pain (Note: Examples are Amitiza or Movantik).

Age Restrictions**Prescriber Restrictions****Coverage Duration**

4 Months

Other Criteria**Prior Authorization Group**

REMICADE

Drug Names

REMICADE

Covered Uses

All FDA-approved indications not otherwise excluded from Part D. Axial spondyloarthritis. Behcet's syndrome. Granulomatosis with polyangiitis (Wegener's granulomatosis). Hidradenitis suppurativa. Juvenile idiopathic arthritis. Pyoderma gangrenosum. Sarcoidosis. Takayasu's arteritis. Uveitis.

Exclusion Criteria**Required Medical Information**

Latent TB screening with either a TB skin test or an interferon gamma release assay (eg, QFT-GIT, T-SPOT.TB) prior to initiating Remicade (or other biologic). For moderately to severely active Crohn's disease (new starts only): 1) Patient has fistulizing disease OR 2) Inadequate response to at least a 3-month trial of self-injectable TNF inhibitor (eg, Cimzia, Humira) OR 3) Intolerance to a self-injectable TNF inhibitor. For moderately to severely active ulcerative colitis (new starts only): 1) Inadequate response to at least one conventional therapy (eg, corticosteroids, sulfasalazine, azathioprine, mesalamine) OR 2) Intolerance or contraindication to conventional therapy. For moderately to severely active rheumatoid arthritis (new starts only): 1) Remicade will be used in combination with methotrexate (MTX) or leflunomide OR patient has intolerance or contraindication to MTX or leflunomide AND 2) Inadequate response to at least a 3-month trial of a self-injectable TNF inhibitor (eg, Cimzia, Humira) or intolerance to a self-injectable TNF inhibitor. For active ankylosing spondylitis and axial spondyloarthritis (new starts only): Inadequate response to at least a 4-week NSAID trial at maximum recommended or tolerated dose OR intolerance and/or contraindication to NSAIDs.

Age Restrictions
Prescriber Restrictions
Coverage Duration
Other Criteria

Plan Year

For active psoriatic arthritis (new starts only): 1) Inadequate response to at least a 3-month trial of MTX, sulfasalazine, or leflunomide OR 2) Intolerance or contraindication to MTX, sulfasalazine, or leflunomide OR 3) Inadequate response to at least a 3-month trial of a self-injectable TNF inhibitor (eg, Humira, Cimzia), OR 4) Intolerance to a self-injectable TNF inhibitor, OR 5) Severely active PsA as evidenced by ANY of the following: a) multiple swollen joints, b) structural damage in the presence of inflammation, c) clinically relevant extra-articular manifestations (eg, extensive skin, bowel, ocular, cardiovascular, urogenital, or pulmonary involvement), OR 6) Active enthesitis and/or dactylitis (ie, sausage finger) OR 7) Predominant axial disease (ie, extensive spinal involvement). For chronic moderate to severe plaque psoriasis (new starts only): 1) At least 5% of BSA is affected or crucial body areas (e.g., feet, hands, face, neck and/or groin) are affected AND 2) Inadequate response to at least a 3-month trial of a self-injectable TNF inhibitor (e.g., Humira) or intolerance to a self-injectable TNF inhibitor. For juvenile idiopathic arthritis (new starts only): 1) Inadequate response to at least a 3-month trial of a self-injectable TNF inhibitor (e.g., Humira) OR 2) Intolerance to a self-injectable TNF inhibitor. For hidradenitis suppurativa (new starts only): patient has severe, refractory disease. For uveitis (new starts only): Patient has experienced an inadequate response or intolerance or has a contraindication to a trial of immunosuppressive therapy for uveitis (e.g., methotrexate, azathioprine, or mycophenolate mofetil).

Prior Authorization Group
Drug Names
Covered Uses
Exclusion Criteria
Required Medical Information

REMODULIN

REMODULIN

All FDA-approved indications not otherwise excluded from Part D.

Patient has had NYHA Functional Class II, III, or IV symptoms. PAH (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.

Age Restrictions
Prescriber Restrictions
Coverage Duration
Other Criteria

Plan Year

Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

Prior Authorization Group
Drug Names

REVLIMID

REVLIMID

Covered Uses

All FDA-approved indications not otherwise excluded from Part D, systemic light chain amyloidosis, classical Hodgkin lymphoma, non-Hodgkin's lymphoma with the following subtypes: chronic lymphocytic leukemia/small lymphocytic lymphoma, AIDS-related diffuse large B-cell lymphoma, primary effusion lymphoma, lymphoma associated with Castleman's disease, diffuse large B-cell lymphoma, follicular lymphoma, nongastric/gastric MALT lymphoma, primary cutaneous B-cell lymphoma, splenic marginal zone lymphoma, multicentric Castleman's disease.

