2020

Prior Authorization Criteria

For

Flagler Health+

Employee Health Plans

abiraterone (Zytiga)

Products Affected

- Abiraterone Acetate

PA Criteria	Criteria Details
Covered Uses	FDA approved indications
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	Abieraterone is indicated to treat metastatic prostate cancer. It is taken orally along with prednisone daily. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

adalimumab (Humira)

Products Affected

- **Humira Pediatric Crohns Start Subcutaneous Prefilled Syringe Kit 40 MG/0.8ML, 80 MG/0.8ML, 80 MG/0.8ML & 40MG/0.4ML**
- **Humira Pen Subcutaneous Pen-Injector Kit**
- **Humira Pen-CD/UC/HS Starter**
- **Humira Pen-Ps/UV/Adol HS Start**
- **Humira Subcutaneous Prefilled Syringe Kit**

PA Criteria	Criteria Details
Covered Uses	Dosing for indication is the FDA approved dose, off label dosing for an indication is not covered. In Commercial and ACA plans- Patient must fail Enbrel, Simponi, Kevzara, Xeljanz, and Renflexis in areas of overlapping indication (RA, PSA,PP, UC,AS), for IBD Disease must fail Renflexis, Entyvio, Simponi/Simponi ARIA, Azathioprine, and 6 Mercaptopurine,xeljanz. For hidradenitis suppurativa must have moderate to severe disease and have failed recent trial 8 to 12 week trial in past month of oral clindamycin and rifampin or doxycycline/Minocycline AND failure of oral retinoid (acitretin or isotretinoin) in the past 6 months. For Uveitis patient must fail 8-12 week trial of methotrexate
Exclusion Criteria	Off label dosing for an indication is not covered.
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Must be written by Rheumatology, Dermatology or Specialist trained in management of prescribed condition.
Coverage Duration	Up to 12 months

PA Criteria	Criteria Details
Other Criteria	Humira is indicated for the treatment of confirmed rheumatoid arthritis (RA), plaque psoriasis (PP), Psoriatic Arthritis (PSA) Crohns disease (CD), ulcerative colitis (UC) Humira, Hydradenitis suppurativa, uveitis. This is non-preferred for ACA and Exchange. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

afatinib (Gilotrif)

Products Affected

- **Gilotrif**

PA Criteria	Criteria Details
Covered Uses	Patient must have NSCLC mutations consistent with FDA label. Test for T790M mutation if previously on a TKI inhibitor
Exclusion Criteria	
Required Medical Information	Medical notes, previous treatment history and associated studies, including test for T790M mutation if previously on a TKI inhibitor
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Prescribing restricted to oncology.
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	Gilotrif is an oral tyrosine kinase inhibitor indicated to treat NCSLC with the genetic tumor markers of exon 19 deletion and exon 21 substitution. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

alectinib (Alecensa)

Products Affected

- **Alecensa**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications, off label use will be covered when there is an NCCN supported indication with a recommendation of class 2A or greater
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Prescriber must be an oncologist
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	Alecensa is indicated to treat patients with ALK+ metastatic Non-Small cell lung cancer. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician

alitretinoin (Panretin)

Products Affected

- **Panretin**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Failure of vinblastine.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Panretin is a retinoid indicated for Karposi sarcoma. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

alosetron (Lotronex)

Products Affected

- Alosetron HCl

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Recent failure of all conventional therapies (past 6 months) .
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Prescribing limited to gastroenterology and registration with monitoring program for Lotronex
Coverage Duration	12 months
Other Criteria	Lotronex is indicated for refractory IBS with severe diarrhea. Medical history and studies are reviewed in Referrals and if approved will notify the physician.

ambrisentan (Letairis)

Products Affected

- Ambrisentan

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Pulmonary hypertension must be diagnosed by heart catheterization. Patient must have failed or have contraindication to sildenafil. Evaluation, EKG, diffusion studies, catheterization results and an objective test of exercise ability (6 minute walk) must be submitted with referral. Approved referrals will initially provide coverage for 12 weeks. Continuation of coverage will be determined by an improvement of an objective test of exercise (6 minute walk) from baseline. Follow-up documentation must be submitted for continuation of coverage. Patients who have had an initial positive response based the 12 week follow-up will be approved for an additional 6 months, and re-evaluation with documentation will be required every 6 months for continuation of coverage.
Exclusion Criteria	This medication is contraindicated in pregnancy, those of childbearing ability who are not using contraception.
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	Initial approval for 12 weeks. See "Covered Use" for continuation of coverage details.

PA Criteria	Criteria Details
Other Criteria	Letairis is an endothelin receptor antagonist used to treat WHO group 1 pulmonary arterial hypertension. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

anakinra (Kineret)

Products Affected

- **Kineret Subcutaneous Solution Prefilled Syringe**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Patient must fail two anti-TNF biologics and Xeljanz.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	Up to 12 months
Other Criteria	Kineret is a biologic agent indicated for treatment of rheumatoid arthritis. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

aprepitant (Emend)

Products Affected

- Aprepitant
- **Emend Oral Suspension Reconstituted**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Patient must have failed Zofran. A pre-packaged three-day course of this medication will be approved per each co-pay incidental to a chemotherapy treatment cycle.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Medication will be approved through referrals when written by Oncology
Coverage Duration	12 months
Other Criteria	Emend is used as part of a three day regimen for chemotherapy induced nausea and vomiting (CINV) of moderate to highly emetogenic Chemotherapy treatments, and Post-Operative Nausea and Vomiting. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

aripiprazole (Abilify)

Products Affected

- **Abilify Maintena Intramuscular Prefilled Syringe**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Failure of oral aripiprazole.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Approved when written/ordered by a Psychiatrist or Neurologist through referrals for new starts.
Coverage Duration	12 months
Other Criteria	Aripiprazole is a psychotropic medication. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy.

asenapine (Saphris)

Products Affected

- **Saphris**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications, AND Approved when written/ordered by a Psychiatrist or Neurologist, AND failure of both quetiapine and aripiprazole.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Psychiatrist or Neurologist
Coverage Duration	12 months
Other Criteria	Saphris is indicated for treatment of Bipolar Disorder or Schizophrenia. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

axitinib (Inlyta)

Products Affected

- **Inlyta**

PA Criteria	Criteria Details
Covered Uses	Inlyta is an oral tyrosine kinase inhibitor indicated for advanced renal cell carcinoma.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Prescribing restricted to oncology.
Coverage Duration	12 months
Other Criteria	Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Benefix

Products Affected

- **BeneFIX Intravenous Kit**

PA Criteria	Criteria Details
Covered Uses	Approval will be based on Diagnosis of Hemophilia B and history of Bleeding or joint effusions OR perioperative prophylaxis
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

bosentan (Tracleer)

Products Affected

- Bosentan

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Pulmonary hypertension must be diagnosed by heart catheterization. Patient must have failed or have contraindication to sildenafil, ambrisentan, and tadalafil. Evaluation, EKG, diffusion studies, catheterization results and an objective test of exercise ability (6 minute walk) must be submitted with referral. Approved referrals will initially provide coverage for 12 weeks. Continuation of coverage will be determined by an improvement of an objective test of exercise (6 minute walk) from baseline. Follow-up documentation must be submitted for continuation of coverage. Patients who have had an initial positive response based the 12 week follow-up will be approved for an additional 6 months, and re-evaluation with documentation will be required every 6 months for continuation of coverage.
Exclusion Criteria	This medication is contraindicated in pregnancy, those of childbearing ability who are not using contraception, those on glyburide or cyclosporine and in those with active liver disease.
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	Initial approval for 12 weeks. See "Covered Use" for continuation of coverage details.

