

2019 Prior Authorization Criteria

Updated 12/01/2019

ACITRETIN

Products Affected

- Acitretin

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, prevention of non-melanoma skin cancers in high risk individuals, Lichen planus, Keratosis follicularis (Darier Disease).
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

ACTIMMUNE

Products Affected

- Actimmune

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, mycosis fungoides, Sezary syndrome, atopic dermatitis.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

ADEMPAS

Products Affected

- Adempas

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For pulmonary arterial hypertension (PAH) (WHO Group 1): PAH was confirmed by right heart catheterization. For chronic thromboembolic pulmonary hypertension (CTEPH) (WHO Group 4): Patient has persistent or recurrent CTEPH after pulmonary endarterectomy (PEA), OR patient has inoperable CTEPH with the diagnosis confirmed by right heart catheterization AND by computed tomography (CT), magnetic resonance imaging (MRI), or pulmonary angiography. For new starts only (excluding recurrent/persistent CTEPH after PEA): 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

AFINITOR

Products Affected

- Afinitor
- Afinitor Disperz

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, classical Hodgkin lymphoma, thymomas and thymic carcinomas, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, soft tissue sarcoma subtypes: perivascular epithelioid cell tumors (PEComa), angiomyolipoma, lymphangioliomyomatosis, neuroendocrine tumor of the thymus, thyroid carcinoma (papillary, Hurthle cell, and follicular), osteosarcoma.
Exclusion Criteria	
Required Medical Information	For breast cancer: 1) The patient has recurrent or metastatic hormone receptor positive, HER2 negative disease, 2) Afinitor will be used in combination with exemestane, and 3) The patient's disease either a) has progressed while on or within 12 months of nonsteroidal aromatase inhibitor therapy, OR b) was previously treated with tamoxifen. For renal cell carcinoma: 1) The disease is relapsed, metastatic or unresectable, and 2) For disease that is of predominantly clear cell histology, disease has progressed on prior antiangiogenic therapy (e.g., sunitinib).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

AIMOVIG

Products Affected

- Aimovig

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	1) The patient received at least 3 months of treatment with the requested drug, and the patient had a reduction in migraine days per month from baseline, OR 2) The patient experienced an inadequate treatment response with a 4-week trial of any of the following: Antiepileptic drugs (AEDs), Beta-adrenergic blocking agents, Antidepressants, OR 3) The patient experienced an intolerance or has a contraindication that would prohibit a 4-week trial of any of the following: Antiepileptic drugs (AEDs), Beta-adrenergic blocking agents, Antidepressants
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial 3 Months, Reauthorization Plan year
Other Criteria	

ALDURAZYME

Products Affected

- Aldurazyme

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of mucopolysaccharidosis I was confirmed by an enzyme assay demonstrating a deficiency of alpha-L-iduronidase enzyme activity or by genetic testing. Patients with Scheie syndrome must have moderate to severe symptoms.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

ALECENSA

Products Affected

- Alecensa

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, anaplastic lymphoma kinase (ALK)-positive recurrent non-small cell lung cancer.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

ALOSETRON

Products Affected

- Alosetron HCl

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	1) The requested drug is being prescribed for a biological female or a person that self-identifies as a female with a diagnosis of severe diarrhea-predominant irritable bowel syndrome (IBS) AND 2) Chronic IBS symptoms lasting at least 6 months AND 3) Gastrointestinal tract abnormalities have been ruled out AND 4) Inadequate response to conventional therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

ALPHA1-PROTEINASE INHIBITOR

Products Affected

- Aralast NP Intravenous Solution Reconstituted
1000 MG, 500 MG
- Prolastin-C
- Zemaira

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Patients must have clinically evident emphysema. Patients must have a pretreatment serum alpha1-proteinase inhibitor level less than 11 micromol/L (80 mg/dl by radial immunodiffusion or 50 mg/dl by nephelometry). Patients must have a pretreatment post-bronchodilation forced expiratory volume in 1 second (FEV1) greater than or equal to 25 percent and less than or equal to 80 percent of predicted.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

ALUNBRIG

Products Affected

- Alunbrig

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	Plan Year
Other Criteria	

AMPYRA

Products Affected

- Dalfampridine ER

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For new starts: Prior to initiating therapy, patient demonstrates sustained walking impairment. For continuation of therapy: Patient must have experienced an improvement in walking speed or other objective measure of walking ability since starting the requested medication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

ANADROL

Products Affected

- Anadrol-50

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, Cachexia associated with AIDS (HIV-wasting), Fanconi's anemia.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 Months
Other Criteria	

APOKYN

Products Affected

- Apokyn Subcutaneous Solution Cartridge

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	Plan Year
Other Criteria	

ARCALYST

Products Affected

- Arcalyst

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, prevention of gout flares in patients initiating or continuing urate-lowering therapy.
Exclusion Criteria	
Required Medical Information	For prevention of gout flares in members initiating or continuing urate-lowering therapy (i.e., allopurinol or febuxostat) (new starts): 1) two or more gout flares within the previous 12 months, AND 2) inadequate response, intolerance or contraindication to maximum tolerated doses of non-steroidal anti-inflammatory drugs and colchicine, AND 3) concurrent use with urate-lowering therapy (i.e., allopurinol or febuxostat). For prevention of gout flares in members initiating or continuing urate-lowering therapy (i.e., allopurinol or febuxostat) (continuation): 1) member must have achieved or maintained a clinical benefit (i.e., fewer number of gout attacks or fewer flare days) compared to baseline, AND 2) continued use of urate-lowering therapy concurrently with the requested drug.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	For prevention of gout flares: 4 months. Other: Plan Year
Other Criteria	

ARMODAFINIL

Products Affected

- Armodafinil

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	1) Diagnosis is narcolepsy confirmed by sleep lab evaluation OR 2) Diagnosis is Shift Work Disorder (SWD) OR 3) Diagnosis is obstructive sleep apnea (OSA) confirmed by polysomnography
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

AURYXIA

Products Affected

- Auryxia

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	Plan Year
Other Criteria	

AUSTEDO

Products Affected

- Austedo

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	Plan Year
Other Criteria	

AVASTIN

Products Affected

- Avastin

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, breast cancer, central nervous system (CNS) tumor types: adult intracranial and spinal ependymoma and anaplastic gliomas, malignant pleural mesothelioma, ovarian malignant sex cord-stromal tumors, soft tissue sarcoma types: AIDS-related Kaposi sarcoma, angiosarcoma and solitary fibrous tumor/hemangiopericytoma, uterine cancer, endometrial cancer, diabetic macular edema, neovascular (wet) age-related macular degeneration including polypoidal choroidopathy and retinal angiomatous proliferation subtypes, macular edema following retinal vein occlusion, proliferative diabetic retinopathy, choroidal neovascularization, neovascular glaucoma, and retinopathy of prematurity.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

B VS. D

Products Affected

- Abelcet
- Abraxane
- Acetylcysteine Inhalation
- Acyclovir Sodium Intravenous Solution
- Adriamycin Intravenous Solution
- Adrucil
- Albuterol Sulfate Inhalation
- Alimta
- AmBisome
- Aminosyn II Intravenous Solution 10 %
- Aminosyn-PF
- Amphotericin B Injection
- Amphotericin B Intravenous
- Aprepitant
- AzaCITIDine
- azaTHIOprine Oral
- Bendeka
- Bleomycin Sulfate
- Brovana
- Budesonide Inhalation Suspension 0.25 MG/2ML, 0.5 MG/2ML
- Calcitonin (Salmon)
- Calcitriol Intravenous Solution 1 MCG/ML
- Calcitriol Oral
- CARBOplatin Intravenous Solution
- Cinacalcet HCl
- CISplatin Intravenous Solution 100 MG/100ML, 200 MG/200ML, 50 MG/50ML
- Clinimix/Dextrose (4.25/10)
- Clinimix/Dextrose (4.25/25)
- Clinimix/Dextrose (4.25/5)
- Clinimix/Dextrose (5/15)
- Clinimix/Dextrose (5/20)
- Clinimix/Dextrose (5/25)
- Clinolipid
- Cromolyn Sodium Inhalation
- Cyclophosphamide Injection
- Cyclophosphamide Oral Capsule
- CycloSPORINE Intravenous
- CycloSPORINE Modified
- CycloSPORINE Oral Capsule
- Cytarabine Injection Solution
- Dacarbazine Intravenous Solution Reconstituted 100 MG
- Depo-Provera Intramuscular Suspension 400 MG/ML
- Dexrazoxane Intravenous Solution Reconstituted 500 MG
- Diphtheria-Tetanus Toxoids DT
- DOCEtaxel CONCENTRATE 80 MG/4ML Intravenous
- DOCEtaxel Intravenous Concentrate 160 MG/8ML, 200 MG/10ML, 80 MG/4ML
- DOCEtaxel Intravenous Concentrate 20 MG/ML
- DOCEtaxel Intravenous Solution 160 MG/16ML, 20 MG/2ML, 80 MG/8ML
- DOCEtaxel SOLUTION 160 MG/16ML Intravenous
- DOCEtaxel SOLUTION 20 MG/2ML Intravenous
- DOCEtaxel SOLUTION 80 MG/8ML Intravenous
- Doxercalciferol Oral
- DOXOrubicin HCl Intravenous Solution
- DOXOrubicin HCl Intravenous Solution Reconstituted 50 MG
- DOXOrubicin HCl Liposomal
- Dronabinol
- Emend Oral Suspension Reconstituted
- Engerix-B Injection
- EpiRUBicin HCl Intravenous Solution 200 MG/100ML, 50 MG/25ML
- Etoposide Intravenous Solution 100 MG/5ML, 500 MG/25ML
- Faslodex Intramuscular Solution 250 MG/5ML
- Fluorouracil Intravenous
- FreAmine HBC
- FreAmine III Intravenous Solution 10 %
- Fulvestrant
- GamaSTAN S/D
- Ganciclovir Sodium Intravenous Solution Reconstituted
- Gemcitabine HCl Intravenous Solution 1 GM/26.3ML, 2 GM/52.6ML, 200 MG/5.26ML
- Gemcitabine HCl Intravenous Solution