Exclusion Criteria***Required Medical Information***

For all indications: The patient will be monitored for thromboembolism. For multiple myeloma: Revlimid is prescribed for primary, maintenance, or salvage therapy. For primary therapy: 1) The prescribed regimen includes dexamethasone, OR 2) The prescribed regimen is Revlimid, melphalan, and prednisone for a patient who is not a stem cell transplant candidate. For myelodysplastic syndrome (MDS): 1) Patient must have low- to intermediate-1 risk MDS with symptomatic anemia. For multicentric Castleman's disease: 1) The disease has progressed following treatment of relapsed, refractory, or progressive disease AND 2) Revlimid will be used as monotherapy. For all subtypes of NHL except Castleman's disease: 1) The disease is relapsed, refractory, or progressive AND 2) Revlimid will be used as monotherapy or in combination with rituximab. For systemic light chain amyloidosis: Revlimid will be used with either: a) dexamethasone OR b) dexamethasone AND cyclophosphamide.

Age Restrictions***Prescriber Restrictions******Coverage Duration******Other Criteria***

Plan Year

Prior Authorization Group***Drug Names******Covered Uses***

RITUXAN

RITUXAN

All FDA-approved indications not otherwise excluded from Part D, primary CNS lymphoma, leptomeningeal metastases from lymphomas, Hodgkin's lymphoma (lymphocyte-predominant), non-Hodgkin's lymphoma subtypes [marginal zone lymphomas (splenic, MALT), Mantle cell lymphoma, Burkitt lymphoma, AIDS-related B-cell lymphoma, relapsed/refractory hairy cell leukemia, small lymphocytic lymphoma (SLL), post-transplant lymphoproliferative disorder (PTLD), primary cutaneous B-cell lymphoma, lymphoblastic lymphoma, Castleman's disease], acute lymphoblastic leukemia, refractory immune or idiopathic thrombocytopenic purpura (ITP), acquired blood factor VIII deficiency, autoimmune hemolytic anemia, chronic graft-versus-host disease (GVHD), Waldenstrom's macroglobulinemia, lymphoplasmacytic lymphoma, Sjogren syndrome, thrombotic thrombocytopenic purpura, and prevention of Epstein-Barr virus (EBV)-related PTLD.

Exclusion Criteria

Required Medical Information	Prior to initiating therapy, patient has been screened for hepatitis B virus (HBV) infection with Hepatitis B serologic assays. For moderately to severely active rheumatoid arthritis (new starts only): 1) Rituxan is used in combination with methotrexate unless methotrexate is contraindicated or not tolerated and 2) member has an inadequate response, intolerance or contraindication to a self-injectable tumor necrosis factor (TNF) inhibitor. Hematologic malignancies must be CD20-positive. For Burkitt lymphoma and ALL, Rituxan is used as a component of a chemotherapy regimen. For diffuse large B-cell lymphoma (DLBCL), patient meets one of the following conditions: 1) has relapsed or refractory disease and will use Rituxan as a component of a chemotherapy regimen if patient is a candidate for high dose therapy with autologous stem cell rescue, 2) has relapsed or refractory disease and is not a candidate for high dose therapy with autologous stem cell rescue OR 3) does not have relapsed or refractory disease and will use Rituxan as a component of a chemotherapy regimen. For Wegener's Granulomatosis (WG) and Microscopic Polyangiitis (MPA), Rituxan will be used in combination with glucocorticoids.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	SABRIL - PENDING CMS REVIEW
Drug Names	SABRIL
Covered Uses	
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	
Prior Authorization Group	SIGNIFOR
Drug Names	SIGNIFOR
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Patient has had pituitary surgery that was not curative or the patient is not a candidate for surgery. Patient must have controlled blood glucose levels or is receiving optimized antidiabetic therapy. Fasting plasma glucose and/or hemoglobin A1c levels must be obtained at baseline. For continuation of therapy, patient must show a clinically meaningful reduction in 24-hour urinary free cortisol levels and/or improvement in signs or symptoms of the disease.
Age Restrictions	
Prescriber Restrictions	Endocrinologist

Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	SILDENAFIL - PENDING CMS REVIEW
Drug Names	REVATIO, SILDENAFIL
Covered Uses	
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	
Prior Authorization Group	SIRTURO - PENDING CMS REVIEW
Drug Names	SIRTURO
Covered Uses	
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	
Prior Authorization Group	SOMATULINE DEPOT
Drug Names	SOMATULINE DEPOT
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, adrenal gland neuroendocrine tumors (NETs), NETs of the gastrointestinal (GI) tract, thymus, and lung, pancreatic NETs, and poorly differentiated (high-grade)/large or small cell NETs.
Exclusion Criteria	

Required Medical Information

Acromegaly: Patient has 1) clinical evidence of acromegaly, AND 2) a high pre-treatment IGF-1 level for age and/or gender, AND 3) had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy. NETs of the GI tract: Patient has 1) distant metastases, OR 2) unresectable disease, OR 3) primary site of the tumor is gastric, tumor is less than or equal to 2 centimeters, AND the patient has hypersecretion of gastrin. NETs of the thymus: Patient has distant metastases OR unresectable disease. NETs of the lung: Patient has distant metastases OR unresectable disease. Pancreatic NETs: 1) For gastrinoma, glucagonoma, and VIPoma, patient's somatostatin receptor status is positive OR patient has hormone-related symptoms, OR 2) For insulinoma, non-functioning pancreatic tumor, somatostatinoma, pancreatic polypeptidoma, cholecystokininoma, ACTH-secreting pancreatic NET, and parathyroid hormone-related protein-secreting pancreatic NET, patient has a) distant metastases or unresectable disease AND b) somatostatin receptor status is positive OR patient has hormone-related symptoms. Adrenal Gland NETs: 1) Patient has a diagnosis of non-ACTH dependent Cushing's syndrome, AND 2) The cortisol production is symmetric, AND 3) Tumors are less than 4 centimeters, AND 4) Somatostatin receptor status is positive. Poorly differentiated (high-grade)/large or small cell NETs (excluding lung): 1) Patient has metastatic or unresectable disease, AND 2) Somatostatin receptor status is positive, AND 3) Patient has hormone-related symptoms.