PA Criteria	Criteria Details
Other Criteria	Tracleer is indicated for the treatment of Primary pulmonary arterial hypertension or pulmonary hypertension related to connective tissue disease. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

bosutinib (Bosulif)

Products Affected

- **Bosulif**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications, off label use will be covered when there is an NCCN supported indication with a recommendation of class 2A or greater. AND Failure of imatinib.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Restricted to hematology/oncology
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	Bosolif is indicated for treatment of Ph+ CML after failure of a first line tyrosine kinase inhibitor. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy.

budesonide inhalant product (Pulmicort)

Products Affected

- Budesonide Inhalation

PA Criteria	Criteria Details
Covered Uses	FDA approved indications.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Approved when written for patients 8 years of age and younger through pharmacy.
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	This medication is a respiratory steroid indicated for treatment of asthma in pediatric patients 8 years of age and younger. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

budesonide oral product (Entocort)

Products Affected

- Budesonide Oral

PA Criteria	Criteria Details
Covered Uses	Entocort is an oral steroid capsule that has low bioavailability. Entocort is indicated for mild to moderately active Crohns disease involving the ileum and/or the ascending colon and the maintenance of clinical remission in mild-to moderate Crohns disease involving the ileum and/or the ascending colon for up to 3 months.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Written by a gastroenterologist.
Coverage Duration	Approved referrals will be for a maximum of 6 months.
Other Criteria	Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

C1 esterase inhibitor (Berinert)

Products Affected

- **Berinert**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Must not be taking medications that can exacerbate the frequency and/or severity of hereditary angioedema(HAE) attacks including estrogens and ACE inhibitors.
Required Medical Information	Must have C1INH deficiency demonstrated by labs (C1INH and C4 labs)
Age Restrictions	
Prescriber Restrictions	Must be prescribed by an immunologist, allergist or hematologist
Coverage Duration	12 months
Other Criteria	BERINERT is a plasma-derived C1 Esterase Inhibitor (Human) indicated for the treatmentof acute abdominal, facial, or laryngeal hereditary angioedema (HAE) attacks in adultand pediatric patients. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

cabozantinib (Cometriq)

Products Affected

- **Cometriq (100 mg Daily Dose) Oral Kit 1 X 80 & 1 X 20 MG**
- **Cometriq (140 mg Daily Dose) Oral Kit 1 X 80 & 3 X 20 MG**
- **Cometriq (60 mg Daily Dose)**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications.
Exclusion Criteria	Combination use with other tyrosine kinase inhibitors is excluded.
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Prescriber must be a Hematologist/Oncologist.
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	Cometriq is indicated for treatment of metastatic medullary thyroid cancer Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

ceritinib (Zykadia)

Products Affected

- **Zykadia Oral Capsule**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Must have progressed on Xalkori.
Exclusion Criteria	Not covered in combination with other tyrosine kinase inhibitors or EGRf inhibitors.
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Must be written by oncologist.
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	Zykadia is a TKI inhibitor indicated for metastatic NSCLC which is ALK (anaplastic lymphoma kinase) positive, it is indicated for patients who have failed/progressed on crizotinib (Xalkori) Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

cinacalcet hydrochloride (Sensipar)

Products Affected

- Cinacalcet HCl

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Patient is identified as having hypercalcemia associated with parathyroid carcinoma OR Patient is identified as having hyperparathyroidism secondary ESRD in patient with elevated PTH. Patient must have failed phosphate binders and active Vitamin-D therapy, iPTH must be >300 in dialysis patients. This information is sent to the Referrals Department.
Exclusion Criteria	Not for use in children, pregnancy, seizure disorder.
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	This medication must be prescribed by Nephrology or Endocrinology or Oncology
Coverage Duration	12 months
Other Criteria	Sensipar is indicated to treat hyperparathyroidism that is secondary to renal insufficiency or hypercalcemia secondary to parathyroid carcinoma. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

clobazam (Onfi)

Products Affected

- Clobazam

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Failure of levetiracetam, topiramate ,and clonazepam.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Approved when written/ordered by a Neurologist through referrals for new starts.
Coverage Duration	12 Months
Other Criteria	Onfi is a benzodiazepine indicated to treat seizures. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

cobimetinib (Cotellic)

Products Affected

- **Cotellic**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications, off label use will be covered when there is an NCCN supported indication with a recommendation of class 2A or greater. Must be prescribed by Oncologist. Must be used in combination with Zelboraf.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Must be prescribed by Oncologist.
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	Cotellic is indicated for treatment of BRAF+ metastatic or unresectable melanoma. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

colesevelam (Welchol)

Products Affected

- Colesevelam HCl Oral Tablet

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. For diabetes must fail metformin and a DPP IV inhibitor. For Hyperlipidemia must fail cholestyramine.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Welchol is a bile acid sequestrant indicated to treat hyperlipidemia or diabetes mellitus type-2. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

crizotinib (Xalkori)

Products Affected

- **Xalkori**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications.
Exclusion Criteria	Not covered in combination with other tyrosine kinase inhibitors or EGRF inhibitors.
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Must be written by oncologist.
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	Xalkori is a TKI inhibitor for metastatic NSCLC which is ALK (anaplastic lymphoma kinase) positive, or ROS positive. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

dabrafenib (Tafinlar)

Products Affected

- **Tafinlar**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications, off label use will be covered when there is an NCCN supported indication with a recommendation of class 2A or greater. Patient must have BRAF V600E/K mutation
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Must be written by an oncologist.
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	Tafinlar is a BRAF inhibitor indicated to treat BRAF+ V600e/k mutation Stage IIIc-IV metastatic Melanoma Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

dalfampridine (Ampyra)

Products Affected

- Dalfampridine ER

PA Criteria	Criteria Details
Covered Uses	Diagnosis of multiple sclerosis AND patient is ambulatory (able to walk at least 25 feet) AND patient has walking impairment. For renewal, walking speed has improved from baseline (based on 25 foot timed walk).AND currently using a disease modifying agent.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	Initial - 3 months. Renewal - 12 months.
Other Criteria	Ampyra is indicated to treat patients with multiple sclerosis who have walking disability. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

dasatinib (Sprycel)

Products Affected

- **Sprycel**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications AND failure of imatinib.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	Sprycel is an oral antineoplastic agent used to treat Philadelphia Chromosome + CML and PH+ ALL. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

deferasirox (Exjade)

Products Affected

- Deferasirox Oral Tablet Soluble

PA Criteria	Criteria Details
Covered Uses	FDA approved indications Patient has failed or is intolerant to Deferoxamine.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Exjade is an oral medication used to treat iron overload typically in patients receiving chronic RBC transfusions. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

degarelix (Firmagon)

Products Affected

- **Firmagon**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Limited to two per month.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Written by oncology or urology
Coverage Duration	12 months
Other Criteria	Firmagon is indicated to treat advanced prostate cancer. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

denosumab (Prolia)

Products Affected

- **Prolia Subcutaneous Solution Prefilled Syringe**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications Intolerance or contraindication to injectable bisphosphonate required for coverage of Prolia.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Prolia is a RANK-L ligand antagonist indicated for treatment of osteoporosis and prevention of osteoporosis for patients taking aromatase inhibitors. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

dextromethorphan / quinidine (Nuedexta)

Products Affected

- **Nuedexta**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications.
Exclusion Criteria	Not covered for off-label use
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	Up to 12 months
Other Criteria	Nuedexta is indicated to treat pseudobulbar affect. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

diclofenac Sodium (Solaraze)

Products Affected

- Diclofenac Sodium Transdermal Gel 3 %

PA Criteria	Criteria Details
Covered Uses	Diagnosis of actinic keratosis.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Prescribed by a dermatologist.
Coverage Duration	12 months
Other Criteria	This medication is a topical NSAID indicated for treatment of Actinic Keratosis. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

dimethyl fumarate (Tecfidera)

Products Affected

- Dimethyl Fumarate Oral
- Dimethyl Fumarate Starter Pack

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Neurology
Coverage Duration	12 months
Other Criteria	Dimethyl fumerate is an oral CMT (disease modifying treatment) indicated to treat relapsing remitting multiple sclerosis. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

dornase alfa (Pulmozyme)

Products Affected

- **Pulmozyme**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Patient must have an FVC ? 40% of predicted value and recurrent pulmonary infections.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Must be written by a pulmonologist.
Coverage Duration	Up to 12 months
Other Criteria	Pulmozyme is indicated to reduce pulmonary exacerbation in patients with cystic fibrosis. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

dronedarone (Multaq)

Products Affected

- **Multaq**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Must have previously failed or have contraindication to both sotalol and amiodarone.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Multaq is indicated for treatment of atrial fibrillation. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

elagolix (Orilissa)

Products Affected

- **Orilissa**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	OB/GYN
Coverage Duration	6 months
Other Criteria	Covered for endometriosis, failure of NSAID and combined estrogen-progestin contraceptive or progestin.

elagolix/estra/noreth (Oriahnn)

Products Affected

- **Oriahnn**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	OB/GYN
Coverage Duration	24 months
Other Criteria	Approve for 24 months to treat heavy menstrual bleeding due to uterine fibroids.

eltrombopag (Promacta)

Products Affected

- **Promacta Oral Packet 12.5 MG**
- **Promacta Oral Tablet**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Patient must have chronic ITP and bleed risk, with platelet count less than 30,000, and refractory to IVIG, corticosteroids or splenectomy.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	Up to 12 months
Other Criteria	Promacta is indicated to treat ITP and thrombocytopenia secondary to HCV treatment. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

enasidenib (Idhifa)

Products Affected

- **Idhifa**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications, off label use will be covered when there is an NCCN supported indication with a recommendation of class 2A or greater.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Prescriber must be a Hematologist/Oncologist
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	Idhifa is indicated for treatment of relapsed or refractory AML in patients with an IDH2 mutation as detected by an approved test Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

entrectinib (Rozlytrek)