- Reconstituted
- Gengraf Oral Capsule 100 MG, 25 MG
- Gengraf Oral Solution
- Granisetron HCl Oral
- Heparin Sodium (Porcine) Injection Solution 1000 UNIT/ML, 10000 UNIT/ML, 20000 UNIT/ML, 5000 UNIT/ML
- Hepatamine
- HumuLIN R U-500 (CONCENTRATED)
- HYDROMORPHONE HCl PF Injection Solution 10 MG/ML, 50 MG/5ML, 500 MG/50ML
- Ibandronate Sodium
- Ifex Intravenous Solution Reconstituted 3 GM
- Ifosfamide Intravenous Solution
- Ifosfamide Intravenous Solution Reconstituted 3 GM
- Imovax Rabies
- Intralipid Intravenous Emulsion 20 %
- Intralipid Intravenous Emulsion 30 %
- Intron A
- Ipratropium Bromide Inhalation
- Ipratropium-Albuterol
- Irinotecan HCl
- Kadcyca
- Leucovorin Calcium Injection Solution 500 MG/50ML
- Leucovorin Calcium Injection Solution Reconstituted
- Levalbuterol HCl Inhalation
- LevOCARNitine Oral Solution
- LevOCARNitine Oral Tablet
- Lidocaine HCl (PF) Injection Solution 0.5 %, 1 %, 1.5 %
- Lidocaine HCl Injection Solution 0.5 %, 1 %, 2 %
- Methotrexate Sodium (PF) Injection Solution 1 GM/40ML, 250 MG/10ML, 50 MG/2ML
- Methotrexate Sodium Injection Solution 250 MG/10ML, 50 MG/2ML
- Methotrexate Sodium Injection Solution Reconstituted
- MitoMYcin Intravenous
- Morphine Sulfate (PF) Injection Solution 10 MG/ML, 2 MG/ML, 4 MG/ML, 5 MG/ML, 8 MG/ML
- Morphine Sulfate (PF) Intravenous Solution 10 MG/ML, 4 MG/ML, 8 MG/ML
- Morphine Sulfate (PF) Intravenous Solution 2 MG/ML
- Morphine Sulfate (PF) SOLUTION 10 MG/ML Intravenous
- Morphine Sulfate (PF) SOLUTION 4 MG/ML Intravenous
- Morphine Sulfate (PF) SOLUTION 8 MG/ML Intravenous
- Morphine Sulfate Intravenous Solution 1 MG/ML
- Mycophenolate Mofetil
- Mycophenolate Sodium
- Nebupent
- NephroAmine
- Nulojix
- Nutrilipid
- Oxaliplatin
- PACLitaxel
- Pamidronate Disodium Intravenous Solution 30 MG/10ML, 90 MG/10ML
- Pamidronate Disodium Intravenous Solution 6 MG/ML
- Pamidronate Disodium Intravenous Solution Reconstituted
- Paricalcitol Oral
- Perforomist
- Premasol Intravenous Solution 10 %
- Premasol Intravenous Solution 6 %
- Procalamine
- Prograf Oral Packet
- Prosol
- RabAvert
- Rapamune Oral Solution
- Recombivax HB
- SandIMMUNE Oral Solution
- Sensipar
- Sirolimus Oral
- Tacrolimus Oral
- Taxotere Intravenous Concentrate 80 MG/4ML
- TDVAX
- Tenivac
- Toposar Intravenous Solution 1 GM/50ML, 100 MG/5ML
- Topotecan HCl Intravenous Solution 4 MG/4ML
- Topotecan HCl Intravenous Solution Reconstituted

- Topotecan HCl SOLUTION 4 MG/4ML Intravenous
- TPN Electrolytes Intravenous Solution
- Travasol
- Trexall
- TrophAmine Intravenous Solution 10 %
- VinBLASStine Sulfate Intravenous Solution
- vinCRISStine Sulfate Intravenous
- Vinorelbine Tartrate
- Xatmep
- Zoledronic Acid Intravenous Concentrate
- Zoledronic Acid Intravenous Solution 5 MG/100ML
- Zortress

PA Criteria	Criteria Details
Covered Uses	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	N/A
Other Criteria	

BALVERSA

Products Affected

- Balversa

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	Plan Year
Other Criteria	

BANZEL

Products Affected

- Banzel

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	1 year of age or older.
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

BENLYSTA

Products Affected

- Benlysta

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Severe active lupus nephritis. Severe active central nervous system lupus.
Required Medical Information	Patient has been diagnosed with active, autoantibody-positive systemic lupus erythematosus (SLE). Patient is currently receiving standard therapy for SLE (e.g., corticosteroids, azathioprine, leflunomide, methotrexate, mycophenolate mofetil, hydroxychloroquine, non-steroidal anti-inflammatory drugs) OR patient is not currently receiving standard therapy for SLE because patient tried and had an inadequate response or intolerance to standard therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

BERINERT

Products Affected

- Berinert

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Patient has hereditary angioedema (HAE) with C1 inhibitor deficiency confirmed by laboratory testing OR patient has hereditary angioedema with normal C1 inhibitor confirmed by laboratory testing. For patients with HAE with normal C1 inhibitor, EITHER 1) Patient tested positive for the F12 gene mutation OR 2) Patient has a family history of angioedema and the angioedema was refractory to a trial of antihistamine for at least one month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

BETASERON

Products Affected

- Betaseron Subcutaneous Kit

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Have a relapsing form of multiple sclerosis (MS) (e.g., relapsing-remitting MS, progressive-relapsing MS, or secondary progressive MS with relapses) OR first clinical episode of MS.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

BEXAROTENE

Products Affected

- Bexarotene
- Targretin External

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, mycosis fungoides, Sezary syndrome (capsules only), primary cutaneous CD30-positive T-cell lymphoproliferative disorder types: primary cutaneous anaplastic large cell lymphoma (capsules only) and lymphomatoid papulosis (capsules only), chronic or smoldering adult T-cell leukemia/lymphoma (gel only), primary cutaneous B-cell lymphoma types: primary cutaneous marginal zone lymphoma (gel only) and primary cutaneous follicle center lymphoma (gel only).
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

BOSENTAN

Products Affected

- Bosentan
- Tracleer Oral Tablet

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Pulmonary arterial hypertension (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

BOSULIF

Products Affected

- Bosulif

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, relapsed/refractory Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL).
Exclusion Criteria	
Required Medical Information	Diagnosis of CML was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, patient meets one of the following: 1) Patient has chronic phase CML, OR 2) Patient has accelerated or blast phase CML, OR 3) Patient received a hematopoietic stem cell transplant.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

BRAFTOVI

Products Affected

- Braftovi Oral Capsule 75 MG

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	Plan Year
Other Criteria	

BRIVIACT

Products Affected

- Briviact

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	4 years of age or older (tablets and oral solution).
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

BUPRENORPHINE

Products Affected

- Buprenorphine HCl Sublingual

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	1) The requested drug is being prescribed for the treatment of opioid dependence AND 2) If the patient is pregnant or breastfeeding and being prescribed the requested drug for induction therapy and/or subsequent maintenance therapy for opioid dependence treatment OR 3) If the requested drug is being prescribed for induction therapy for transition from opioid use to opioid dependence treatment OR 4) If the requested drug is being prescribed for maintenance therapy for opioid dependence treatment in a patient who is intolerant to naloxone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 Months
Other Criteria	

CABOMETYX

Products Affected

- Cabometyx

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, non-small cell lung cancer.
Exclusion Criteria	
Required Medical Information	For renal cell carcinoma: The disease is relapsed, unresectable, or metastatic.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

CALCIPOTRIENE

Products Affected

- Calcipotriene External
- Calcitrene
- Enstilar
- Taclonex External Suspension

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	1) The requested drug is being prescribed for the treatment of psoriasis AND 2) The patient experienced an inadequate treatment response, intolerance, or contraindication to a generic topical steroid.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

CALQUENCE

Products Affected

- Calquence

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	Plan Year
Other Criteria	

CAPRELSA

Products Affected

- Caprelsa

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, non-small lung cancer and differentiated thyroid carcinoma: papillary, follicular, Hurthle cell.
Exclusion Criteria	
Required Medical Information	For non-small cell lung cancer (NSCLC): the requested drug is used for NSCLC with RET gene rearrangements.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

CARBAGLU

Products Affected

- Carbaglu

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, methylmalonic acidemia, propionic acidemia.
Exclusion Criteria	
Required Medical Information	Diagnosis of NAGS deficiency was confirmed by enzymatic or genetic testing.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

CAYSTON

Products Affected

- Cayston

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Pseudomonas aeruginosa is present in the patient's airway cultures OR the patient has a history of pseudomonas aeruginosa infection or colonization in the airways.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

CERDELGA

Products Affected

- Cerdelga

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of Gaucher disease was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing. The patient's CYP2D6 metabolizer status has been established using an FDA-cleared test. The patient is a CYP2D6 extensive metabolizer, an intermediate metabolizer, or a poor metabolizer.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

CEREZYME

Products Affected

- Cerezyme Intravenous Solution Reconstituted
400 UNIT

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, type 3 Gaucher disease.
Exclusion Criteria	
Required Medical Information	Diagnosis of Gaucher disease was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

CLOMIPRAMINE

Products Affected

- ClomiPRAMINE HCl Oral

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, Depression, Panic Disorder.
Exclusion Criteria	
Required Medical Information	1) Obsessive-Compulsive Disorder (OCD) or Panic Disorder AND 2) The patient has experienced an inadequate treatment response, intolerance or contraindication to one of the following: a generic selective serotonin reuptake inhibitor (SSRI), a generic serotonin and norepinephrine reuptake inhibitor (SNRI), mirtazapine OR 3) Depression AND 4) The patient has experienced an inadequate treatment response, intolerance or contraindication to one of the following: a generic selective serotonin reuptake inhibitor (SSRI), a generic serotonin and norepinephrine reuptake inhibitor (SNRI), mirtazapine, bupropion.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

CLORAZEPATE

Products Affected

- Clorazepate Dipotassium

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	1) For the management of anxiety disorders, the requested drug is being used with a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI) until the antidepressant becomes effective for the symptoms of anxiety OR the patient has experienced an inadequate treatment response, intolerance or contraindication to a selective serotonin reuptake inhibitor (SSRI) or a serotonin-norepinephrine reuptake inhibitor (SNRI) OR 2) For adjunctive therapy in the management of partial seizures OR 3) Symptomatic relief in acute alcohol withdrawal OR 4) For the short-term relief of the symptoms of anxiety AND 5) The benefit of therapy with the prescribed medication outweighs the potential risk in a patient 65 years of age or older.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Short-term relief anxiety-1 Month, Anxiety Disorders-4 Months, All other Diagnoses-Plan Year
Other Criteria	This Prior Authorization requirement only applies to patients 65 years of age or older. The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.