Age Restrictions**Prescriber Restrictions****Coverage Duration****Other Criteria**

Plan Year

For acromegaly continuation of therapy: patient's IGF-1 level has decreased or normalized since initiation of therapy.

Prior Authorization Group**Drug Names****Covered Uses****Exclusion Criteria****Required Medical Information**

SOMAVERT

SOMAVERT

All FDA-approved indications not otherwise excluded from Part D.

Patient must meet all of the following: 1) Patient has clinical evidence of acromegaly, AND 2) Patient has a high pre-treatment IGF-1 level for age and/or gender, AND 3) Patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy, AND 4) Patient had an inadequate or partial response to a) octreotide (Sandostatin or Sandostatin LAR), or b) lanreotide (Somatuline Depot), or c) pasireotide (Signifor LAR) OR patient is intolerant or has a contraindication to a) octreotide, or b) lanreotide, or c) pasireotide.

Age Restrictions**Prescriber Restrictions****Coverage Duration**

Plan Year

Other Criteria	For continuation of therapy: patient's IGF-1 level has decreased or normalized since initiation of therapy.
Prior Authorization Group	SOVALDI
Drug Names	SOVALDI
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, chronic hepatitis C genotype 5 or 6 infection.
Exclusion Criteria	
Required Medical Information	Chronic hepatitis C infection confirmed by presence of HCV RNA in serum prior to treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated variants (eg, NS3 Q80K polymorphism) where applicable, liver transplantation status if applicable. For patients with genotype 1, 2, 3, or 4 infection and hepatocellular carcinoma awaiting liver transplantation: must meet MILAN criteria. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Criteria will be applied consistent with current AASLD-IDSA guidance
Other Criteria	For HCV/HIV coinfection, patient meets criteria for requested regimen and will not receive treatment with tipranavir. For patients prescribed a treatment regimen that includes Olysio, no prior treatment failure with an HCV protease inhibitor (eg, telaprevir, simeprevir, boceprevir, paritaprevir) despite adequate dosing and duration of therapy. MILAN criteria defined as: 1) tumor size 5 cm or less in diameter in pts with single hepatocellular carcinoma OR 3 tumor nodules or less, each 3 cm or less in diameter in pts with multiple tumors, and 2) no extrahepatic manifestations of the cancer or evidence of vascular invasion of tumor.
Prior Authorization Group	SPRYCEL
Drug Names	SPRYCEL
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, gastrointestinal stromal tumor (GIST).
Exclusion Criteria	
Required Medical Information	For CML or Ph+ ALL, diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, patient has experienced resistance, intolerance or toxicity to imatinib or an alternative tyrosine kinase inhibitor (e.g., nilotinib). If patient experienced resistance to imatinib or an alternative tyrosine kinase inhibitor for CML, patient is negative for T315I mutation. For GIST, patient must have PDGFRA D842V mutation and disease progression on imatinib, sunitinib, or regorafenib.

Age Restrictions	15 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	STIVARGA
Drug Names	STIVARGA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For unresectable advanced or metastatic colorectal cancer, KRAS/NRAS mutation testing is performed on either the primary tumor or metastases to confirm RAS mutation status. The patient must have been previously treated with fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy, and, if KRAS or NRAS wild type, an anti-EGFR therapy. Stivarga must be used as a single agent. For locally advanced, unresectable or metastatic gastrointestinal stromal tumor (GIST), the patient must have been previously treated with imatinib or sunitinib.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	SUTENT
Drug Names	SUTENT
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, thyroid carcinoma (follicular, papillary, Hurthle cell, or medullary), angiosarcoma, solitary fibrous tumor, hemangiopericytoma, chordoma (bone cancer), lung neuroendocrine tumor, thymic carcinoma.
Exclusion Criteria	
Required Medical Information	For renal cell carcinoma: 1) The disease is relapsed or medically unresectable and 2) Sutent will be used as a single agent. For gastrointestinal stromal tumor: The patient experienced disease progression on imatinib or was intolerant to imatinib. For follicular, papillary, or Hurthle cell thyroid carcinoma: 1) Nexavar is not an appropriate option for the patient, 2) the disease is unresectable or metastatic, 3) the disease is radioiodine-refractory, and 4) the disease is progressive or symptomatic. For medullary thyroid carcinoma: 1) The patient has progressive disease or symptomatic distant metastatic disease and 2) the disease has progressed on vandetanib or cabozantinib OR vandetanib or cabozantinib are not appropriate options for the patient. For thymic carcinoma: 1) Sutent will be used as a single agent and 2) the disease has progressed on a platinum-based chemotherapy regimen.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year

Other Criteria

Prior Authorization Group

Drug Names

Covered Uses

SYLATRON

SYLATRON

All FDA-approved indications not otherwise excluded from Part D, giant cell tumor of the bone.