Products Affected

- **Rozlytrek**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Rozyltrek is a kinase inhibitor indicated for solid tumors with NTRK-Fusions and ROS-1 mutated Non-Small Cell lung cancer. Medical history, studies, and appropriate confirmatory tests are reviewed in Referrals and if approved will notify pharmacy and the physician.

enzalutamide (Xtandi)

Products Affected

- **Xtandi**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Coverage will be based on failure of Abiraterone for overlapping indications.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Must be prescribed by oncologist or urologist.
Coverage Duration	Covered for 6 months and continuation based on lack of disease progression.
Other Criteria	Xtandi is an androgen receptor blocker used for Castrate Resistant Prostate Cancer pre- and post-chemotherapy. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

epoetin alpha-epbx (Retacrit)

Products Affected

- **Retacrit Injection Solution 10000 UNIT/ML, 2000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Pharmacy coverage criteria as follows:FDA approved indications. Patient must have adequate iron stores (ferritin greater than or equal to 100 ng/ml, transferrin saturation greater than 20%). Hemoglobin for initiation and maintenance must be compliant with current FDA labeling.
Exclusion Criteria	ESAs are not indicated for patients receiving myelosuppressive therapy when the anticipated outcome is cure.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	ESAs are used to treat anemia related to Chronic Kidney Disease, Chemotherapy, Myelodysplastic Syndrome, Antiviral therapy. Prior authorization is required for pharmacy coverage of medication. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy.

erlotinib (Tarceva)

Products Affected

- Erlotinib HCl

PA Criteria	Criteria Details
Covered Uses	FDA approved indications, off label use will be covered when there is an NCCN supported indication with a recommendation of class 2A or greater.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Tarceva is indicated to treat patients with metastatic non-small cell lung cancer who possess an EGFR mutation. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

eslicarbazepine (Aptiom)

Products Affected

- **Aptiom**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Failure of Oxcarbazepine and carbamazepine.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Must be written by neurology for adjunctive treatment of seizures.
Coverage Duration	12 months
Other Criteria	Aptiom is an anti-convulsant indicated for adjunctive treatment of partial seizures. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy.

estrogens, esterified (USP) (Menest)

Products Affected

- **Menest Oral Tablet 0.3 MG, 0.625 MG, 1.25 MG**

PA Criteria	Criteria Details
Covered Uses	Used for palliative treatment of breast cancer.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Must be written by an oncologist.
Coverage Duration	Up to 12 months
Other Criteria	Menest is only covered for palliative treatment of breast cancer. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

etanercept (Enbrel)

Products Affected

- **Enbrel Mini**
- **Enbrel Subcutaneous Solution 25 MG/0.5ML**
- **Enbrel Subcutaneous Solution Prefilled Syringe**
- **Enbrel Subcutaneous Solution Reconstituted**
- **Enbrel SureClick Subcutaneous Solution Auto-Injector**

PA Criteria	Criteria Details
Covered Uses	Indicated for RA, JRA, PSA, and Plaque Psoriasis. See "Guidelines for Enbrel" form.
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history and associated studies
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Rheumatology, Dermatology or Specialist trained in management of prescribed condition
Coverage Duration	Up to 12 months
Other Criteria	For RA, patient must fail adequate trial of MTX in combination with a DMARD. If MTX is contraindicated, must try combination of 2-nonbiologic DMARDS (3month trial in past 6 months). For Ankylosing Spondylitis, patient must fail MTX (3 month trial in past 6 months)or sulfasalazine and 2 NSAIDS within past 6 months. For Plaque Psoriasis, patient must fail MTX or Soriatane (3 month trial in past 6 months) and topical therapy. For Psoriatic Arthritis, patient must fail adequate trial of MTX or LEF (3month trial in past 6 months).

everolimus (Afinitor)

Products Affected

- Everolimus

PA Criteria	Criteria Details
Covered Uses	Afinitor is an oral tyrosine kinase inhibitor indicated to treat several malignancies.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Prescribing restricted to oncology.
Coverage Duration	12 months
Other Criteria	Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

everolimus (Zortress)

Products Affected

- Everolimus
- **Zortress Oral Tablet 1 MG**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Patient must have failure or intolerance to a calcineurin inhibitor.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Prescriber must be a transplant specialist.
Coverage Duration	12 months
Other Criteria	Zortress is an immunosuppressive anti-rejection agent for solid organ transplant. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

fentanyl transdermal product (Duragesic)

Products Affected

- Fentanyl Transdermal Patch 72 Hour 100 MCG/HR, 12 MCG/HR, 25 MCG/HR, 50 MCG/HR, 75 MCG/HR

PA Criteria	Criteria Details
Covered Uses	FDA approved indications.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Approved when written/ordered by an Oncologist or Pain Management through referrals.
Coverage Duration	12 months
Other Criteria	Fentanyl patch is a long acting opioid analgesic indicated for moderate to severe chronic pain. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

fingolimod (Gilenya)

Products Affected

- **Gilenya Oral Capsule 0.5 MG**

PA Criteria	Criteria Details
Covered Uses	Covered for patients who have failed a trial of glatiramer and Dimethyl Fumerate
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Must be written by a neurologist
Coverage Duration	12 months
Other Criteria	Gilenya is an oral medication indicated for treatment of relapsing remitting multiple sclerosis Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

galcanezumab (Emgality)

Products Affected

- **Emgality**
- **Emgality (300 MG Dose)**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Emgality is an anti-CGRP antibody indicated for prophylaxis of Episodic and Chronic Migrianes, and Cluster HeadachesEpisodic MigrainesEmgality 120 mg will be approved based upon all of thefollowing criteria:(1) Diagnosis of episodic migraines with both of the following:(a) Less than 15 headache days per month(b) Patient has 4 to 14 migraine days per month-AND-(2) Recent trial and failure (trial of at least three months) of two generic medications FDA indicated for migraine prophylaxis (topiramate/divalproex). If either or both are contraindicated or not tolerated the medications below could be used :(a) Amitriptyline (b) atenolol, metoprolol, nadolol, propranolol, or timolol(e) Venlafaxine (Effexor/Effexor XR)AND (3) Medication will not be used in combination with an oral CGRPantagonist or inhibitorAuthorization will be issued for 6 months.B. Chronic Migraines1. Initial TherapyEmgality 120 mg will be approved based upon all of thefollowing criteria:(1) Diagnosis of chronic migraines with both of the following:(a) Greater than or equal to 15 headache days per monthContinued.(b) Greater than or equal to 8 migraine days per month-AND-Recent trial and failure (trial of at least three months) of two generic medications FDA indicated for migraine prophylaxis (topiramate/divalproex). If either or both are contraindicated or not tolerated the medications below could be used :(a) Amitriptyline (b) atenolol, metoprolol, nadolol, propranolol, or timolol(e) Venlafaxine (Effexor/Effexor XR)-AND-(3) Medication will not be used in combination with an oral CGRPantagonist Authorization will be issued for 6 months.C. Episodic Cluster Headache1. Initial Therapya. Emgality 100 mg will be approved based
	upon all of the following criteria:(1) Diagnosis of episodic cluster headache-AND-(2) Patient has experienced at least 2 cluster periods lasting from 7 days to 365days, separated by pain-free periods lasting at least three months.-AND-(3) Medication will not be used in combination with an oral CGRPantagonist.Authorization will be issued for 6 months.

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	consultation with NEUROLOGY
Coverage Duration	See covered uses
Other Criteria	

gefitinib (Iressa)

Products Affected

- **Iressa**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications, off label use will be covered when there is an NCCN supported indication with a recommendation of class 2A or greater. T790 mutation testing when indicated i.e. previously treated with a TKI inhibitor
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Must be prescribed by Oncologist
Coverage Duration	12 Months
Other Criteria	Iressa is indicated to treat non-small cell lung cancer with EGFR mutation exon 19 deletion or Exon 21 substitution mutations. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

glucagon (Baqsimi) nasal powder

Products Affected

- **Baqsimi One Pack**

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Ordered by an endocrinologist.
Coverage Duration	12 months
Other Criteria	Baqsimi is indicated for severe hypoglycemia where patient is unable to eat, drink or follow commands. Baqsimi is intranasal but does not need to be inhaled, patient does not need to be conscious for Baqsimi to be administered. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy. Limit of 1 device per dispensing, two per year.

golimumab (Simponi)

Products Affected

- **Simponi Subcutaneous Solution Auto-Injector**
- **Simponi Subcutaneous Solution Prefilled Syringe**