CLOZAPINE ODT

Products Affected

- CloZAPine Oral Tablet Dispersible

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	Plan Year
Other Criteria	

COMETRIQ

Products Affected

- Cometriq (100 mg Daily Dose)
- Cometriq (140 mg Daily Dose)
- Cometriq (60 mg Daily Dose)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, non-small lung cancer and differentiated thyroid carcinoma: papillary, follicular, Hurthle cell.
Exclusion Criteria	
Required Medical Information	For non-small cell lung cancer (NSCLC): The requested drug is used for NSCLC with RET gene rearrangements.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

COPIKTRA

Products Affected

- Copiktra

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	Plan Year
Other Criteria	

COTELLIC

Products Affected

- Cotellic

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	Plan Year
Other Criteria	

CYSTAGON

Products Affected

- Cystagon

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of nephropathic cystinosis was confirmed by the presence of increased cystine concentration in leukocytes or by genetic testing.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

CYSTARAN

Products Affected

- Cystaran

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of cystinosis was confirmed by the presence of increased cystine concentration in leukocytes or by DNA testing. The patient has corneal cystine crystal accumulation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

DAURISMO

Products Affected

- Daurismo

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	Plan Year
Other Criteria	

DEFERASIROX

Products Affected

- Jadenu
- Jadenu Sprinkle

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For chronic iron overload due to blood transfusions: pretreatment serum ferritin level is greater than 1000 mcg/L.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

DEMSEER

Products Affected

- Demser

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	Plan Year
Other Criteria	

DESVENLAFAXINE

Products Affected

- Desvenlafaxine Succinate ER

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Patient experienced an inadequate treatment response, intolerance, or contraindication to any of the following: a generic serotonin and norepinephrine reuptake inhibitor (SNRI), a generic selective serotonin reuptake inhibitor (SSRI), mirtazapine, bupropion.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

DIAZEPAM

Products Affected

- Diazepam Intensol
- DiazePAM Oral Solution
- diazePAM Oral Tablet

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	1) For the management of anxiety disorders, the requested drug is being used with a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI) until the antidepressant becomes effective for the symptoms of anxiety OR the patient has experienced an inadequate treatment response, intolerance or contraindication to a selective serotonin reuptake inhibitor (SSRI) or a serotonin-norepinephrine reuptake inhibitor (SNRI) OR 2) For symptomatic relief in acute alcohol withdrawal OR 3) For use as an adjunct for the relief of skeletal muscle spasms OR 4) For adjunctive therapy in the treatment of convulsive disorders OR 5) For the short-term relief of the symptoms of anxiety AND 6) The benefit of therapy with the prescribed medication outweighs the potential risk in a patient 65 years of age or older.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Short-term relief anxiety-1 Month, Anxiety Disorders-4 Months, All other Diagnoses-Plan Year
Other Criteria	This Prior Authorization requirement only applies to patients 65 years of age or older. The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored

EMGALITY

Products Affected

- Emgality

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	1) The patient received at least 3 months of treatment with the requested drug, and the patient had a reduction in migraine days per month from baseline, OR 2) The patient experienced an inadequate treatment response with a 4-week trial of any of the following: Antiepileptic drugs (AEDs), Beta-adrenergic blocking agents, Antidepressants, OR 3) The patient experienced an intolerance or has a contraindication that would prohibit a 4-week trial of any of the following: Antiepileptic drugs (AEDs), Beta-adrenergic blocking agents, Antidepressants
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial 3 Months, Reauthorization Plan year
Other Criteria	

EMSAM

Products Affected

- Emsam

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	1) Patient experienced an inadequate treatment response, intolerance, or contraindication to any of the following antidepressants: bupropion, trazodone, mirtazapine, serotonin norepinephrine reuptake inhibitors (e.g., venlafaxine), selective serotonin reuptake inhibitors (e.g., citalopram, fluoxetine, fluvoxamine, paroxetine, sertraline), tricyclic or tetracyclic antidepressants (e.g., amitriptyline, nortriptyline) OR 2) Patient is unable to swallow oral formulations.
Age Restrictions	18 years of age or older.
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

ENDARI

Products Affected

- Endari

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	5 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

EPCLUSA

Products Affected

- Epclusa

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Chronic hepatitis C infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions where applicable, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Criteria will be applied consistent with current AASLD-IDSA guidance.
Other Criteria	

EPIDIOLEX

Products Affected

- Epidiolex

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	Plan Year
Other Criteria	

EPO

Products Affected

- Procrit

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, anemia due to myelodysplastic syndromes (MDS), anemia in congestive heart failure (CHF), anemia in rheumatoid arthritis (RA), anemia due to hepatitis C treatment (ribavirin in combination with either interferon alfa or peginterferon alfa), anemia in primary myelofibrosis, post-polycythemia vera myelofibrosis, and post-essential thrombocythemia myelofibrosis.
Exclusion Criteria	Patients receiving chemotherapy with curative intent. Patients with myeloid cancer.
Required Medical Information	For all uses except surgery: Pretreatment (no erythropoietin treatment in previous month) Hgb is less than 10 g/dL (less than 9 g/dL for anemia in CHF only). Additional requirements for primary myelofibrosis (MF), post-polycythemia vera MF, post-essential thrombocythemia MF: 1) Patient has symptomatic anemia and 2) For initial therapy, pretreatment serum erythropoietin level is less than 500mU/mL. For surgery: 1) Patient is scheduled for elective, noncardiac, nonvascular surgery and 2) Pretreatment Hgb is greater than 10 but not more than 13 g/dL.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	16 weeks

PA Criteria	Criteria Details
Other Criteria	<p>Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual (e.g., used for treatment of anemia for a patient with chronic renal failure who is undergoing dialysis, or furnished from physician's supply incident to a physician service). Coverage includes use in anemia in patients whose religious beliefs forbid blood transfusions. Requirements regarding Hgb values exclude values due to a recent transfusion. For reauthorizations (patient received erythropoietin in previous month): 1) For all uses except surgery, there is an increase in Hgb of at least 1 g/dL after at least 12 weeks of therapy, 2) For anemia in CKD, MDS, CHF, RA, HIV, hepatitis C treatment, primary MF, post-polycythemia vera MF, post-essential thrombocythemia MF, or patients whose religious beliefs forbid blood transfusions: current Hgb is less than or equal to 12 g/dL, and 3) For anemia due to myelosuppressive cancer chemotherapy: current Hgb is less than 11 g/dL.</p>

ERIVEDGE

Products Affected

- Erivedge

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	Plan Year
Other Criteria	

ERLEADA

Products Affected

- Erleada

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	The requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

ESBRIET

Products Affected

- Esbriet

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Initial Review Only: The patient does not have a known etiology for interstitial lung disease and meets one of the following: 1) a high-resolution computed tomography (HRCT) study of the chest or surgical lung biopsy reveals the usual interstitial pneumonia (UIP) pattern, or 2) HRCT study of the chest reveals a possible UIP pattern and the diagnosis is supported either by surgical lung biopsy or by a multidisciplinary discussion between at least a radiologist and pulmonologist who are experienced in idiopathic pulmonary fibrosis if surgical lung biopsy has not been conducted. For continuation: The patient does not have a known etiology for interstitial lung disease.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

FABRAZYME

Products Affected

- Fabrazyme

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of Fabry disease was confirmed by an enzyme assay demonstrating a deficiency of alpha-galactosidase enzyme activity or by genetic testing, or the patient is an obligate female carrier with a first degree male relative diagnosed with Fabry disease.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

FARYDAK

Products Affected

- Farydak

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	Plan Year
Other Criteria	

FENTANYL PATCH

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	1) The requested drug is being prescribed for pain associated with cancer, sickle cell disease, a terminal condition, or pain being managed through palliative care OR 2) The requested drug is being prescribed for pain severe enough to require daily, around-the-clock, long-term treatment in a patient who has been taking an opioid [Note: This drug should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.] AND 3) The patient can safely take the requested dose based on their history of opioid use AND 4) The patient has been evaluated and will be monitored for the development of opioid use disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

FETZIMA

Products Affected

- Fetzima
- Fetzima Titration

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Patient experienced an inadequate treatment response, intolerance, or contraindication to two generic alternatives from the following drug classes: selective serotonin reuptake inhibitors (SSRIs) or serotonin-norepinephrine reuptake inhibitors (SNRIs).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

FIRAZYR

Products Affected

- Firazyr
- Icatibant Acetate

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	The requested drug is being used for the treatment of acute angioedema attacks. Patient has hereditary angioedema (HAE) with C1 inhibitor deficiency confirmed by laboratory testing OR patient has hereditary angioedema with normal C1 inhibitor confirmed by laboratory testing. For patients with HAE with normal C1 inhibitor, EITHER 1) Patient tested positive for the F12 gene mutation OR 2) Patient has a family history of angioedema and the angioedema was refractory to a trial of antihistamine for at least one month.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

FORTEO

Products Affected

- Forteo Subcutaneous Solution 600 MCG/2.4ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For postmenopausal osteoporosis: patient has ONE of the following (1. or 2.): 1) A history of fragility fractures, OR 2) A pre-treatment T-score of less than or equal to -2.5 or osteopenia with a high pre-treatment FRAX fracture probability and patient has ANY of the following: a) Indicators for higher fracture risk (e.g., advanced age, frailty, glucocorticoid therapy, very low T-scores, or increased fall risk), OR b) Patient has failed prior treatment with or is intolerant to a previous osteoporosis therapy (i.e., oral bisphosphonates or injectable antiresorptive agents). For primary or hypogonadal osteoporosis in men: patient has a) a history of osteoporotic vertebral or hip fracture OR b) a pre-treatment T-score of less than or equal to -2.5 OR c) osteopenia with a high pre-treatment FRAX fracture probability. For glucocorticoid-induced osteoporosis: Patient has had an oral bisphosphonate trial of at least 1-year duration unless patient has a contraindication or intolerance to an oral bisphosphonate, AND Patient has a) a history of fragility fracture, OR b) a pre-treatment T-score of less than or equal to -2.5, OR c) osteopenia with a high pre-treatment FRAX fracture probability.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 months (lifetime)
Other Criteria	Patient has high FRAX fracture probability if the 10 year probability is either greater than or equal to 20% for any major osteoporotic fracture or greater than or equal to 3% for hip fracture