Exclusion Criteria

Required Medical Information

For giant cell tumor of the bone, patient has unresectable disease OR surgical resection is likely to result in severe morbidity.

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

Plan Year

For melanoma, Sylatron must be requested within 84 days (12 weeks) of the surgical resection.

Prior Authorization Group

Drug Names

Covered Uses

Exclusion Criteria

SYMLIN

SYMLINPEN 120, SYMLINPEN 60

All FDA-approved indications not otherwise excluded from Part D.

Recurrent severe hypoglycemia that required assistance during the past 6 months. Gastroparesis. Patient requires drug therapy to stimulate gastrointestinal motility. Hypoglycemia unawareness (i.e., inability to detect and act upon the signs or symptoms of hypoglycemia). HbA1c level greater than 9 percent.

Required Medical Information

1) The patient is currently receiving optimal mealtime insulin therapy AND 2) The patient has experienced an inadequate treatment response to insulin AND 3) The patient has a diagnosis of type 1 or type 2 diabetes mellitus

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

Plan Year

1) If the patient has been receiving Symlin for at least 3 months, patient demonstrated a reduction in HbA1c since starting Symlin therapy

Prior Authorization Group

Drug Names

Covered Uses

Exclusion Criteria

Required Medical Information

SYNRIBO

SYNRIBO

All FDA-approved indications not otherwise excluded from Part D.

For CML, the patient has experienced resistance, toxicity or intolerance to prior therapy with at least two tyrosine kinase inhibitors (TKIs) (eg, imatinib, dasatinib, nilotinib, bosutinib, ponatinib).

Age Restrictions

Prescriber Restrictions

Coverage Duration

Other Criteria

Plan Year

Prior Authorization Group	TAFINLAR
Drug Names	TAFINLAR
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, CNS metastases, and non-small cell lung cancer.
Exclusion Criteria	
Required Medical Information	For unresectable or metastatic melanoma: 1) Tafenlar will be used in combination with Mekinist for patients with a diagnosis of BRAF V600E or V600K mutation positive disease OR 2) Tafenlar will be used as a single agent for BRAF V600E or V600K mutation positive disease AND clinical deterioration is anticipated in less than or equal to 12 weeks. For CNS metastases: Tafenlar has activity against the primary tumor (melanoma) AND Tafenlar will be used as a single agent. For NSCLC: The tumor is positive for the BRAF V600E mutation
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	TAGRISSE
Drug Names	TAGRISSE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	TARCEVA
Drug Names	TARCEVA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, chordoma, renal cell carcinoma (RCC).
Exclusion Criteria	

Required Medical Information

For locally advanced, recurrent or metastatic non-small cell lung cancer (NSCLC) with positive EGFR mutation (exon 19 deletions or exon 21 L858R substitution mutations), Tarceva is prescribed for use as ANY of the following: 1) First-line therapy as a single agent (EGFR mutation discovered prior to first-line chemotherapy or during first-line chemotherapy), 2) Subsequent therapy as a single agent following disease progression on erlotinib, 3) Subsequent therapy in combination with chemotherapy following disease progression on afatinib or erlotinib, or 4) Subsequent therapy as a single agent following progression on a cytotoxic regimen for metastatic disease in members who have not previously received erlotinib. For metastatic NSCLC with negative or unknown EGFR mutation, Tarceva is prescribed for use as subsequent therapy as a single agent following progression on a cytotoxic regimen in a patient who has not previously received erlotinib. For pancreatic cancer, Tarceva is prescribed in combination with gemcitabine for locally advanced unresectable or metastatic pancreatic cancer. For chordoma, Tarceva is prescribed as a single agent for recurrent disease. For RCC, Tarceva is prescribed as a single agent for relapsed or unresectable stage IV disease with non-clear cell histology.

Age Restrictions**Prescriber Restrictions****Coverage Duration****Other Criteria**

Plan Year

Prior Authorization Group**Drug Names****Covered Uses**

TASIGNA

TASIGNA

All FDA-approved indications not otherwise excluded from Part D, Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), gastrointestinal stromal tumor (GIST).

Exclusion Criteria**Required Medical Information**

For CML or Ph+ ALL, diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, patient has experienced resistance, intolerance or toxicity to imatinib or an alternative tyrosine kinase inhibitor (eg, dasatinib). If patient experienced resistance to imatinib or an alternative tyrosine kinase inhibitor for CML, patient is negative for T315I mutation. For Ph+ ALL, 1) patient has relapsed or refractory Ph+ ALL, OR 2) patient has received hematopoietic stem cell transplant after achieving complete response to induction chemotherapy. If patient relapsed after or is refractory to initial tyrosine kinase inhibitor-containing therapy for ALL, patient is negative for T315I mutation. For GIST, patient must have progressed on imatinib, sunitinib or regorafenib.