PA Criteria	Criteria Details
Covered Uses	For use in RA must be written by rheumatology, fail adequate trial of MTX in combination with a DMARD If MTX contraindicated, must try combination of 2-nonbiologic DMARDS (3month trial in past 6 months).For use in Ankylosing Spondylitis PT must fail MTX or sulfasalazine and 2 NSAIDS within past 6 months.For Psoriatic Arthritis must fail adequate trial of MTX or LEF in past 6 months.For with ulcerative colitis must be written by a gastroenterologist and had recent failure of an immunosuppressant (Azathioprine, 6-mp or Methotrexate) and an anti-inflammatory (5-asa, sulfasalazine, balsalazide, mesalamine)
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	For use in RA Simponi must be written by rheumatology. For Simponi coverage in ulcerative colitis must be written by a gastroenterologist.
Coverage Duration	Up to 12 months

PA Criteria	Criteria Details
Other Criteria	Simponi is a TNF antagonist indicated for Moderate to severe rheumatoid arthritis, ankylosing spondylitis, active psoriatic arthritis, moderate to severe ulcerative colitis. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Hepatitis C Direct Acting Antivirals (DAA)

Products Affected

- **Mavyret**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Mavyret is the preferred DAA for all genotypes, other DAAs will be covered on a case by case basis if Mavyret use is not supported by current FDA indication or HCV guidelines based on patient specific characteristics.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Gastroenterologist or Infectious Disease
Coverage Duration	12 months
Other Criteria	Mavyret is the exclusive and preferred DAA for treatment of HCV in chronically infected non-cirrhotic and compensated cirrhotic patients for genotypes 1-6. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Humulin U-500

Products Affected

- **Humulin R U-500 (Concentrated)**
- **Humulin R U-500 KwikPen Subcutaneous Solution Pen-Injector**

PA Criteria	Criteria Details
Covered Uses	Initiation restricted to endocrinology. Insulin requirements of >200 units/day.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Initiation restricted to endocrinology.
Coverage Duration	12 months
Other Criteria	Humulin U 500 is used to treat insulin resistant diabetes mellitus. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

ibrutinib (Imbruvica)

Products Affected

- **Imbruvica Oral Capsule**
- **Imbruvica Oral Tablet 420 MG, 560 MG**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. NCCN supported use with evidence rating 2a or greater.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Must be prescribed by Hematologist/oncologist.
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	Imbruvica is a BTK inhibitor used to treat B cell lymphomas. It is indicated for relapsed waldenstroms macroglobinemia, refractory chronic lymphocytic leukemia and Mantle Cell Lymphoma, and first line CLL. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

idelalisib (Zydelig)

Products Affected

- **Zydelig**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Must be written by oncologist.
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	Zydelig is a PI3K kinase inhibitor for treatment of relapsed Chronic lymphocytic leukemia, relapsed follicular lymphoma, and small lymphocytic lymphoma. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

iloperidone (Fanapt)

Products Affected

- **Fanapt**
- **Fanapt Titration Pack**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Failure of aripiprazole, risperidone.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Approved when written/ordered by a Psychiatrist or Neurologist through referrals for new start.
Coverage Duration	12 months
Other Criteria	Fanapt is indicated to treat schizophrenia. Prior authorization only applies to existing members who are new starts on the drug. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

incobotulinumtoxinA (Xeomin)

Products Affected

- **Xeomin**

PA Criteria	Criteria Details
Covered Uses	FHCP covers this medication only for medically necessary purposes, like cervical dystonia, not responsive to physical therapy, blepharospasm that interferes significantly with vision, and headache not responsive to preventive and acute therapy by Neurology for at least 16 weeks.
Exclusion Criteria	FDA labeled contraindications OR cosmetic conditions
Required Medical Information	Medical notes, previous treatment history and associated studies
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	

interferon beta-1a (Avonex)

Products Affected

- **Avonex Prefilled Syringe Kit**
- **Avonex Pen Intramuscular Auto-Injector Kit**
- **Avonex Prefilled Intramuscular**

PA Criteria	Criteria Details
Covered Uses	Failure of glatiramer and Dimethyl Fumerate for new starts.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Avonex is an interferon indicated to treat multiple sclerosis. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

interferon beta-1a (Rebif)

Products Affected

- **Rebif Rebidose Subcutaneous Solution Auto-Injector**
- **Rebif Rebidose Titration Pack Subcutaneous Solution Auto-Injector**
- **Rebif Subcutaneous Solution Prefilled Syringe**
- **Rebif Titration Pack Subcutaneous Solution Prefilled Syringe**

PA Criteria	Criteria Details
Covered Uses	Failure of glatiramer and Dimethyl Fumerate for new starts.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Rebif is an interferon indicated to treat multiple sclerosis. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

interferon beta-1b (Betaseron)

Products Affected

- **Betaseron Subcutaneous Kit**

PA Criteria	Criteria Details
Covered Uses	Failure of glatiramer for new starts.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Betaseron is an interferon indicated to treat multiple sclerosis. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Interferon gamma-1b (Actimmune)

Products Affected

- **Actimmune**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Coverage will be based on medical history/status, antibiotic failure for chronic granulomatous disease.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Limited to specialist trained in management of prescribed condition.
Coverage Duration	Up to 12 months
Other Criteria	Actimmune is indicated to prevent infection in Chronic Granulomatous disease, and also delay the time to progression with severe malignant osteopetrosis. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

isavuconazonium (Cresemba)

Products Affected

- **Cresemba Oral**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications.
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history and associated studies
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Infectious Disease or Pulmonology Specialist
Coverage Duration	Up to 12 months
Other Criteria	For treatment of Invasive aspergillosis patient must have failed or have contraindication to voriconazole. For treatment of invasive mucormycosis patient must have failed or have contraindication to amphotericin B.

itraconazole (Sporanox)

Products Affected

- Itraconazole Oral

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. These pathogens are identified by culture and sensitivity, pathology or stain in a patient with evidence of infection. Patient has been treated with fluconazole or ketoconazole or amphotericin first and failed. For onychomycosis patient must fail terbinafine.
Exclusion Criteria	
Required Medical Information	Medical notes, previous treatment history, and associated studies, including fungal culture and sensitivity, pathology, or stain
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	Up to 12 months
Other Criteria	Itraconazole is a triazole antifungal medication useful in the treatment of fungal infections including aspergillus, candida, blastomyces, cryptococcus, coccidiomycosis, sporotrichosis and histoplasthma Medical history and microbiology will be reviewed in Referrals and if approved will notify pharmacy and the physician.

ivacaftor (Kalydeco)

Products Affected

- **Kalydeco Oral Tablet**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Patient must have an FDA approved mutation.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Must be prescribed by a Pulmonologist.
Coverage Duration	12 months
Other Criteria	Kalydeco is an oral medication indicated to treat Cystic fibrosis patients with specific genetic mutations in the CFTR gene. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

ixazomib (Ninlaro)

Products Affected

- **Ninlaro**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications, off label use will be covered when there is an NCCN supported indication with a recommendation of class 2A or greater. Must have failed Pomalyst.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Must be prescribed by Oncology.
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	Ninlaro is an oral proteasome inhibitor indicated to treat relapsed or refractory multiple myeloma. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

lacosamide (Vimpat)

Products Affected

- **Vimpat Oral**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Failure of Levetiracetam, topiramate, and lamotrigine.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Approved when written/ordered by a Neurologist.
Coverage Duration	12 months
Other Criteria	Vimpat is indicated as an adjunct agent used to treat partial onset seizures. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

lanreotide (Somatuline)

Products Affected

- **Somatuline Depot**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Failure of octreotide.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Prescriber must be an endocrinologist.
Coverage Duration	12 months
Other Criteria	This medication is used to treat Acromegaly. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

lanthanum carbonate (Fosrenol)

Products Affected

- Lanthanum Carbonate

PA Criteria	Criteria Details
Covered Uses	Patient has ESRD. Patient has elevated calcium on phosphate binders, or not a candidate for calcium based phosphate binders based on KDOQI guidelines. Failure of Sevelamer.
Exclusion Criteria	Not covered in combination with other non-calcium based phosphate binders.
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Prescribed by a nephrologist.
Coverage Duration	12 months
Other Criteria	Fosrenol is a non-calcium based, chewable, phosphate binder indicated to manage hyperphosphatemia in ESRD. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

lapatinib (Tykerb)

Products Affected

- **Tykerb**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Patient has HER2/neu + breast cancer that has failed treatment/progressed with a regimen including an anthracycline, a taxane and Herceptin. Used to treat Metastatic HR+ HER2/neu+ breast cancer in combination with an aromatase inhibitor.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Prescriber is an oncologist.
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	Tykerb is indicated to treat Advanced HER2+ breast cancer in combination with Xeloda. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

lenalidomide (Revlimid)