FYCOMPA

Products Affected

- Fycompa

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Partial-onset seizures - 4 years of age or older. Primary generalized tonic-clonic seizures - 12 years of age or older.
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

GATTEX

Products Affected

- Gattex

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For initial therapy: Patient was dependent on parenteral support for at least 12 months. For continuation: Requirement for parenteral support has decreased from baseline while on teduglutide therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

GILENYA

Products Affected

- Gilenya Oral Capsule 0.5 MG

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	Plan Year
Other Criteria	

GILOTRIF

Products Affected

- Gilotrif

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For non-small cell lung cancer (NSCLC), patient meets either of the following: 1) patient has metastatic squamous NSCLC that progressed after platinum-based chemotherapy, OR 2) patient has a known sensitizing epidermal growth factor receptor (EGFR) mutation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

GLATIRAMER

Products Affected

- Glatiramer Acetate
- Glatopa

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, first clinical episode of MS.
Exclusion Criteria	
Required Medical Information	Have a relapsing form of multiple sclerosis (MS) (e.g., relapsing-remitting MS, progressive-relapsing MS, or secondary progressive MS with relapses) OR first clinical episode of MS.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

GRALISE

Products Affected

- Gralise
- Gralise Starter

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	Plan Year
Other Criteria	

GRANIX

Products Affected

- Granix

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, treatment of chemotherapy-induced febrile neutropenia (FN), stem cell transplantation related indications, acute lymphocytic leukemia (ALL), acute myeloid leukemia (AML), severe chronic neutropenia (congenital, cyclic, or idiopathic), myelodysplastic syndromes (MDS), agranulocytosis, aplastic anemia, HIV-related neutropenia, neutropenia related to renal transplantation.
Exclusion Criteria	Use of the requested product within 24 hours prior to or following chemotherapy.
Required Medical Information	For prophylaxis or treatment of myelosuppressive chemotherapy-induced FN patients must meet all of the following: 1) Patient has a non-myeloid cancer, 2) Patient has received, is currently receiving, or will be receiving treatment with myelosuppressive anti-cancer therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	

GROWTH HORMONE

Products Affected

- Genotropin
- Genotropin MiniQuick

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Pediatric patients with closed epiphyses (except in patients with PWS).
Required Medical Information	Pediatric GHD: 1) Younger than 2.5 yrs old, when applicable: a) Pre-treatment (pre-tx) height (ht) more than 2 SD below mean and slow growth velocity. 2) 2.5 yrs old or older: a) Pre-tx 1-year ht velocity more than 2 SD below mean OR b) Pre-tx ht more than 2 SD below mean and 1-year ht velocity more than 1 SD below mean. Pediatric GHD: 1) Failed 2 stimulation tests (peak below 10 ng/mL) prior to starting treatment, OR 2) Pituitary/CNS disorder (eg, genetic defects, CNS tumors, congenital structural abnormalities) and pre-tx IGF-1 more than 2 SD below mean, OR 3) Patient is a neonate or was diagnosed with GHD as a neonate. TS: 1) Confirmed by karyotyping AND 2) Pre-treatment height is less than the 5th percentile for age. SGA: 1) Birth weight (wt) below 2500g at gestational age (GA) more than 37 weeks OR birth wt or length below 3rd percentile for GA or at least 2 SD below mean for GA, AND 2) Did not manifest catch-up growth by age 2. Adult GHD: 1) Failed 2 stimulation tests (peak below 5 ng/mL) or test with Macrilen (peak below 2.8 ng/ml) prior to starting tx, OR 2) Structural abnormality of the hypothalamus/pituitary AND 3 or more pituitary hormone deficiencies, OR 3) Childhood-onset GHD with congenital (genetic or structural) abnormality of the hypothalamus/pituitary/CNS, OR 4) Low pre-tx IGF-1 and failed 1 stimulation test prior to starting tx.
Age Restrictions	SGA: 2 years of age or older
Prescriber Restrictions	Endocrinologist, pediatric endocrinologist, pediatric nephrologist, infectious disease specialist, gastroenterologist/nutritional support specialist, geneticist.
Coverage Duration	Plan Year
Other Criteria	Renewal for pediatric GHD, TS, SGA, and adult GHD: patient is experiencing improvement.

HAEGARDA

Products Affected

- Haegarda

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	This medication is being used for the prevention of acute angioedema attacks. Patient has hereditary angioedema (HAE) with C1 inhibitor deficiency confirmed by laboratory testing OR patient has hereditary angioedema with normal C1 inhibitor confirmed by laboratory testing. For patients with HAE with normal C1 inhibitor, EITHER 1) Patient tested positive for the F12 gene mutation OR 2) Patient has a family history of angioedema and the angioedema was refractory to a trial of antihistamine for at least one month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

HARVONI

Products Affected

- Harvoni Oral Tablet 90-400 MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Chronic hepatitis C infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions where applicable, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Criteria applied consistent with current AASLD-IDSA guidance. Reminder for 8wk option if appropriate.
Other Criteria	

HERCEPTIN

Products Affected

- Herceptin

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, neoadjuvant treatment for HER2-positive breast cancer, recurrent HER2-positive breast cancer, leptomeningeal metastases from HER2-positive breast cancer, HER2-positive esophageal and esophagogastric junction cancer.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Neoadjuvant therapy for breast cancer: 6 months. Other: Plan Year.
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

HERCEPTIN HYLECTA

Products Affected

- Herceptin Hylecta

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

HETLIOZ

Products Affected

- Hetlioz

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For initial therapy and continuation of Hetlioz therapy: 1) diagnosis of Non-24 Hour Sleep-Wake Disorder and 2) diagnosis of total blindness in both eyes (e.g., nonfunctioning retinas) and 3) unable to perceive light in both eyes. For patients currently on therapy with the requested medication, must meet at least one of the following: 1) increased total nighttime sleep or 2) decreased daytime nap duration.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initiation: 6 Months, Renewal: Plan Year
Other Criteria	

HIGH RISK MEDICATION

Products Affected

- Cyproheptadine HCl Oral
- Digitek Oral Tablet 250 MCG
- Digox Oral Tablet 250 MCG
- Digoxin Oral Solution
- Digoxin Oral Tablet 250 MCG
- GuanFACINE HCl ER
- Scopolamine
- Transderm-Scop (1.5 MG)

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	Plan Year
Other Criteria	This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.

HRM-ANTICONSULSANTS

Products Affected

- PHENobarbital Oral Elixir
- PHENobarbital Oral Tablet
- PHENobarbital Sodium Injection Solution 130 MG/ML
- PHENobarbital Sodium Injection Solution 65 MG/ML

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	Plan Year
Other Criteria	This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.

HRM-ANTIPARKINSON

Products Affected

- Benztropine Mesylate Oral
- Trihexyphenidyl HCl

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	Plan Year
Other Criteria	<p>This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) EPS (extrapyramidal symptoms): 1) One non-HRM alternative drug amantadine has not been tried. AND 2) The patient has a contraindication to one non-HRM alternative drug amantadine AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. OR 4) One non-HRM alternative drug amantadine has been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to one non-HRM alternative drug amantadine AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. Parkinson's: 1) Two non-HRM alternative drugs amantadine, carbidopa/levodopa, pramipexole, or ropinirole have been tried. AND 2) The patient experienced an inadequate treatment response OR intolerance to two non-HRM alternative drugs amantadine, carbidopa/levodopa, pramipexole, or ropinirole AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.</p>

HRM-HYDROXYZINE

Products Affected

- HydrOXYzine HCl Oral Syrup
- hydrOXYzine HCl Oral Tablet
- hydrOXYzine Pamoate Oral Capsule 25 MG
- HydrOXYzine Pamoate Oral Capsule 50 MG

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	Plan Year
Other Criteria	<p>This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) For pruritus: 1) A non-HRM alternative drug levocetirizine has not been tried AND 2) The patient has a contraindication to a non-HRM alternative drug levocetirizine AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient OR 4) A non-HRM alternative drug levocetirizine has been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to a non-HRM alternative drug levocetirizine AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. For anxiety: 1) Two non-HRM alternative drugs buspirone, duloxetine, escitalopram, sertraline, or venlafaxine extended-release have been tried AND 2) The patient experienced an inadequate treatment response OR intolerance to two non-HRM alternative drugs buspirone, duloxetine, escitalopram, sertraline, or venlafaxine extended-release AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.</p>

HRM-HYDROXYZINE INJ

Products Affected

- hydrOXYzine HCl Intramuscular

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	Plan Year
Other Criteria	<p>This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Alcohol Withdrawal Syndrome: 1) One non-HRM alternative drug clorazepate or lorazepam has not been tried AND 2) The patient has a contraindication to one non-HRM alternative drug clorazepate or lorazepam AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient OR 4) One non-HRM alternative drug clorazepate or lorazepam has been tried AND 5) The patient experienced an inadequate treatment response OR intolerance to one non-HRM alternative drug clorazepate or lorazepam AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient Anxiety: 1) Two non-HRM alternative drugs buspirone, duloxetine, escitalopram, sertraline or venlafaxine extended-release have been tried AND 2) The patient experienced an inadequate treatment response OR intolerance to two non-HRM alternative drugs buspirone, duloxetine, escitalopram, sertraline or venlafaxine extended-release AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient OR 4) If being requested for nausea/vomiting, prescriber must acknowledge that medication benefits outweigh potential risks for this patient.</p>

HRM-HYPNOTICS

Products Affected

- Zolpidem Tartrate Oral

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	Plan Year
Other Criteria	This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) 1) One non-HRM alternative drug Silenor (3mg or 6mg) or trazodone has not been tried AND 2) The patient has a contraindication to two non-HRM alternative drugs Silenor (3mg or 6mg) and trazodone AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient OR 4) One non-HRM alternative drug Silenor (3mg or 6mg) or trazodone has been tried AND 5) The patient experienced an inadequate treatment response OR intolerance to one non-HRM alternative drug Silenor (3mg or 6mg) or trazodone AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. APPLIES TO GREATER THAN CUMULATIVE 90 DAYS OF THERAPY PER YEAR.