Age Restrictions**Prescriber Restrictions****Coverage Duration****Other Criteria**

18 years of age or older

Plan Year

Prior Authorization Group	TAZORAC
Drug Names	TAZORAC
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	1) For patients being treated for plaque psoriasis Tazorac must be applied to less than 20 percent of the patient's body surface area AND 2) For patients being treated for plaque psoriasis a trial of at least one topical corticosteroid (e.g., clobetasol, fluocinonide, mometasone, triamcinolone) (patient may still be using a corticosteroid product in addition to Tazorac) OR 3) patient experienced an adverse event, intolerance, or contraindication to topical corticosteroids.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	For female patients who are able to bear children, the pregnancy status of the patient has been evaluated and the patient made aware of the potential risks of fetal harm and importance of birth control while using Tazorac.
Prior Authorization Group	TECENTRIQ
Drug Names	TECENTRIQ
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	TESTOSTERONE CYPIONATE INJ
Drug Names	TESTOSTERONE CYPIONATE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, Gender Identity Disorder in Female-to-Male transgender
Exclusion Criteria	

Required Medical Information

1) Drug is being prescribed for a male patient with congenital or acquired primary hypogonadism (i.e., testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, or orchidectomy) who had or currently has at least two confirmed low testosterone levels according to current practice guidelines or your standard lab reference values OR 2) Drug is being prescribed for a male patient with congenital or acquired hypogonadotropic hypogonadism (i.e., gonadotropin or luteinizing hormone-releasing hormone [LHRH] deficiency, or pituitary-hypothalamic injury from tumors, trauma, or radiation) who had or currently has at least two confirmed low testosterone levels according to current practice guidelines or your standard lab reference values OR 3) Drug is being prescribed for female-to-male gender reassignment in a patient who is 14 years of age or older and able to make an informed, mature decision to engage in therapy
14 years of age or older (female-to-male gender reassignment)

Age Restrictions**Prescriber Restrictions****Coverage Duration****Other Criteria**

Plan Year

Prior Authorization Group**Drug Names****Covered Uses****Exclusion Criteria****Required Medical Information**

TESTOSTERONE ENANTHATE INJ

TESTOSTERONE ENANTHATE

All FDA-approved indications not otherwise excluded from Part D.

1) Drug is being prescribed for inoperable metastatic breast cancer in a female patient who is 1 to 5 years postmenopausal and who has had an incomplete response to other therapy for metastatic breast cancer OR 2) Drug is being prescribed for a pre-menopausal female patient with breast cancer who has benefited from oophorectomy and is considered to have a hormone-responsive tumor OR 3) Drug is being prescribed for a male patient with congenital or acquired primary hypogonadism (i.e., testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, or orchidectomy) who had or currently has at least two confirmed low testosterone levels according to current practice guidelines or your standard lab reference values OR 4) Drug is being prescribed for a male patient with congenital or acquired hypogonadotropic hypogonadism (i.e., gonadotropin or luteinizing hormone-releasing hormone [LHRH] deficiency, or pituitary-hypothalamic injury from tumors, trauma, or radiation) who had or currently has at least two confirmed low testosterone levels according to current practice guidelines or your standard lab reference values OR 5) Drug is being prescribed for delayed puberty in a male patient.

Age Restrictions**Prescriber Restrictions****Coverage Duration****Other Criteria**

Plan Year

Prior Authorization Group	TETRABENAZINE
Drug Names	TETRABENAZINE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, chronic tics associated with Tourette's syndrome, tardive dyskinesia, hemiballismus, chorea not associated with Huntington's disease.
Exclusion Criteria	Active suicide ideation. Untreated or inadequately treated depression.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	THALOMID
Drug Names	THALOMID
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, systemic light chain amyloidosis, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, recurrent aphthous stomatitis, recurrent HIV-associated aphthous ulcers, cachexia, HIV-associated diarrhea, Kaposi's sarcoma, Behcet's syndrome, chronic graft-versus-host disease, Crohn's disease, myelofibrosis with myeloid metaplasia, multicentric Castleman's disease.
Exclusion Criteria	
Required Medical Information	For all indications: The patient will be monitored for thromboembolism. For cachexia: Cachexia must be due to cancer or HIV-infection. For Kaposi's sarcoma: The patient has HIV infection.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	TOBRAMYCIN
Drug Names	TOBRAMYCIN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, non-cystic fibrosis bronchiectasis.
Exclusion Criteria	
Required Medical Information	The patient has a diagnosis of cystic fibrosis that is confirmed by appropriate diagnostic or genetic testing OR the patient has a diagnosis of non-cystic fibrosis bronchiectasis. Pseudomonas aeruginosa is present in the patient's airway cultures OR the patient has a history of pseudomonas aeruginosa infection or colonization in the airways.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year

Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual
Prior Authorization Group	TOPICAL LIDOCAINE
Drug Names	LIDOCAINE, LIDOCAINE HCL, LIDOCAINE HCL JELLY, LIDOCAINE/PRILOCAINE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Months
Other Criteria	1) The prescribed quantity falls within the manufacturer's published dosing guidelines. 2) If being used as part of a compounded product, all active ingredients in the compounded product are FDA approved for topical use. 3) Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prior Authorization Group	TOPICAL TESTOSTERONES
Drug Names	ANDRODERM, AXIRON
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	1) Drug is being prescribed for a male patient with congenital or acquired primary hypogonadism (i.e., testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, or orchidectomy) who had or currently has at least two confirmed low testosterone levels according to current practice guidelines or your standard lab reference values OR 2) Drug is being prescribed for a male patient with congenital or acquired hypogonadotropic hypogonadism (i.e., gonadotropin or luteinizing hormone-releasing hormone [LHRH] deficiency, or pituitary-hypothalamic injury from tumors, trauma, or radiation) who had or currently has at least two confirmed low testosterone levels according to current practice guidelines or your standard lab reference values
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	TOPICAL TRETINOIN
Drug Names	AVITA, TRETINOIN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	

Prescriber Restrictions
Coverage Duration
Other Criteria

Plan Year

Prior Authorization Group
Drug Names
Covered Uses

TRELSTAR

TRELSTAR MIXJECT

All FDA-approved indications not otherwise excluded from Part D, adjuvant therapy for prostate cancer, initial ADT for prostate cancer, progressive, metastatic, and recurrent prostate cancer.

Exclusion Criteria
Required Medical Information

If the patient has regional disease as initial ADT, metastatic disease as initial ADT, progressive castration-naïve disease, or recurrent disease as defined as a biochemical failure after previous therapy, then no further information is required. If the patient has lymph node-positive disease found during pelvic lymph node dissection (PLND), then Trelstar must be used without external beam radiation therapy (EBRT) as adjuvant therapy. If the patient has none of the abovementioned criteria and has intermediate risk stratification, then Trelstar must be used with EBRT as initial ADT. If the patient has none of the abovementioned criteria and has high or very high risk stratification, then Trelstar must be used with EBRT or EBRT and docetaxel as initial ADT. If the patient has none of the abovementioned criteria and has very high risk stratification and is not a candidate for definitive therapy, Trelstar may be used without EBRT as initial ADT.

Age Restrictions
Prescriber Restrictions
Coverage Duration
Other Criteria

For immediate risk stratification: 6 months. Others: Plan Year.

Use as neoadjuvant therapy prior to radical prostatectomy is not approvable.

Prior Authorization Group
Drug Names
Covered Uses

TYKERB

TYKERB

All FDA-approved indications not otherwise excluded from Part D, metastatic CNS lesions.

Exclusion Criteria
Required Medical Information

For advanced, recurrent, or metastatic HER2-positive breast cancer, Tykerb will be used in combination with: 1) aromatase inhibitor (e.g., anastrozole, letrozole, exemestane) for a postmenopausal woman with hormone receptor-positive disease, or 2) capecitabine or trastuzumab (without cytotoxic therapy) for a patient who has received prior trastuzumab-containing regimen. For metastatic CNS lesions, 1) member has recurrent HER2-positive breast cancer, 2) Tykerb is active against the primary tumor (breast), and 3) Tykerb will be used in combination with capecitabine in a patient with recurrent HER2-positive breast cancer.

Age Restrictions
Prescriber Restrictions

Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	TYSABRI
Drug Names	TYSABRI
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Use as monotherapy. For Crohn's disease (CD), patient must have an inadequate response, intolerance or contraindication to one conventional CD therapy (eg, corticosteroid, azathioprine, mesalamine) and one TNF-inhibitor (eg, Humira, Cimzia).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	UPTRAVI - PENDING CMS REVIEW
Drug Names	UPTRAVI
Covered Uses	
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	
Prior Authorization Group	VALCHLOR
Drug Names	VALCHLOR
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, adult T-cell leukemia/lymphoma, primary cutaneous marginal zone lymphoma, primary cutaneous follicle center lymphoma, lymphomatoid papulosis.
Exclusion Criteria	
Required Medical Information	Lymphomatoid papulosis: Valchlor will be used as a single agent
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Prior Authorization Group	VELCADE
Drug Names	VELCADE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, systemic light chain amyloidosis, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, multicentric Castleman's disease.
Exclusion Criteria	

Required Medical Information	For multiple myeloma: Velcade is prescribed for primary, maintenance, or salvage therapy. For primary therapy: 1) the prescribed regimen includes dexamethasone, OR 2) the prescribed regimen is Velcade, melphalan, and prednisone for a patient who is not a stem cell transplant candidate. For multicentric Castleman's disease: 1) The disease has progressed following treatment of relapsed, refractory, or progressive disease, and 2) Velcade will be prescribed as monotherapy or in combination with rituximab.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prior Authorization Group	VENCLEXTA
Drug Names	VENCLEXTA, VENCLEXTA STARTING PACK
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	VENTAVIS
Drug Names	VENTAVIS
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Patient has had NYHA Functional Class III or IV symptoms. PAH (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.
Prior Authorization Group	VERSACLOZ
Drug Names	VERSACLOZ
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria	History of clozapine-induced agranulocytosis or severe granulocytopenia. Dementia-related psychosis.
Required Medical Information	The patient is unwilling or unable to take tablets or capsules orally or is at high risk for non-compliance.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	VOLTAREN GEL
Drug Names	DICLOFENAC SODIUM
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Use during the peri-operative period in the setting of coronary artery bypass graft (CABG) surgery. Experienced asthma, urticaria, or other allergic-type reactions after taking aspirin or other NSAIDS.
Required Medical Information	The patient is unable to tolerate or not a suitable candidate for oral NSAID therapy (e.g., bleeding ulcer, etc.).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	VOTRIENT
Drug Names	VOTRIENT
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, dermatofibrosarcoma protuberans, thyroid carcinoma (follicular, papillary, Hurthle cell, or medullary), uterine sarcoma.
Exclusion Criteria	