Products Affected

- **Revlimid**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Patient must have failed Aranesp & Procrit for MDS anemia. Mantle cell Lymphoma requires failure of two prior treatment regimens one of which being bortezomib.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Prescriber is a hematologist/oncologist.
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	Revlimid is indicated for treatment of Multiple Myeloma , Myelodysplastic syndrome, anemia that is transfusion dependent and has 5q deletion karyotype, mantle cell lymphoma Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

lenvatinib (Lenvima)

Products Affected

- **Lenvima (10 MG Daily Dose)**
- **Lenvima (12 MG Daily Dose)**
- **Lenvima (14 MG Daily Dose)**
- **Lenvima (18 MG Daily Dose)**
- **Lenvima (20 MG Daily Dose)**
- **Lenvima (24 MG Daily Dose)**
- **Lenvima (4 MG Daily Dose)**
- **Lenvima (8 MG Daily Dose)**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Must be written by an oncologist/hematologist.
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	Lenvima is indicated for differentiated thyroid cancer Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

lidocaine (Lidoderm)

Products Affected

- Lidocaine External Patch 5 %

PA Criteria	Criteria Details
Covered Uses	Coverage will be based on failure or contraindications of other therapies including failure of Gabapentin.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	This is a transdermal formulation of lidocaine indicated for treatment of post-herpetic neuralgia. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

linaclotide (Linzess)

Products Affected

- **Linzess**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Failure of lactulose and Miralax.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Linzess is indicated for chronic constipation and irritable bowel syndrome. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

liraglutide (Victoza)

Products Affected

- **Victoza Subcutaneous Solution Pen-Injector**

PA Criteria	Criteria Details
Covered Uses	Covered after failure of metformin and Bydureon. Covered for use in established cardiovascular disease for patients on a Statin who have failed metformin.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Victoza is a medication indicated for treatment of type 2 diabetes mellitus.

lubiprostone (Amitiza)

Products Affected

- **Amitiza**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Must have failed lactulose and Miralax.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Prescriber must be a gastroenterologist.
Coverage Duration	12 months
Other Criteria	Amitiza is indicated for chronic constipation and irritable bowel syndrome Medical history and studies are reviewed in Referrals and if approved will notify pharmacy.

lurasidone (Latuda)

Products Affected

- **Latuda Oral Tablet 120 MG, 20 MG, 40 MG, 60 MG, 80 MG**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Failure of aripiprazole, risperidone and quetiapine Approved through referrals.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Latuda is indicated for bipolar depression, prior authorization only applies to existing members who are new starts on the drug. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

mecasermin (Increlex)

Products Affected

- **Increlex**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Coverage will be based on medical history/status, response to previous treatments, and the consideration of other therapeutic options.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Must be prescribed by a Pediatric Endocrinologist.
Coverage Duration	12 months
Other Criteria	Increlex is indicated to treat short stature in patient with primary Insulin like Growth Factor deficiency, and patients with neutralizing antibodies to HGH. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

mepolizumab (Nucala)

Products Affected

- **Nucala Subcutaneous Solution Reconstituted**

PA Criteria	Criteria Details
Covered Uses	The following criteria must be met for coverage for severe eosinophilic asthma: Prescriber must be a pulmonologist or allergist. Two or more severe exacerbations in the past 12 months. Patient must fail 3 months of therapy on maximal indicated doses of Trelegy and Montelukast.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Nucala is an interleukin 5 antagonist indicated for eosinophillic asthma and eosophilic granulomatosis with polyangiitis. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

methylnaltrexone (Relistor)

Products Affected

- **Relistor Subcutaneous Solution 12 MG/0.6ML, 8 MG/0.4ML**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Covered for patients with advanced illness receiving palliative opioid treatment who fail Lactulose and Miralax at therapeutic doses. Failure of Movantik.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Prescriber must be a gastroenterologist, Pain management physician, or oncologist.
Coverage Duration	12 months
Other Criteria	Relistor is an opioid antagonist indicated to treat opioid induced constipation. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

midostaurin (Rydapt)

Products Affected

- **Rydapt**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications, off label use will be covered when used in alignment with NCCN recommendations of class 2A or greater.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Must be prescribed by an oncologist/hematologist.
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	Rydapt is a kinase inhibitor indicated to treat AML, MCL, and systemic mastocytosis. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

mipomersen (Kynamro)

Products Affected

- **Kynamro Subcutaneous Solution Prefilled Syringe**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Genetic confirmation that patient is HoFH. Failure of Statin, Ezetimibe, and PCSK-9 therapy. Continuation of Kynamro after 3 month trial based on LDL reduction of at least 25% while on therapy.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	3 months initially, up to 12 months after response
Other Criteria	Kynamro is indicated to treat Homozygous Familial hypercholesterolemia Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

mirabegron (Myrbetriq)

Products Affected

- **Myrbetriq**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Failure of solifenacin, trospium, and Toviaz.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	This medication is used to treat over active bladder. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

nafarelin acetate (Synarel)

Products Affected

- **Synarel**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Approved when written by an endocrinologist or gynecologist.
Coverage Duration	Up to 12 months
Other Criteria	Synarel is a GNRH analog (intranasal formulation) indicated to treat precocious puberty in children or endometriosis in adults. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

naloxegol (Movantik)

Products Affected

- **Movantik**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Requires failure of lactulose and Miralax.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Movantik is a Peripherally Acting Mu Opioid Antagonist (PAMORA) indicated for opioid induced constipation Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

neratinib (Nerlynx)

Products Affected

- **Nerlynx**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications, off label use will be covered when there is an NCCN supported indication with a recommendation of class 2A or greater.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Prescriber must be a Hematologist/Oncologist
Coverage Duration	12 Months
Other Criteria	Nerlynx is indicated for extended adjuvant treatment of early stage HER2 breast cancer Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

nicotine (Nicotrol)

Products Affected

- **Nicotrol**

PA Criteria	Criteria Details
Covered Uses	Must have previously failed or have contraindication to Bupropion. Coverage is approved for 24 weeks of treatment. Copayment will be applied per package.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	24 weeks
Other Criteria	Indicated for smoking cessation therapy. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

nilotinib (Tasigna)

Products Affected

- **Tasigna**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Covered for treatment failure with imatinib.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	Tasigna is an oral antineoplastic agent used to treat Philadelphia Chromosome + CML Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

niraparib (Zejula)

Products Affected

- **Zejula**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications, off label use will be covered when used in alignment with NCCN recommendations of class 2A or greater.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Must be prescribed by an oncologist/hematologist.
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	Zejula is a poly (ADP-ribose) polymerase (PARP) inhibitor indicated for the maintenance treatment of adult patients with recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in a complete or partial response to platinum-based chemotherapy. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

ocrelizumab (Ocrevus)

Products Affected

- **Ocrevus**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. For Relapsing Remitting Multiple Sclerosis - must have failed rituximab AND Dimethyl Fumerate or Glatiramer
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Must be prescribed by a neurologist.
Coverage Duration	12 months
Other Criteria	Ocrevus is a CD20-directed cytolytic antibody indicated for the treatment of relapsing remitting or primary progressive forms of multiple sclerosis. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

olanzapine (Zyprexa)

Products Affected

- **Zyprexa Relprevv**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Failure of oral aripiprazole and olanzapine.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Approved when written/ordered by a Psychiatrist or Neurologist through referrals for new starts.
Coverage Duration	12 months
Other Criteria	Zyprexa Relprevv is a psychotropic medication. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy.

olaparib (Lynparza)

Products Affected

- **Lynparza**

PA Criteria	Criteria Details
Covered Uses	Lynparza is used to treat BRCA+ ovarian or breast cancers.
Exclusion Criteria	Progression on a PARP inhibitor
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Restricted to Hematology/Oncology.
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

omalizumab (Xolair)

Products Affected

- **Xolair**

PA Criteria	Criteria Details
Covered Uses	The following criteria must be met for coverage for severe asthma:Prescriber must be a pulmonologist or allergist.Patient must have baseline IGE levels within indicated range for Xolair labeling.Patient must test positive to an aeroallergen (either skin test or blood test).Patient must fail 3 months of therapy on maximal indicated doses of Trelegy.Patient must have failed leukotriene receptor antagonist Failed Nucala if eosophillic asthma.The following criteria must be met for coverage for chronic idiopathic urticaria:Prescribed by an allergist, immunologist, or dermatologistPatient must have a diagnosis of chronic idiopathic urticaria (at least a 6 week history)Patient must have tried, for a minimum of 2 weeks and failed 2 of the following antihistamines at maximal doses used to treat CIU: cetirizine(40mg/day), levocetirizine (20mg/day), desloratadine(20mg/day), fexofenadine (540mg/day), loratadine (40mg/day)and montelukast
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	For coverage for severe asthma, prescriber must be a pulmonologist or allergist. For coverage for chronic idiopathic urticaria, prescribed by an allergist, immunologist, or dermatologist.