HRM-NITROFURANTOIN

Products Affected

- Nitrofurantoin Macrocrystal Oral Capsule 100 MG, 50 MG
- Nitrofurantoin Monohyd Macro

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	Plan Year
Other Criteria	This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) 1) Two non-HRM alternative drugs cephalexin, ciprofloxacin, levofloxacin, sulfamethoxazole/trimethoprim, or trimethoprim have not been tried AND 2) The patient has a contraindication to two non-HRM alternative drugs cephalexin, ciprofloxacin, levofloxacin, sulfamethoxazole/trimethoprim, or trimethoprim AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient OR 4) Two non-HRM alternative drugs cephalexin, ciprofloxacin, levofloxacin, sulfamethoxazole/trimethoprim, or trimethoprim have been tried AND 5) The patient experienced an inadequate treatment response OR intolerance to two non-HRM alternative drugs cephalexin, ciprofloxacin, levofloxacin, sulfamethoxazole/trimethoprim, or trimethoprim AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. APPLIES TO GREATER THAN CUMULATIVE 90 DAYS OF THERAPY PER YEAR.

HRM-PROMETHAZINE

Products Affected

- Promethazine HCl Injection
- Promethazine HCl Oral Syrup
- Promethazine HCl Oral Tablet

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	Plan Year
Other Criteria	<p>This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Rhinitis: 1) One non-HRM alternative drug levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal has been tried AND 2) The patient experienced an inadequate treatment response OR intolerance to one non-HRM alternative drug levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient. Urticaria: 1) One non-HRM alternative drug levocetirizine has not been tried AND 2) The patient has a contraindication to one non-HRM alternative drug levocetirizine AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient OR 4) One non-HRM alternative drug levocetirizine has been tried AND 5) The patient experienced an inadequate treatment response OR intolerance to one non-HRM alternative drug levocetirizine AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient OR 7) The drug is being requested for antiemetic therapy in postoperative patients or motion sickness AND 8) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.</p>

HRM-SKELETAL MUSCLE RELAXANTS

Products Affected

- Cyclobenzaprine HCl Oral Tablet 10 MG, 5 MG

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	Plan Year
Other Criteria	This Prior Authorization requirement only applies to patients 70 years of age or older. (The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) Prescriber must acknowledge that medication benefits outweigh potential risks for this patient.

HUMIRA

Products Affected

- Humira Pediatric Crohns Start Subcutaneous Prefilled Syringe Kit
- 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	All FDA-approved indications not otherwise excluded from Part D, axial spondyloarthritis.
Exclusion Criteria	
Required Medical Information	<p>For moderately to severely active rheumatoid arthritis (new starts only): 1) Inadequate response, intolerance or contraindication to methotrexate (MTX), OR 2) inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD (e.g., tofacitinib).</p> <p>For moderately to severely active polyarticular juvenile idiopathic arthritis (new starts only): 1) Inadequate response, intolerance or contraindication to MTX, 2) inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD). For active ankylosing spondylitis and axial spondyloarthritis (new starts only): 1) Inadequate response to a non-steroidal anti-inflammatory drug (NSAID) trial OR 2) intolerance or contraindication to NSAIDs. For moderate to severe chronic plaque psoriasis (new starts only): 1) At least 5% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis, AND 2) Patient meets any of the following: a) Patient has experienced an inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, b) Pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated, or c) Patient has severe psoriasis that warrants a biologic DMARD as first-line therapy. For moderately to severely active Crohn's disease (new starts only): 1) Inadequate response to at least one conventional therapy (e.g., corticosteroids, sulfasalazine, azathioprine, mesalamine), OR 2) intolerance or contraindication to conventional therapy. For moderately to severely active ulcerative colitis (new starts only): 1) Inadequate response to at least one immunosuppressant therapy (e.g., corticosteroids, azathioprine, mercaptopurine), OR 2) intolerance or contraindication to immunosuppressant therapy.</p>
Age Restrictions	

PA Criteria	Criteria Details
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

HYPNOTIC BENZODIAZEPINES

Products Affected

- Temazepam Oral Capsule 15 MG, 7.5 MG

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

IBRANCE

Products Affected

- Ibrance

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

ICLUSIG

Products Affected

- Iclusig

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For chronic myeloid leukemia (CML) or Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

IDHIFA

Products Affected

- IDHIFA

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	Plan Year
Other Criteria	

IMATINIB

Products Affected

- Imatinib Mesylate

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, desmoid tumors, pigmented villonodular synovitis/tenosynovial giant cell tumor (PVNS/TGCT), chordoma, and melanoma.
Exclusion Criteria	
Required Medical Information	For chronic myeloid leukemia (CML) or Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, patient did not fail (excluding failure due to intolerance) prior therapy with a tyrosine kinase inhibitor (eg, dasatinib, nilotinib, bosutinib, ponatinib). For melanoma, c-Kit mutation is positive.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

IMBRUVICA

Products Affected

- Imbruvica

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, gastric mucosa-associated lymphoid tissue (MALT) lymphoma, non-gastric MALT lymphoma, hairy cell leukemia, and lymphoplasmacytic lymphoma.
Exclusion Criteria	
Required Medical Information	For mantle cell lymphoma: 1) the requested medication will be used in a patient who has received at least one prior therapy, OR 2) the requested medication will be used in combination with rituximab as pretreatment to induction therapy with RHyperCVAD (cyclophosphamide, vincristine, doxorubicin, and dexamethasone) regimen. For gastric MALT lymphoma and non-gastric MALT lymphoma: 1) disease is recurrent, refractory, or progressive, AND 2) the requested medication will be used as second-line or subsequent therapy. For hairy cell leukemia: the requested medication will be used as a single agent for disease progression.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

INCRELEX

Products Affected

- Increlex

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Must meet all of the following prior to beginning therapy with the requested medication (new starts only): 1) height 3 or more standard deviations below the mean for children of the same age and gender AND 2) basal IGF-1 level 3 or more standard deviations below the mean for children of the same age and gender AND 3) provocative growth hormone test showing a normal or elevated growth hormone level. For renewal, patient is experiencing improvement.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

INLYTA

Products Affected

- Inlyta

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, papillary, Hurthle cell, or follicular thyroid carcinoma.
Exclusion Criteria	
Required Medical Information	For renal cell carcinoma: The disease is relapsed, metastatic, or unresectable.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

INREBIC

Products Affected

- Inrebic

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	Plan Year
Other Criteria	

IR BEFORE ER

Products Affected

- Hysingla ER
- Methadone HCl Intensol
- Methadone HCl Oral Solution
- Methadone HCl Oral Tablet
- Morphine Sulfate ER Oral Tablet Extended Release
- Nucynta ER

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	1) The requested drug is being prescribed for pain associated with cancer, sickle cell disease, a terminal condition, or pain being managed through palliative care OR 2) The requested drug is being prescribed for pain severe enough to require daily, around-the-clock, long-term treatment in a patient who has been taking an opioid [Note: This drug should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.] AND 3) The patient can safely take the requested dose based on their history of opioid use AND 4) The patient has been evaluated and will be monitored for the development of opioid use disorder AND 5) The request is for continuation of therapy for a patient who has been receiving an extended-release opioid agent for at least 30 days OR 6) The patient has severe continuous pain and has received an immediate-release opioid for at least one week
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

IRESSA

Products Affected

- Iressa

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For non-small cell lung cancer, patient has a known sensitizing EGFR mutation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

ISOTRETINOIN

Products Affected

- Amnesteem
- Claravis
- ISOTretinoin Oral
- Myorisan
- Zenatane

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, refractory acne, severe refractory rosacea, neuroblastoma, cutaneous T-cell lymphoma (CTCL) (e.g., mycosis fungoides, Sezary syndrome), high risk for developing skin cancer (squamous cell cancers), transient acantholytic dermatosis (Grover's Disease), keratosis follicularis (Darier Disease), lamellar ichthyosis, pityriasis rubra pilaris.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

ITRACONAZOLE

Products Affected

- Itraconazole Oral Capsule

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, Coccidioidomycosis, Cryptococcosis, Microsporidiosis, Penicilliosis, Sporotrichosis, Pityriasis versicolor/Tinea versicolor, Tinea corporis/Tinea cruris, Tinea manuum/Tinea pedis.
Exclusion Criteria	
Required Medical Information	If for the treatment of onychomycosis due to tinea, the diagnosis has been confirmed by a fungal diagnostic test.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	

IVIG

Products Affected

- Bivigam Intravenous Solution 5 GM/50ML
- Carimune NF Intravenous Solution Reconstituted 12 GM
- Flebogamma DIF
- Gammagard
- Gammagard S/D Less IgA
- Gammaked
- Gammaplex Intravenous Solution 10 GM/100ML, 10 GM/200ML, 20 GM/200ML, 20 GM/400ML, 5 GM/100ML, 5 GM/50ML
- Gamunex-C
- Octagam
- Panzyga
- Privigen

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, primary immunodeficiency, chronic inflammatory demyelinating polyneuropathy, multifocal motor neuropathy, dermatomyositis, polymyositis, Guillain-Barre syndrome (GBS), myasthenia gravis, Lambert-Eaton myasthenic syndrome, Kawasaki syndrome, idiopathic thrombocytopenic purpura, pure red cell aplasia (PRCA), fetal/neonatal alloimmune thrombocytopenia, Stiff-person syndrome, and prophylaxis of bacterial infections in B-cell chronic lymphocytic leukemia (CLL), bone marrow/hematopoietic stem cell transplant (BMT/HSCT) recipients, and pediatric HIV infection.
Exclusion Criteria	
Required Medical Information	For CLL: serum IgG less than 500 mg/dL OR a history of recurrent bacterial infections. For BMT/HSCT: IVIG is requested within the first 100 days post-transplant OR serum IgG less than 400 mg/dL. For pediatric HIV infection: 1) Serum IgG less than 400 mg/dL, OR 2) History of recurrent bacterial infections. For dermatomyositis and polymyositis: at least one standard first-line treatment (corticosteroids or immunosuppressants) has been tried but was unsuccessful or not tolerated OR patient is unable to receive standard therapy because of a contraindication or other clinical reason. PRCA is secondary to parvovirus B19 infection.
Age Restrictions	For pediatric HIV infection: age 12 years or younger.
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