Required Medical Information

For renal cell carcinoma: 1) The disease is relapsed or medically unresectable and 2) Votrient will be used as a single agent. For soft tissue sarcoma (STS): 1) The patient does not have an adipocytic soft tissue sarcoma and 2) the patient has one of the following subtypes of STS: a) gastrointestinal stromal tumor (GIST), b) angiosarcoma, c) pleomorphic rhabdomyosarcoma, d) retroperitoneal/intra-abdominal sarcoma, or e) extremity/superficial trunk sarcoma. For GIST, the disease has progressed on treatment with imatinib, sunitinib, or regorafenib. For angiosarcoma or pleomorphic rhabdomyosarcoma, Votrient will be used as a single agent. For retroperitoneal/intra-abdominal sarcoma or extremity/superficial trunk sarcoma, Votrient will be used as a single agent for progressive, unresectable, or metastatic disease. For uterine sarcoma: 1) Votrient will be used as a single agent and 2) for stage I disease, the disease is medically inoperable. For follicular, papillary, or Hurthle cell thyroid carcinoma: 1) Nexavar is not an appropriate option for the patient, 2) the disease is unresectable or metastatic, 3) the disease is radioiodine-refractory, and 4) the disease is progressive or symptomatic. For medullary thyroid carcinoma: 1) The patient has progressive disease or symptomatic distant metastatic disease and 2) the disease has progressed on vandetanib or cabozantinib OR vandetanib or cabozantinib are not appropriate options for the patient. For dermatofibrosarcoma protuberans: 1) The disease is metastatic and 2) Votrient will be used as a single agent.

Age Restrictions**Prescriber Restrictions****Coverage Duration****Other Criteria**

Plan Year

Prior Authorization Group**Drug Names****Covered Uses**

XALKORI

XALKORI

All FDA-approved indications not otherwise excluded from Part D, non-small cell lung cancer (NSCLC) with MET amplification, inflammatory myofibroblastic tumors (IMT).

Exclusion Criteria**Required Medical Information**

For NSCLC, patient meets all of the following: 1) Tumor is ALK-positive, ROS1-positive, or demonstrates MET amplification, and 2) Patient has recurrent or metastatic disease, and 3) Xalkori is being used as a single agent. For IMT, the tumor is ALK-positive and Xalkori is being used as a single agent.

Age Restrictions**Prescriber Restrictions****Coverage Duration****Other Criteria**

Plan Year

Prior Authorization Group**Drug Names****Covered Uses**

XELJANZ

XELJANZ, XELJANZ XR

All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria	Combination therapy with a potent immunosuppressant such as azathioprine or cyclosporine
Required Medical Information	Latent TB screening with either a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB) prior to initiating Xeljanz, Xeljanz XR or previous biologic DMARD. For moderately to severely active rheumatoid arthritis (new starts only), patient must meet both of the following requirements: 1) Patient has an inadequate response to at least a 3-month trial of methotrexate (MTX) despite adequate dosing (i.e., titrated to 25 mg/week) or intolerance or contraindication to MTX, AND 2) Patient has experienced an inadequate response to at least a 3-month trial of any biologic DMARD (e.g., TNF-alpha inhibitor, Actemra, Kineret, Orencia, or Rituxan) or meets at least one of the following requirements: a) Patient has an intolerance or contraindication to any biologic DMARD, b) Patient has a history of a demyelinating disorder, congestive heart failure, chronic hepatitis B, or autoantibody formation/lupus-like syndrome.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	XGEVA - PENDING CMS REVIEW
Drug Names	XGEVA
Covered Uses	
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	
Prior Authorization Group	XIFAXAN
Drug Names	XIFAXAN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Reduction in risk of overt HE recurrence-6 Months, IBS-D-Plan Year
Other Criteria	
Prior Authorization Group	XOLAIR - PENDING CMS REVIEW
Drug Names	XOLAIR
Covered Uses	
Exclusion Criteria	

Required Medical Information**Age Restrictions****Prescriber Restrictions****Coverage Duration****Other Criteria****Prior Authorization Group****Drug Names****Covered Uses****Exclusion Criteria****Required Medical Information**

XTANDI

XTANDI

All FDA-approved indications not otherwise excluded from Part D.

For metastatic, castration-resistant disease, the patient has been previously treated with Zytiga unless the patient has a contraindication to Zytiga therapy. For non-castration-resistant disease, Xtandi will be used in combination with androgen deprivation therapy to: 1) enhance the effectiveness of radiation therapy, OR 2) supplement androgen deprivation therapy if the patient experienced inadequate testosterone suppression, OR 3) prevent androgen flare in androgen deprivation therapy naive patients who are at risk of developing symptoms.