PA Criteria	Criteria Details
Coverage Duration	12 months
Other Criteria	Xolair is an anti-IgE monoclonal antibody indicated for patients 12 years and older with moderate to severe persistent asthma who have a positive skin test or in-vitro reactivity to an aeroallergen and chronic idiopathic urticaria. Xolair was not studied in patients who smoke. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

onabotulinumtoxinA (Botox)

Products Affected

- **Botox**

PA Criteria	Criteria Details
Covered Uses	Non-Cosmetic FDA approved indications
Exclusion Criteria	FDA labeled contraindications, and excluded for cosmetic conditions
Required Medical Information	Medical notes, previous treatment history and associated studies
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	FHCP covers this medication only for medically necessary purposes, like cervical dystonia, not responsive to physical therapy, blepharospasm that interferes significantly with vision, and headache not responsive to preventive and acute therapy by Neurology for at least 16 weeks

osimertinib mesylate (Tagrisso)

Products Affected

- **Tagrisso**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications, off label use will be covered when there is an NCCN supported indication with a recommendation of class 2A or greater. Must possess the t790m mutation if being used after progression on an EGFR tyrosine kinase inhibitor.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	Tagrisso is indicated to treat patients with metastatic non-small cell lung cancer who possess an EGFR mutation. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

oxandrolone (Oxandrin)

Products Affected

- Oxandrolone Oral

PA Criteria	Criteria Details
Covered Uses	FDA approved indications.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Approved when written by Oncology, through referrals.
Coverage Duration	up to 12 months
Other Criteria	Oxandrin is an anabolic steroid indicated for weight gain in cachexia. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

oxymetholone (Anadrol-50)

Products Affected

- **Anadrol-50**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Medical history and information reviewed by referrals. Coverage will be response to previous treatments, and the consideration of other therapeutic options (ESAs, B12/folate, iron).
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	Up to 12 months
Other Criteria	Anadrol is an anabolic steroid indicated to treat various types of anemia. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

palbociclib (Ibrance)

Products Affected

- **Ibrance**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Diagnosis Metastatic ER+ HER- Breast cancer.
Exclusion Criteria	Progression on a CDK 4/6 inhibitor
Required Medical Information	Medical notes, previous treatment history and associated studies, including diagnosis of metastatic ER+ HER- breast cancer.
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Must be prescribed by Hematologist/oncologist.
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	Ibrance is a CDK 4/6 inhibitor indicated for first-line/second line treatment of metastatic ER+/HER- breast cancer used in combination with an aromatase inhibitor Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

paliperidone (Invega Sustenna) injection

Products Affected

- **Invega Sustenna Intramuscular Suspension**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Failure of oral aripiprazole, paliperidone and risperidone.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Approved when written/ordered by a Psychiatrist or Neurologist through referrals.
Coverage Duration	12 months
Other Criteria	Invega Sustenna is a psychotropic medication. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy.

panobinostat (Farydak)

Products Affected

- **Farydak**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Must be written by an oncologist.
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	Farydak is indicated to treat multiple myeloma in patients who have received at least two therapies including Velcade and an immunomodulatory agent. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

pazopanib (Votrient)

Products Affected

- **Votrient**

PA Criteria	Criteria Details
Covered Uses	Votrient is an oral tyrosine kinase inhibitor indicated to treat Renal cell carcinoma, and soft tissue sarcoma.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Prescribing restricted to oncology.
Coverage Duration	12 months
Other Criteria	Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

PegFilgrastim

Products Affected

- **Fulphila**
- **Udenyca**

PA Criteria	Criteria Details
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	All FDA approved uses, Off-Label uses must be NCCN supported with a grade 2a recommendation or greater.

peginterferon alfa-2b (Sylatron)

Products Affected

- **Sylatron Subcutaneous Kit 200 MCG, 300 MCG, 600 MCG**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Must be used as adjuvant treatment within 84 days of surgical resection in patients with metastatic melanoma with nodal involvement.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Up to 12 months
Other Criteria	Sylatron is an adjuvant treatment for metastatic melanoma. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

penicillamine (Cuprimine)

Products Affected

- Penicillamine Oral Capsule

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Coverage for Rheumatoid Arthritis requires failure of a TNF Agent, and a JAK inhibitor or Abatacept.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Written by a Rheumatologist, or Neurologist, or Urologist or Hepatologist.
Coverage Duration	12 Months
Other Criteria	Cuprimine is indicated for treatment of Rheumatoid arthritis, Wilsons Disease and cystinuria. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

pentamidine isothionate (Nebupent) nebulized

Products Affected

- Pentamidine Isethionate Inhalation

PA Criteria	Criteria Details
Covered Uses	Failure of topical ketoconazole, econazole, clotrimazole betamethasone, nystatin triamcinolone.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Nebupent is a inhaled solution used to treat PCP pneumonia. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

perampanel (Fycompa)

Products Affected

- **Fycompa Oral Tablet**

PA Criteria	Criteria Details
Covered Uses	Written by a neurologist for treatment of seizures. Failure of Levetiracetam, topiramate, and lamotrigine.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Written by a neurologist.
Coverage Duration	12 months
Other Criteria	Fycompa is an anti-convulsant indicated for adjunctive treatment of partial seizures. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

pomalidomide (Pomalyst)

Products Affected

- **Pomalyst**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications, Off label use must be supported by NCCN with evidence rating of 2a or greater. Coverage requires failure of Revlimid and Velcade.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Restricted to Hematology/Oncology.
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	Pomalyst is thalidomide analog used to treat refractory Multiple Myeloma Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

ponatinib (Iclusig)

Products Affected

- **Iclusig**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Must be prescribed by Hematologist/oncologist.
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	Iclusig is a tyrosine Kinase inhibitor indicated to treat Chronic Myelogenous Leukemia. Coverage will be based on failure of first or second line TKI for CML or presence of T350I mutation. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

pramlintide acetate (Symlin)

Products Affected

- **SymlinPen 120 Subcutaneous Solution Pen-Injector**
- **SymlinPen 60 Subcutaneous Solution Pen-Injector**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Patient is uncontrolled despite optimal insulin utilization with Ha1c between 7%-9%. Not for use in patients with gastroparesis.
Exclusion Criteria	
Required Medical Information	Medical notes, previous treatment history, and labs, including HA1c
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Prescriber is an endocrinologist.
Coverage Duration	12 months
Other Criteria	Symlin is indicated to treat Type 1 and 2 Diabetes. Symlin is indicated for adjunctive treatment of DM with insulin. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

pyrimethamine (Daraprim)

Products Affected

- Pyrimethamine Oral

PA Criteria	Criteria Details
Covered Uses	Toxoplasmosis. Patient must have failed recent trial of combination of inhaled corticosteroids AND long acting beta Agonist AND inhaled anti-cholinergic.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	12 Months
Other Criteria	Daraprim is used to treat toxoplasmosis. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

quinine (Qualaquin)

Products Affected

- Quinine Sulfate Oral

PA Criteria	Criteria Details
Covered Uses	FDA approved indications.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	This medication is indicated for treatment of malaria. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

rasagiline (Azilect)

Products Affected

- Rasagiline Mesylate Oral

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Must have failed recent trial of combination selegiline and Levodopa/Carbidopa.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Azilect is a monoamine oxidase inhibitor type B indicated for treatment of Parkinsons disease Medical history and studies are reviewed in Referrals and if approved will notify pharmacy.

regorafenib (Stivarga)

Products Affected

- **Stivarga**

PA Criteria	Criteria Details
Covered Uses	Stivarga is an oral tyrosine kinase inhibitor indicated to treat Colorectal cancer and , Hepatocellular carcinoma.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Prescribing restricted to oncology.
Coverage Duration	12 Months
Other Criteria	Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

rilonacept (Arcalyst)

Products Affected

- **Arcalyst**

PA Criteria	Criteria Details
Covered Uses	Diagnosis of CAPS and Documentation of disability due to the condition, failure of anakinra, and nsaids.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Prescribing limited to immunologist.
Coverage Duration	Up to 12 months
Other Criteria	Arcalyst is indicated to treat Cryopyrin Associated Periodic Syndromes (CAPS). Medical history and studies are reviewed in Referrals and if approved will notify pharmacy.

riluzole (Rilutek)

Products Affected

- Riluzole

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Diagnosis is definite or probable ALS by Neurology. Symptoms have been present for less than 5 years. Vital Capacity is 60% or more of predicted. Patient does not have a tracheostomy.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Rilutek is indicated for the treatment of ALS. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

risperidone (Risperdal Consta) injection

Products Affected

- **RisperDAL Consta Intramuscular Suspension Reconstituted**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Failure of oral aripiprazole and risperidone.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Approved when written/ordered by a Psychiatrist or Neurologist through referrals.
Coverage Duration	12 months
Other Criteria	Risperdal Consta is a psychotropic medication. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy.