JAKAFI

Products Affected

- Jakafi

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, low-risk, intermediate-risk, accelerated phase, or blast phase myelofibrosis, polycythemia vera in patients with inadequate response or intolerance to interferon therapy (interferon alfa-2b, peginterferon alfa-2a, or peginterferon alfa-2b).
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

JUXTAPID

Products Affected

- Juxtapid

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For initiation of therapy: 1) Patient has a diagnosis of homozygous familial hypercholesterolemia (HoFH) confirmed by genetic analysis or clinical criteria (see Other Criteria), AND 2) Prior to initiation of treatment with the requested drug, patient is/was receiving a combination lipid-lowering regimen consisting of at least 2 of the following treatment options: high-intensity statin (eg, atorvastatin, rosuvastatin), fibrate (eg, fenofibrate, fenofibric acid, gemfibrozil), bile acid sequestrant (eg, cholestyramine, colesevelam, colestipol), ezetimibe, or niacin, at maximally tolerated doses or at the maximum doses approved by the FDA, AND 3) Prior to initiation of treatment with the requested drug, patient is/was experiencing an inadequate response to such combination regimen as demonstrated by treated LDL-C greater than 100 mg/dl (or greater than 70 mg/dL with clinical atherosclerotic cardiovascular disease). For renewal of therapy: 1) Patient meets all initial criteria AND 2) Has responded to therapy as demonstrated by a reduction in LDL-C.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year

PA Criteria	Criteria Details
Other Criteria	<p>Diagnosis of HoFH must be confirmed by one of the following: 1) Genetic diagnosis: Mutations in both alleles at LDL receptor, ApoB, PCSK9 or LDL receptor adaptor protein/ARH gene locus, or 2) Clinical diagnosis: Untreated LDL-C greater than 500 mg/dL or unknown untreated LDL-C with treated LDL-C greater than 300 mg/dL plus one of the following: a) Tendon or cutaneous xanthomas at age 10 or younger, or b) Diagnosis of FH by genetic analysis, Simon-Broome Diagnostic Criteria or Dutch Lipid Clinic Network Criteria in both parents, or c) Evidence of FH in both parents with a history including any of the following: Total cholesterol greater than or equal to 310 mg/dL, premature ASCVD [before 55 years in men and 60 years in women], tendon xanthoma, or sudden premature cardiac death. Diagnosis of FH must be confirmed by one of the following: 1) Genetic diagnosis: An LDL-receptor mutation, familial defective apo B-100, or a PCSK9 gain-of-function mutation, or 2) Simon-Broome Diagnostic Criteria for FH: Total cholesterol greater than 290 mg/dL or LDL-C greater than 190 mg/dL, plus tendon xanthoma in patient, first-degree (parent, sibling or child) or second-degree relative (grandparent, uncle or aunt), or family history of myocardial infarction in a first degree relative before the age 60 or in a second degree relative before age 50, or total cholesterol greater than 290 mg/dL in an adult first or second degree relative, or total cholesterol greater than 260 mg/dL in a child, brother, or sister aged younger than 16 years, or 3) Dutch Lipid Clinic Network Criteria for FH: Total score greater than 5 points.</p>

KALYDECO

Products Affected

- Kalydeco

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	The patient has one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to ivacaftor potentiation based on clinical and/or in vitro assay data. If the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of a CFTR mutation.
Age Restrictions	6 months of age or older.
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	The requested drug will not be used in combination with lumacaftor/ivacaftor or tezacaftor/ivacaftor.

KETOCONAZOLE

Products Affected

- Ketoconazole Oral

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, Cushing's syndrome.
Exclusion Criteria	Acute or chronic liver disease. Current use with dofetilide, quinidine, pimozide, cisapride, methadone, disopyramide, dronedarone, ranolazine, ergot alkaloids, alprazolam or simvastatin.
Required Medical Information	1) Patient has one of the following diagnoses: blastomycosis, coccidioidomycosis, histoplasmosis, chromomycosis, or paracoccidioidomycosis, OR 2) The requested drug is being prescribed for a patient with Cushing's syndrome who cannot tolerate surgery or surgery has not been curative.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	

KEYTRUDA

Products Affected

- Keytruda

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, malignant pleural mesothelioma, Merkel cell carcinoma.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

KISQALI

Products Affected

- Kisqali (200 MG Dose)
- Kisqali (400 MG Dose)
- Kisqali (600 MG Dose)
- Kisqali 200 Dose
- Kisqali 400 Dose
- Kisqali 600 Dose
- Kisqali Femara (400 MG Dose)
- Kisqali Femara (600 MG Dose)
- Kisqali Femara(200 MG Dose)

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	Plan Year
Other Criteria	

KORLYM

Products Affected

- Korlym

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	Plan Year
Other Criteria	

KUVAN

Products Affected

- Kuvan

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For patients who have not yet received a therapeutic trial of the requested drug, the patient's pretreatment, including before dietary management, phenylalanine level is greater than 6 mg/dL (360 micromol/L). For patients who completed a therapeutic trial of the requested drug, the patient must have experienced a reduction in blood phenylalanine level of greater than or equal to 30 percent from baseline OR the patient has demonstrated an improvement in neuropsychiatric symptoms.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 2 months. All others: Plan Year.
Other Criteria	

KYNAMRO

Products Affected

- Kynamro Subcutaneous Solution Prefilled Syringe

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For initiation of therapy: 1) Patient has a diagnosis of homozygous familial hypercholesterolemia (HoFH) confirmed by genetic analysis or clinical criteria (see Other Criteria), AND 2) Prior to initiation of treatment with the requested drug, patient is/was receiving a combination lipid-lowering regimen consisting of at least 2 of the following treatment options: high-intensity statin (eg, atorvastatin, rosuvastatin), fibrate (eg, fenofibrate, fenofibric acid, gemfibrozil), bile acid sequestrant (eg, cholestyramine, colesevelam, colestipol), ezetimibe, or niacin, at maximally tolerated doses or at the maximum doses approved by the FDA, AND 3) Prior to initiation of treatment with the requested drug, patient is/was experiencing an inadequate response to such combination regimen, as demonstrated by treated LDL-C greater than 100 mg/dl (or greater than 70 mg/dL with clinical atherosclerotic cardiovascular disease). For renewal of therapy, 1) Patient meets all initial criteria AND 2) Has responded to therapy as demonstrated by a reduction in LDL-C.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year

PA Criteria	Criteria Details
Other Criteria	<p>Diagnosis of HoFH must be confirmed by one of the following: 1) Genetic diagnosis: Mutations in both alleles at LDL receptor, ApoB, PCSK9 or LDL receptor adaptor protein/ARH gene locus, or 2) Clinical diagnosis: Untreated LDL-C greater than 500 mg/dL or unknown untreated LDL-C with treated LDL-C greater than 300 mg/dL plus one of the following: a) Tendon or cutaneous xanthomas at age 10 or younger, or b) Diagnosis of FH by genetic analysis, Simon-Broome Diagnostic Criteria or Dutch Lipid Clinic Network Criteria in both parents, or c) Evidence of FH in both parents with a history including any of the following: Total cholesterol greater than or equal to 310 mg/dL, premature ASCVD [before 55 years in men and 60 years in women], tendon xanthoma, sudden premature cardiac death. Diagnosis of FH must be confirmed by one of the following: 1) Genetic diagnosis: An LDL-receptor mutation, familial defective apo B-100, or a PCSK9 gain-of-function mutation, or 2) Simon-Broome Diagnostic Criteria for FH: Total cholesterol greater than 290 mg/dL or LDL-C greater than 190 mg/dL, plus tendon xanthoma in patient, first-degree (parent, sibling or child) or second-degree relative (grandparent, uncle or aunt), or family history of myocardial infarction in a first degree relative before the age 60 or in a second degree relative before age 50, or total cholesterol greater than 290 mg/dL in an adult first or second degree relative, or total cholesterol greater than 260 mg/dL in a child, brother, or sister aged younger than 16 years, or 3) Dutch Lipid Clinic Network Criteria for FH: Total score greater than 5 points.</p>

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	All FDA-approved indications not otherwise excluded from Part D, medullary thyroid carcinoma.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

LETAIRIS

Products Affected

- Ambrisentan

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Pulmonary arterial hypertension (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

LIDOCAINE PATCHES

Products Affected

- Lidocaine External Patch 5 %

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, pain associated with diabetic neuropathy, pain associated with cancer-related neuropathy (including treatment-related neuropathy [e.g., neuropathy associated with radiation treatment or chemotherapy]).
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

LONSURF

Products Affected

- Lonsurf

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For colorectal cancer: The disease is unresectable advanced or metastatic. Patient has progressed on treatment with EITHER a) FOLFOXIRI (fluorouracil, leucovorin, oxaliplatin, and irinotecan) regimen OR b) irinotecan- AND oxaliplatin-based regimens.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

LORBRENA

Products Affected

- Lorbrena

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	Plan Year
Other Criteria	

LUMIZYME

Products Affected

- Lumizyme

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of Pompe disease was confirmed by an enzyme assay demonstrating a deficiency of acid alpha-glucosidase (GAA) enzyme activity or by genetic testing.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

LUPRON

Products Affected

- Leuprolide Acetate Injection
- Lupron Depot (1-Month) Intramuscular Kit 3.75 MG
- Lupron Depot (3-Month) Intramuscular Kit 11.25 MG
- Lupron Depot-Ped (1-Month)
- Lupron Depot-Ped (3-Month)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, in combination with growth hormone for children with growth failure and advancing puberty (leuprolide acetate only), breast cancer (3.75 mg and 11.25 mg only), malignant sex cord-stromal tumors (3.75 mg and 11.25 mg), epithelial ovarian cancer/fallopian tube cancer/primary peritoneal cancer (3.75 mg and 11.25 mg), preoperative use for uterine leiomyomata (3.75 mg and 11.25 mg).
Exclusion Criteria	
Required Medical Information	For central precocious puberty (CPP), patients not currently receiving therapy must meet all of the following criteria: 1) Diagnosis of CPP confirmed by: a) a pubertal response to a gonadotropin releasing hormone (GnRH) agonist test OR a pubertal level of a third generation luteinizing hormone (LH) assay AND b) assessment of bone age versus chronological age, and 2) The onset of secondary sexual characteristics occurred prior to 8 years of age for female patients OR prior to 9 years of age for male patients. For uterine fibroids, patient must meet one of the following: 1) Diagnosis of anemia (eg, hematocrit less than or equal to 30 percent and/or hemoglobin less than or equal to 10 g/dL), OR 2) the requested drug will be used prior to surgery for uterine fibroids.
Age Restrictions	CPP: Less than 12 years old if female and less than 13 years old if male.
Prescriber Restrictions	
Coverage Duration	Fibroids: 3 months (mo), max 6 mo total. Endometriosis: 6 mo, max 12 mo total. Others: Plan Year
Other Criteria	For prostate cancer: Use as neoadjuvant therapy prior to radical prostatectomy is not approvable.