Age Restrictions**Prescriber Restrictions****Coverage Duration****Other Criteria**

Plan Year

Prior Authorization Group**Drug Names****Covered Uses****Exclusion Criteria****Required Medical Information****Age Restrictions****Prescriber Restrictions****Coverage Duration****Other Criteria**

XYREM - PENDING CMS REVIEW

XYREM

Prior Authorization Group**Drug Names****Covered Uses****Exclusion Criteria**

YERVOY

YERVOY

All FDA-approved indications not otherwise excluded from Part D, CNS metastases from primary tumor (melanoma).

Required Medical Information	For unresectable or metastatic melanoma, Yervoy will be used as a single agent or in combination with nivolumab (Opdivo). For the adjuvant treatment of melanoma, member must meet all of the following: 1) Yervoy will be used as adjuvant therapy following complete resection, including total lymphadenectomy, AND 2) the disease has pathologic involvement of regional lymph nodes of more than 1 millimeter. For CNS metastases from primary tumor (melanoma), member must meet all of the following: 1) Yervoy was active against the primary tumor (melanoma), 2) the disease is recurrent, and 3) Yervoy will be used as a single agent.
-------------------------------------	--

Age Restrictions
Prescriber Restrictions
Coverage Duration
Other Criteria

Plan Year

Prior Authorization Group
Drug Names
Covered Uses
Exclusion Criteria
Required Medical Information

ZAVESCA
ZAVESCA
All FDA-approved indications not otherwise excluded from Part D.

Age Restrictions
Prescriber Restrictions
Coverage Duration
Other Criteria

Diagnosis of Type 1 Gaucher disease was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by DNA testing. Enzyme replacement therapy is not a therapeutic option (e.g., due to constraints such as allergy, hypersensitivity, or poor venous access).
18 years of age and older.

Prior Authorization Group
Drug Names
Covered Uses

ZELBORAF
ZELBORAF
All FDA-approved uses not otherwise excluded from Part D, melanoma with BRAF V600K mutation, CNS metastases from primary tumor (melanoma), NSCLC with BRAF V600E mutation, and hairy cell leukemia.

Exclusion Criteria
Required Medical Information

For unresectable or metastatic melanoma: The tumor is positive for either BRAF V600E or V600K mutation AND clinical deterioration is anticipated in less than or equal to 12 weeks. For CNS metastases: Zelboraf has activity against the primary tumor (melanoma) AND Zelboraf will be used as a single agent. For NSCLC: The tumor is positive for the BRAF V600E mutation. For refractory hairy cell leukemia: Zelboraf will be used as a single agent.

Age Restrictions
Prescriber Restrictions
Coverage Duration
Other Criteria

Plan Year

Prior Authorization Group	ZOLINZA
Drug Names	ZOLINZA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, mycosis fungoides, Sezary syndrome, multiple myeloma.
Exclusion Criteria	
Required Medical Information	For multiple myeloma: Zolinza will be used as salvage therapy in combination with bortezomib (Velcade).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	ZYDELIG
Drug Names	ZYDELIG
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, relapsed or refractory chronic lymphocytic leukemia (CLL) as a single agent, relapsed or refractory small lymphocytic lymphoma as a single agent or in combination with rituximab, refractory or progressive follicular lymphoma, primary cutaneous B-cell lymphoma [primary cutaneous marginal zone lymphoma and follicle center lymphoma], and marginal zone lymphomas [gastric mucosa associated lymphoid tissue (MALT) lymphoma, non-gastric MALT lymphoma, and splenic marginal zone lymphoma].
Exclusion Criteria	History of serious allergic reactions including anaphylaxis or toxic epidermal necrolysis.
Required Medical Information	For relapsed or refractory CLL, Zydelig is used as a single agent or in combination with rituximab. For relapsed or refractory SLL, Zydelig is used as a single agent or in combination with rituximab and the patient has received at least two prior systemic therapies. For relapsed, refractory, or progressive follicular B-cell non-Hodgkin lymphoma, Zydelig is used as a single agent and the patient has received at least two prior systemic therapies. For gastric mucosa associated lymphoid tissue (MALT) lymphoma, the disease is recurrent or progressive. For non-gastric MALT and Splenic marginal zone lymphomas, the disease is refractory or progressive.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	ZYKADIA
Drug Names	ZYKADIA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, anaplastic lymphoma kinase (ALK)-positive inflammatory myofibroblastic tumor.
Exclusion Criteria	

Required Medical Information	For NSCLC, patient meets all of the following: 1) Tumor is ALK-positive, and 2) Disease is recurrent or metastatic, and 3) Patient has progressed on or is intolerant to crizotinib. For ALK-positive inflammatory myofibroblastic tumor: Zykadia is prescribed as a single agent.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Prior Authorization Group	ZYPREXA RELPREVV - PENDING CMS REVIEW
Drug Names	ZYPREXA RELPREVV
Covered Uses	
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	
Prior Authorization Group	ZYTIGA
Drug Names	ZYTIGA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Patient has metastatic prostate cancer. Patient's disease is castration-resistant. Zytiga will be used in combination with prednisone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	