roflumilast (Daliresp)

Products Affected

- **Daliresp**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Patient must have failed recent trial of combination of inhaled corticosteroids AND long acting beta Agonist AND inhaled anti-cholinergic.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Daliresp is indicated to treat COPD, it is a selective phosphodiesterase type 4 inhibitor Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

rotigotine (Neupro)

Products Affected

- **Neupro**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Failure of Ropinorole and Pramipexole.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Neupro is a transdermal dopamine agonist indicated for treatment of Parkinsons disease. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

rufinamide (Banzel)

Products Affected

- **Banzel Oral Tablet**
- Rufinamide

PA Criteria	Criteria Details
Covered Uses	FDA approved indications
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Approved when written/ordered by a Neurologist for seizures through referrals.
Coverage Duration	12 months
Other Criteria	Banzel is indicated for treatment of Lennox Gastaut syndrome. Prior authorization only applies to existing members who are new starts on the drug. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy.

ruxolitinib (Jakafi)

Products Affected

- **Jakafi**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Not used in combination with lenalidomide/thalidomide, other JAK or TKI inhibitors. Continuation in therapy will require 50% reduction in baseline spleen size, or 35% reduction in spleen volume, or a 50% reduction in baseline Myelofibrosis symptom score.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Prescriber is a hematologist/oncologist.
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	Jakafi is an oral JAK inhibitor indicated for treatment of intermediate to high risk myelofibrosis including primary myelofibrosis, polycythemia vera, myelofibrosis, and essential thrombocythemia myelofibrosis Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

sarilumab (Kevzara)

Products Affected

- **Kevzara**

PA Criteria	Criteria Details
Covered Uses	Coverage is limited to Rheumatoid arthritis. Must fail a preferred specialty agent (Enbrel, Xeljanz, Simponi). Most have clear documentation of moderate to severe rheumatoid arthritis
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Kevzara is a injectible Il-6 antagonist indicated for rheumatoid arthritis. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

selegiline (Emsam)

Products Affected

- **Emsam**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Patient has failed a 6 week trial of two or more generic antidepressants.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Medication is written by a psychiatrist.
Coverage Duration	12 months
Other Criteria	Emsam is indicated for the treatment of major depression Medical history and studies are reviewed in Referrals and if approved will notify pharmacy.

sildenafil (Revatio)

Products Affected

- Sildenafil Citrate Oral Tablet 20 MG

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Pulmonary hypertension must be diagnosed by heart catheterization. Evaluation, EKG, catheterization results and an objective test of exercise ability (6 minute walk) must be submitted with referral.
Exclusion Criteria	This medication is contraindicated in patients using organic nitrates either regularly or intermittently
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Revatio is indicated for the treatment of Primary pulmonary hypertension or pulmonary hypertension related to connective tissue disease. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

sitagliptin (Januvia)

Products Affected

- **Januvia**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Patient must be on maximal doses of Metformin and Sulfonylurea or other combination therapy if metformin contraindicated for at least 6 months, or have intolerance/ contraindication. Failure of Onglyza.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Januvia is an oral anti-diabetic agent used to treat Type 2 Diabetes (DPP-IV inhibitor). Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

sodium oxybate (Xyrem)

Products Affected

- **Xyrem**

PA Criteria	Criteria Details
Covered Uses	Only covered for narcolepsy with cataplexy. Coverage will be based on recent failure of Modafinil AND Armodafinil AND Amphetamine/Dextroamphetamine. Tricyclic Antidepressant shown to be effective in cataplexy(Clomipramine/Protriptyline) Three month discontinuation trials for moderate to highly sedating s medications such as benzodiazepines, opioids, anticholinergics, muscle relaxers, atypical antipsychotics, dopamine agonists.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Must be prescribed by physician board certified in sleep medicine.
Coverage Duration	Up to 12 months
Other Criteria	This medication is used for treatment of narcolepsy with cataplexy or excessive daytime sleepiness due to narcolepsy. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

sodium zirconium cyclosilicate (Lokelma)

Products Affected

- **Lokelma**

PA Criteria	Criteria Details
Covered Uses	Hyperkalemia after discontinuation trial of potassium sparring medications, trial of a loop diuretic if clinically indicated.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Lokelma is indicated for the treatment of hyperkalemia. Medical history and studies are reviewed in referrals and if approved will notify pharmacy and the physician.

somatropin (Omnitrope)

Products Affected

- **Omnitrope Subcutaneous Solution**
- **Omnitrope Subcutaneous Solution Reconstituted**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. This information with the lab attached is sent to the Referrals Department.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Growth Hormone is a pituitary hormone used for endogenous HGH deficiencies Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

sonidegib (Odomzo)

Products Affected

- **Odomzo**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Must be prescribed by Oncology.
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	Odomzo is an oral oncology agent indicated to treat locally advanced basal cell carcinoma which has recurred following radiation or surgery. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

sorafenib (Nexavar)

Products Affected

- **NexAVAR**

PA Criteria	Criteria Details
Covered Uses	Nexavar is an oral tyrosine kinase inhibitor indicated to treat Renal cell carcinoma, Hepatocellular carcinoma, and thyroid carcinoma.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribing restricted to oncology.
Coverage Duration	12 months
Other Criteria	Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

sunitinib (Sutent)

Products Affected

- **Sutent**

PA Criteria	Criteria Details
Covered Uses	Sutent is an oral tyrosine kinase inhibitor indicated to treat Renal cell carcinoma, Gastrointestinal Stromal Tumors, and pancreatic neuroendocrine tumors.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribing restricted to oncology.
Coverage Duration	12 Months
Other Criteria	Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

tazarotene (Tazorac)

Products Affected

- Tazarotene External
- **Tazorac External Cream 0.05 %**
- **Tazorac External Gel**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. For Psoriasis patient must have failed medium to high potency topical corticosteroid. For acne patient must have failed adapalene or tretinoin or oral tetracycline class antibiotic.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Must be written by dermatology.
Coverage Duration	12 months
Other Criteria	Tazorac is a topical retinoid indicated to treat Acne or Psoriasis. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

tetrabenazine (Xenazine)

Products Affected

- Tetrabenazine

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Patient must have moderate to severe chorea that is refractory to amantadine, neuroleptics or anticonvulsants.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be a neurologist.
Coverage Duration	12 months
Other Criteria	Xenazine is indicated to treat chorea associated with Huntingtons disease. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

tetrahydrocannabinol (Marinol)

Products Affected

- Dronabinol

PA Criteria	Criteria Details
Covered Uses	For cachexia, patient must fail megestrol acetate. For nausea and vomiting patient must fail Ondansetron and Emend.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Dronabinol is indicated to treat HIV/Cancer related Cachexia and chemotherapy induced nausea and vomiting. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

thalidomide (Thalomid)

Products Affected

- **Thalomid**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Approved when written by Oncology, Infectious Disease or in HIV through referrals.
Coverage Duration	12 months
Other Criteria	Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

tipiracil / trifluridine (Lonsurf)

Products Affected

- **Lonsurf**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications, off label use will be covered when there is an NCCN supported indication with a recommendation of class 2A or greater.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Must be prescribed by an Oncologist
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	Lonsurf is indicated to treat patients with metastatic colorectal cancer who have progressed on two to three lines of treatment Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

tofacitinib (Xeljanz)

Products Affected

- **Xeljanz**
- **Xeljanz XR**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. For rheumatoid arthritis must be written by Rheumatology, Patient must fail adequate trial of MTX in combination with a DMARD If MTX contraindicated, must try combination of 2-nonbiologic DMARDS (3 month trial in past 6 months). For Psoriatic Arthritis Patient must fail adequate trial of MTX or LEF in past 6 months. For with ulcerative colitis must be written by a gastroenterologist and had recent failure of an immunosuppressant (Azathioprine, 6-mp or Methotrexate) and an anti-inflammatory (5-asa, sulfasalazine, balsalazide, mesalamine)
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	For rheumatoid arthritis must be written by Rheumatology. For with ulcerative colitis must be written by a gastroenterologist.
Coverage Duration	Up to 12 months
Other Criteria	Xeljanz is indicated for treatment of Moderate to severe Rheumatoid arthritis in adults, Psoriatic Arthritis, Ulcerative colitis Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

trametinib (Mekinist)

Products Affected

- **Mekinist**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications, off label use will be covered when there is an NCCN supported indication with a recommendation of class 2A or greater. Patient must have BRAF V600E/K mutation.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Must be written by an oncologist.
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	Mekinist is a MEK inhibitor indicated to treat BRAF+ V600e/k mutation Stage IIIc-IV metastatic Melanoma. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

tretinoin ()