LYNPARZA

Products Affected

- Lynparza Oral Tablet

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For HER2-negative, recurrent or metastatic breast cancer patient must meet both of the following criteria: 1) patient has a deleterious or suspected deleterious germline BRCA mutation, and 2) patient has received prior treatment with chemotherapy or endocrine therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

LYRICA CR

Products Affected

- Lyrica CR

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	Plan Year
Other Criteria	

MAVYRET

Products Affected

- Mavyret

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Decompensated cirrhosis/moderate or severe hepatic impairment (Child Turcotte Pugh class B or C)
Required Medical Information	Chronic hepatitis C infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions where applicable, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Criteria will be applied consistent with current AASLD-IDSA guidance.
Other Criteria	

MEGESTROL

Products Affected

- Megestrol Acetate Oral Suspension 625 MG/5ML

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	Plan Year
Other Criteria	

MEKINIST

Products Affected

- Mekinist

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For melanoma, tumor is positive for BRAF V600 activating mutation (e.g., BRAF V600E or BRAF V600K mutation).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

MEKTOVI

Products Affected

- Mektovi

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	Plan Year
Other Criteria	

MEMANTINE

Products Affected

- Memantine HCl ER
- Memantine HCl Oral Solution 2 MG/ML
- Memantine HCl Oral Tablet 10 MG, 5 MG

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	Plan Year
Other Criteria	This edit only applies to patients less than 30 years of age.

MODAFINIL

Products Affected

- Modafinil

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	1) Diagnosis is narcolepsy confirmed by sleep lab evaluation OR 2) Diagnosis is shift work disorder (SWD) OR 3) Diagnosis is obstructive sleep apnea (OSA) confirmed by polysomnography.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

MYLOTARG

Products Affected

- Mylotarg Intravenous Solution Reconstituted 4.5 MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, acute promyelocytic leukemia (APL).
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

NAGLAZYME

Products Affected

- Naglazyme

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of mucopolysaccharidosis VI disease was confirmed by an enzyme assay demonstrating a deficiency of N-acetylgalactosamine 4-sulfatase (arylsulfatase B) enzyme activity or by genetic testing.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

NATPARA

Products Affected

- Natpara

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Acute postsurgical hypoparathyroidism (within 6 months of surgery) and expected to recover from the hypoparathyroidism.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

NERLYNX

Products Affected

- Nerlynx

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	The requested medication is initiated within two years after completing adjuvant trastuzumab based therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

NEUPOGEN

Products Affected

- Neupogen Injection Solution 300 MCG/ML, 480 MCG/1.6ML
- Neupogen Injection Solution Prefilled Syringe

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, treatment of chemotherapy-induced febrile neutropenia (FN), following chemotherapy for acute lymphocytic leukemia (ALL), stem cell transplantation-related indications, myelodysplastic syndromes (MDS), agranulocytosis, aplastic anemia, HIV-related neutropenia, neutropenia related to renal transplantation.
Exclusion Criteria	Use of the requested product within 24 hours prior to or following chemotherapy or radiotherapy.
Required Medical Information	For prophylaxis or treatment of myelosuppressive chemotherapy-induced FN patients must meet all of the following: 1) Patient has a non-myeloid cancer, 2) Patient has received, is currently receiving, or will be receiving treatment with myelosuppressive anti-cancer therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	

NEXAVAR

Products Affected

- NexAVAR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, acute myeloid leukemia, soft tissue sarcoma subtypes: angiosarcoma, desmoid tumors (aggressive fibromatosis), gastrointestinal stromal tumor (GIST), medullary thyroid carcinoma, osteosarcoma, chordoma.
Exclusion Criteria	
Required Medical Information	For renal cell carcinoma: the patient has relapsed, metastatic, or unresectable disease. For thyroid carcinoma: histology is follicular, papillary, Hurthle cell or medullary. For acute myeloid leukemia: 1) the disease is relapsed or refractory, and 2) the patient has FLT3-ITD mutation-positive disease.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

NINLARO

Products Affected

- Ninlaro

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	The requested drug will be used in combination with lenalidomide and dexamethasone, pomalidomide and dexamethasone, or dexamethasone therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

NITYR

Products Affected

- Nityr

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of hereditary tyrosinemia type 1 is confirmed by one of the following: 1) biochemical testing (e.g., detection of succinylacetone in urine) or 2) DNA testing (mutation analysis).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

NORTHERA

Products Affected

- Northera

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Prior to initial therapy, patient has a persistent, consistent decrease in systolic blood pressure of at least 20 mmHg OR decrease in diastolic blood pressure of at least 10 mmHg within 3 minutes of standing. The requested drug will be used for patients with neurogenic orthostatic hypotension associated with one of the following diagnoses: 1) Primary autonomic failure due to Parkinson's disease, multiple system atrophy, or pure autonomic failure, OR 2) Dopamine beta hydroxylase deficiency, OR 3) Non-diabetic autonomic neuropathy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	Patients currently on Northera must experience a sustained decrease in dizziness.

NUBEQA

Products Affected

- Nubeqa

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	Plan Year
Other Criteria	

NUEDEXTA

Products Affected

- Nuedexta

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	Plan Year
Other Criteria	

NUPLAZID

Products Affected

- Nuplazid

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	Plan Year
Other Criteria	

OCTREOTIDE

Products Affected

- Octreotide Acetate Injection Solution 100 MCG/ML, 1000 MCG/ML, 200 MCG/ML, 50 MCG/ML, 500 MCG/ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, meningiomas, thymomas and thymic carcinomas, and neuroendocrine tumors (NETs) of the gastrointestinal (GI) tract, thymus, lung, pancreas and adrenal gland.
Exclusion Criteria	
Required Medical Information	For acromegaly: 1) Patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender, and 2) Patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy. For NETs of the GI tract, thymus, and lung: patient has metastatic or unresectable disease. For meningiomas: patient has unresectable disease.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	For acromegaly continuation of therapy: patient's IGF-1 level has decreased or normalized since initiation of therapy.

ODOMZO

Products Affected

- Odomzo

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	Plan Year
Other Criteria	

OFEV

Products Affected

- Ofev

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For idiopathic pulmonary fibrosis: Initial Review Only: The patient does not have a known etiology for interstitial lung disease and meets one of the following: 1) a high-resolution computed tomography (HRCT) study of the chest or surgical lung biopsy reveals the usual interstitial pneumonia (UIP) pattern, or 2) HRCT study of the chest reveals a possible UIP pattern and the diagnosis is supported either by surgical lung biopsy or by a multidisciplinary discussion between at least a radiologist and pulmonologist who are experienced in idiopathic pulmonary fibrosis if surgical lung biopsy has not been conducted. For idiopathic pulmonary fibrosis continuation: The patient does not have a known etiology for interstitial lung disease.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

ONFI

Products Affected

- CloBAZam

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	2 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

OPSUMIT

Products Affected

- Opsumit

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Pulmonary arterial hypertension (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

ORAL-INTRANASAL FENTANYL

Products Affected

- FentaNYL Citrate Buccal
- Fentora Buccal Tablet 100 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	1) The requested drug is indicated for the treatment of breakthrough CANCER related pain only. The requested drug is being prescribed for the management of breakthrough pain in a CANCER patient who is currently receiving around-the-clock opioid therapy for underlying CANCER pain AND 2) The ICD diagnosis code provided supports the CANCER RELATED diagnosis [Note: For drug coverage approval, ICD diagnosis code provided MUST support the CANCER RELATED diagnosis.]
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

ORFADIN

Products Affected

- Orfadin

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of hereditary tyrosinemia type 1 is confirmed by one of the following: 1) biochemical testing (e.g., detection of succinylacetone in urine) or 2) DNA testing (mutation analysis).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

ORKAMBI

Products Affected

- Orkambi

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	The patient is positive for the F508del mutation on both alleles of the cystic fibrosis transmembrane conductance regulator (CFTR) gene.
Age Restrictions	2 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	The requested drug will not be used in combination with ivacaftor or tezacaftor/ivacaftor.