Products Affected

- Tretinoin Oral

PA Criteria	Criteria Details
Covered Uses	FDA approved indications.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Approved when written by Oncology through referrals.
Coverage Duration	12 months
Other Criteria	Vesanoid is indicated to treat promyelocytic leukemia. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

tretinoin (Retin-A)

Products Affected

- Tretinoin External Cream
- Tretinoin External Gel 0.01 %, 0.025 %

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. This medication is not covered for wrinkles or photo aging.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Prior authorization only required for patients greater than 19 years of age.
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Tretinoin is indicated to treat moderate to severe acne and diseases of keratinization such as ichthyosis and keratosis follicularis. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

vandetanib (Caprelsa)

Products Affected

- **Caprelsa**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications, off label use will be covered when there is an NCCN supported indication with a recommendation of class 2A or greater.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be a Hematologist/Oncologist.
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	Caprelsa medication indicated for treatment of metastatic medullary thyroid cancer Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

vemurafenib (Zelboraf)

Products Affected

- **Zelboraf**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications, off label use will be covered when there is an NCCN supported indication with a recommendation of class 2A or greater. Patient must have BRAF V600E/K mutation.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Must be written by an oncologist.
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	Zelboraf is a BRAF inhibitor indicated to treat BRAF+ V600e/k mutation Stage IIIc-IV metastatic Melanoma, NSCLC, and Metastatic colorectal cancer. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

venetoclax (Venclexta)

Products Affected

- **Venclexta**
- **Venclexta Starting Pack**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Restricted to Hematology/Oncology.
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	Venclexta is a BCL-2 inhibitor indicated for treatmentBCell Lymphomas. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

vismodegib (Erivedge)

Products Affected

- **Erivedge**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications.Patient has Metastatic basal cell cancer, or recurrent basal cell cancer, or who are not candidates for surgery and not candidates for radiation.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber is a hematologist/oncologist.
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	Erivedge is indicated for treatment of metastatic or locally advanced basal cell carcinoma that has recurred following surgery or who are not candidates for surgery and are not candidates for radiation. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

voriconazole (Vfend)

Products Affected

- Voriconazole Oral

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Two of the following medications have been tried, unless resistance or contraindication precludes use, Itraconazole, fluconazole, ketoconazole. Exclusions to pre-requisite medications are Invasive pulmonary aspergillosis, Scedosporium apiospermum, and fusarium.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Voriconazole is an antifungal medication used to treat aspergillosis and other invasive fungal infections. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

vorinostat (Zolinza)

Products Affected

- **Zolinza**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Failed minimum of two systemic treatments, one of which must be Targretin, unless contraindicated.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Up to 12 months or until disease progression or toxicity
Other Criteria	Zolinza is indicated for cutaneous manifestations of cutaneous T-cell Lymphoma Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

vortioxetine (Trintellix)

Products Affected

- **Trintellix**

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Failure or intolerance to two generically available anti-depressants in past 6 months.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Trintellix is an antidepressant used to treat major depressive disorder. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

zileuton (Zyflo)

Products Affected

- Zileuton ER

PA Criteria	Criteria Details
Covered Uses	FDA approved indications. Uncontrolled Asthma while on maximal doses of long acting bronchodilators and inhaled corticosteroids AND montelukast. 6 months of medication compliance with maintenance treatments.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Must be written by a pulmonologist.
Coverage Duration	12 months
Other Criteria	Zyflo is indicates for treatment of asthma. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

ziprasidone (Geodon) injection

Products Affected

- Ziprasidone Mesylate

PA Criteria	Criteria Details
Covered Uses	FDA approved indications.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Approved when written/ordered by a Psychiatrist or Neurologist through referrals for new starts.
Coverage Duration	12 months
Other Criteria	Geodon is a psychotropic medication. Prior authorization only applies to existing members who are new starts on the drug. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

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Florida Health Care Plans
An Independent Licensee of the Blue Cross and Blue Shield Association

Discrimination is Against the Law

Florida Health Care Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Florida Health Care Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Florida Health Care Plans:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified Interpreters
  - Information written in other languages

If you need these services, contact:

- Florida Health Care Plans : 1-877-615-4022

If you believe that Florida Health Care Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Florida Health Care Plans
Civil Rights Coordinator
1340 Ridgewood Avenue,
Holly Hill, FL 32117.
Phone: 1-844-219-6137,
TTY: 1-800-955-8770
Fax: 386-676-7149,
Email: rights@fhcp.com.

You can file grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

If you or someone you're helping has questions about Florida Health Care Plans, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-877-615-4022. (TTY: TRS Relay 711)

Si usted o alguien a quien ayuda tienen preguntas sobre Florida Health Care Plans, tienen derecho a obtener ayuda e información en su idioma de manera gratuita. Para hablar con un intérprete, llame al 1-877-615-4022. (TTY: TRS Relay 711)

Si ou menm, oswa yon moun w ap ede, gen kesyon sou Florida Health Care Plans ,ou gen dwa pou jwenn enfòmasyon nan lang ou gratis. Pou ale ak yon entèprèt, rele 1-877-615-4022. (TTY: TRS Relay 711)

Nếu quý vị, hoặc người nào đó mà quý vị đang giúp đỡ, có các thắc mắc về Florida Health Care Plans, quý vị có quyền được nhận trợ giúp và thông tin bằng ngôn ngữ của quý vị miễn phí. Để trao đổi với phiên dịch, hãy gọi theo số 1-877-615-4022. (TTY: TRS Relay 711)

Se você, ou alguém que estiver a ajudar, tiver dúvidas sobre Florida Health Care Plans, tem o direito de obter ajuda e informações na sua língua, sem nenhumas custas. Para falar com um intérprete, ligue para 1-877-615-4022. (TTY: TRS Relay 711)

**如果您或您正協助的某人對Florida Health Care Plans
有疑問，您有權免費以您的語言取得本協助及資訊。如欲與口譯員交談，請致電1-877-615-4022. (TTY: TRS Relay 711)**

Si vous ou une personne que vous aidez avez des questions au sujet de Florida Health Care Plans, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler à un interprète, veuillez appeler le 1-877-615-4022. (TTY: TRS Relay 711)

Kung ikaw, o ang isang taong tinutulungan mo, ay may mga tanong tungkol sa Florida Health Care Plans, mayroon kang karapatang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang interpreter, tumawag sa 1-877-615-4022. (TTY: TRS Relay 711)

Если у Вас или у кого-то, кому Вы помогаете, есть вопросы о программе Florida Health Care Plans, Вы имеет право бесплатно получить ответы в переводе на Ваш язык. Для того чтобы воспользоваться помощью устного переводчика, позвоните по телефону 1-877-615-4022. (TTY: TRS Relay 711)

ذا كان لديك أو الشخص الذي تساعده استفسارات حول **Florida Health Care Plans**, يحق لك تلقي المساعدة والمعلومات بلغتك مجاناً. تحدث إلى مترجم فوري، اتصل على الرقم [**1-877-615-4022. (TTY: TRS Relay 711)**].

se voi, o una persona che state aiutando, avete domande relative al Florida Health Care Plans, avete diritto a ottenere assistenza e informazioni gratuitamente nella vostra lingua. Per parlare con un interprete, chiamare il numero 1-877-615-4022. (TTY: TRS Relay 711)

Falls Sie oder jemand, dem Sie helfen, irgendwelche Fragen über Florida Health Care Plans haben, so haben Sie Anspruch auf kostenlose Unterstützung und Informationen in Ihrer eigenen Sprache. Bitte rufen Sie uns unter der Nummer 1-877-615-4022. (TTY: TRS Relay 711) an, um mit einem Dolmetscher/einer Dolmetscherin zu sprechen.

귀하 또는 귀하가 도와드리고 있는 분이Florida Health Care Plans에 관한 질문이 있을 경우, 귀하에게는 무료로 본인이 구사하는 언어로 도움과 정보를 받을 권리가 있습니다. 통역으로 전화 연결되려면1-877-615-4022. (TTY: TRS Relay 711) 번으로 전화해 주십시오.

Jeśli Ty lub ktoś, komu pomagasz macie pytania dotyczące Florida Health Care Plans, macie prawo uzyskać pomoc i informacje w swoim języku, bez żadnych kosztów. Porozmawiaj z tłumaczem, zadzwoń pod numer 1-877-615-4022. (TTY: TRS Relay 711)

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หากคุณ หรือคนที่คุณกำลังช่วยเหลืออยู่มีคำถามเกี่ยวกับ **Florida Health Care Plans** คุณจะได้รับการช่วยเหลือและได้รับข้อมูลในภาษาของคุณโดยที่ไม่มีค่าใช้จ่ายใดๆ หากต้องการพูดคุยกับล่ามแปลภาษา โทร.
1-877-615-4022. (TTY: TRS Relay 711)

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