OXANDROLONE

Products Affected

- Oxandrolone Oral

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, Cachexia associated with AIDS (HIV-wasting) or to enhance growth in patients with Turner's Syndrome.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	

PEGASYS

Products Affected

- Pegasys ProClick Subcutaneous Solution 180 MCG/0.5ML
- Pegasys Subcutaneous Solution

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, myeloproliferative neoplasm (essential thrombocythemia, polycythemia vera, primary myelofibrosis and post-polycythemia vera or post-essential thrombocythemia myelofibrosis).
Exclusion Criteria	
Required Medical Information	For chronic hepatitis C (CHC): CHC infection confirmed by presence of HCV RNA in serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions where applicable, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD-IDSA treatment guidelines.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	HCV=Criteria will be applied consistent with current AASLD-IDSA guidance. HBV=48 wks. Other=Plan Yr
Other Criteria	

PHENYLBUTYRATE

Products Affected

- Sodium Phenylbutyrate Oral Powder 3 GM/TSP
- Sodium Phenylbutyrate Oral Tablet

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of urea cycle disorder (UCD) was confirmed by enzymatic, biochemical or genetic testing.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

PIQRAY

Products Affected

- Piqray (200 MG Daily Dose)
- Piqray (250 MG Daily Dose)
- Piqray (300 MG Daily Dose)

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	Plan Year
Other Criteria	

POMALYST

Products Affected

- Pomalyst

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, systemic light chain amyloidosis.
Exclusion Criteria	
Required Medical Information	Multiple myeloma: The patient has previously received at least two prior therapies for multiple myeloma, including an immunomodulatory agent (i.e., thalidomide, lenalidomide) AND a proteasome inhibitor (ie, bortezomib, carfilzomib, ixazomib).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

PRALUENT

Products Affected

- Praluent Subcutaneous Solution Auto-Injector

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	Plan Year
Other Criteria	

PROMACTA

Products Affected

- Promacta

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For chronic or persistent immune thrombocytopenia (ITP): 1) For new starts: a) patient has had an inadequate response or is intolerant to corticosteroids, immunoglobulins or splenectomy, AND b) untransfused platelet count at any point prior to the requested medication is less than 30,000/mcL OR 30,000-50,000/mcL with symptomatic bleeding or risk factor(s) for bleeding. 2) For continuation of therapy, platelet (plt) count response to the requested drug: a) current plt count is less than or equal to 200,000/mcL OR b) current plt count is greater than 200,000/mcL and dosing will be adjusted to a plt count sufficient to avoid clinically important bleeding. For thrombocytopenia associated with chronic hepatitis C: 1) For new starts: the requested drug is used for initiation and maintenance of interferon-based therapy. 2) For continuation of therapy: patient is receiving interferon-based therapy. For severe aplastic anemia (AA): 1) For continuation of therapy, plt count response to the requested drug: a) current plt count is 50,000-200,000/mcL, OR b) current plt count is less than 50,000/mcL and patient has not received appropriately titrated therapy for at least 16 weeks, OR c) current plt count is less than 50,000/mcL and patient is transfusion-independent, OR d) current plt count is greater than 200,000/mcL and dosing will be adjusted to achieve and maintain an appropriate target plt count.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	HCV:6mo, INITIAL: ITP/AA-6mo, REAUTH: 1) ITP/AA APR-Plan Yr, 2) AA IPR-16wks
Other Criteria	APR: adequate platelet response (greater than 50k/mcL), IPR: inadequate platelet response (less than 50k/mcL)

PULMOZYME

Products Affected

- Pulmozyme

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of cystic fibrosis was confirmed by appropriate diagnostic or genetic testing.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

QUININE SULFATE

Products Affected

- QuiNINE Sulfate Oral

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, Babesiosis, uncomplicated Plasmodium vivax malaria.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 month
Other Criteria	

REGRANEX

Products Affected

- Regranex

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For the treatment of lower extremity diabetic neuropathic ulcers that extend into the subcutaneous tissue or beyond and have an adequate blood supply.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	20 weeks
Other Criteria	

RELISTOR INJ

Products Affected

- Relistor Subcutaneous Solution

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	1) The requested drug is being prescribed for opioid-induced constipation in an adult patient with advanced illness or pain caused by active cancer who requires opioid dosage escalation for palliative care OR 2) The requested drug is being prescribed for opioid-induced constipation in an adult patient with chronic non-cancer pain, including chronic pain related to prior cancer or its treatment who does not require frequent (e.g., weekly) opioid dosage escalation AND 3) The patient is unable to tolerate oral medications OR 4) An oral drug indicated for opioid-induced constipation in an adult patient with chronic non-cancer pain has been tried. (Note: Examples are Amitiza or Movantik) AND 5) The patient experienced an inadequate treatment response or intolerance to an oral drug indicated for opioid-induced constipation in an adult patient with chronic non-cancer pain. (Note: Examples are Amitiza or Movantik) OR 6) The patient has a contraindication to an oral drug indicated for opioid-induced constipation in an adult patient with chronic non-cancer pain (Note: Examples are Amitiza or Movantik).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	4 Months
Other Criteria	

REMICADE

Products Affected

- Remicade

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, axial spondyloarthritis, Behcet's syndrome, granulomatosis with polyangiitis (Wegener's granulomatosis), hidradenitis suppurativa, juvenile idiopathic arthritis, pyoderma gangrenosum, sarcoidosis, Takayasu's arteritis, uveitis.
Exclusion Criteria	
Required Medical Information	For moderately to severely active Crohn's disease (new starts only): 1) Patient has fistulizing disease OR 2) inadequate response or intolerance to a self-injectable tumor necrosis factor (TNF) inhibitor (e.g., adalimumab). For moderately to severely active ulcerative colitis (new starts only): 1) Inadequate response to at least one conventional therapy (e.g., corticosteroids, sulfasalazine, azathioprine, mesalamine) OR 2) intolerance or contraindication to conventional therapy. For moderately to severely active rheumatoid arthritis (new starts only): 1) Will be used in combination with methotrexate (MTX) or leflunomide OR patient has intolerance or contraindication to MTX or leflunomide AND 2) inadequate response or intolerance to a self-injectable tumor necrosis factor (TNF) inhibitor (e.g., adalimumab) or a targeted synthetic disease-modifying antirheumatic drug (DMARD) (e.g., tofacitinib). For active ankylosing spondylitis and axial spondyloarthritis (new starts only): 1) Inadequate response to a non-steroidal anti-inflammatory drug (NSAID) trial OR 2) intolerance or contraindication to NSAIDs. For moderate to severe chronic plaque psoriasis (new starts only): 1) At least 5% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at time of diagnosis, AND 2) inadequate response or intolerance to a self-injectable tumor necrosis factor (TNF) inhibitor (e.g., adalimumab). For juvenile idiopathic arthritis (new starts only): Inadequate response or intolerance to a self-injectable tumor necrosis factor (TNF) inhibitor (e.g., adalimumab). For hidradenitis suppurativa (new starts only): patient has severe, refractory disease. For uveitis (new starts only): Patient has experienced an inadequate response or intolerance or has a contraindication to a trial of immunosuppressive therapy for uveitis (e.g., methotrexate, azathioprine, or mycophenolate mofetil).
Age Restrictions	

PA Criteria	Criteria Details
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

REVLIMID

Products Affected

- Revlimid

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, systemic light chain amyloidosis, classical Hodgkin lymphoma, myelofibrosis-associated anemia, non-Hodgkin's lymphoma with the following subtypes: chronic lymphocytic leukemia/small lymphocytic lymphoma, AIDS-related diffuse large B-cell lymphoma, primary effusion lymphoma, lymphoma associated with Castleman's disease, diffuse large B-cell lymphoma, follicular lymphoma, nongastric/gastric MALT lymphoma, primary cutaneous B-cell lymphoma, splenic/nodal marginal zone lymphoma, multicentric Castleman's disease, adult T-cell leukemia/lymphoma, mycosis fungoides/Sezary syndrome, angioimmunoblastic T-cell lymphoma, peripheral T-cell lymphoma not otherwise specified, enteropathy-associated T-cell lymphoma and primary cutaneous anaplastic large cell lymphoma.
Exclusion Criteria	
Required Medical Information	Myelodysplastic syndrome (MDS): Low- to intermediate-1 risk MDS with symptomatic anemia
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

RITUXAN

Products Affected

- Rituxan Intravenous Solution

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, non-Hodgkin's lymphoma subtypes [small lymphocytic lymphoma (SLL), mantle cell lymphoma, marginal zone lymphomas (nodal, splenic, MALT), Burkitt lymphoma, primary cutaneous B-cell lymphoma, Castleman's disease, AIDS-related B-cell lymphoma, hairy cell leukemia, post-transplant lymphoproliferative disorder (PTLD), lymphoblastic lymphoma], refractory immune or idiopathic thrombocytopenic purpura (ITP), autoimmune hemolytic anemia, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, chronic graft-versus-host disease (GVHD), Sjogren syndrome, thrombotic thrombocytopenic purpura, refractory myasthenia gravis, Hodgkin's lymphoma (nodular lymphocyte-predominant), primary CNS lymphoma, leptomeningeal metastases from lymphomas, acute lymphoblastic leukemia, prevention of Epstein-Barr virus (EBV)-related PTLT, multiple sclerosis.
Exclusion Criteria	
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): 1) The requested medication is used in combination with methotrexate (MTX) unless MTX is contraindicated or not tolerated AND 2) Patient has an inadequate response, intolerance or contraindication to a self-injectable tumor necrosis factor (TNF) inhibitor (e.g., adalimumab) or a targeted synthetic disease-modifying antirheumatic drug (DMARD) (e.g., tofacitinib). Hematologic malignancies must be CD20-positive. For Wegener's Granulomatosis (WG) and Microscopic Polyangiitis (MPA): The requested medication will be used in combination with glucocorticoids. For multiple sclerosis: 1) Patient has a diagnosis of relapsing remitting multiple sclerosis and 2) Patient has had an inadequate response to two or more disease-modifying drugs indicated for multiple sclerosis despite adequate duration of treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year

PA Criteria	Criteria Details
Other Criteria	

RITUXAN HYCELA

Products Affected

- Rituxan Hycela

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Malignancies must be CD20 positive. Patient must receive at least one full dose of a rituximab product by intravenous infusion without experiencing severe adverse reactions.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

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	Plan Year
Other Criteria	

RUBRACA

Products Affected

- Rubraca

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	Plan Year
Other Criteria	

RYDAPT

Products Affected

- Rydapt

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For newly diagnosed FLT3 mutation-positive acute myeloid leukemia (AML), the requested medication is/was used in combination with standard cytarabine with daunorubicin or idarubicin induction followed by cytarabine consolidation chemotherapy.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

SIGNIFOR

Products Affected

- Signifor

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Patient has had pituitary surgery that was not curative or the patient is not a candidate for surgery.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

SILDENAFIL

Products Affected

- Sildenafil Citrate Oral Tablet 20 MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Pulmonary arterial hypertension (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

SIRTURO

Products Affected

- Sirturo

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	The requested drug is being prescribed for the treatment of latent infection due to <i>Mycobacterium tuberculosis</i> , drug-sensitive tuberculosis, extra-pulmonary tuberculosis, or infection caused by the non-tuberculous mycobacteria
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 Months
Other Criteria	

SOMATULINE DEPOT

Products Affected

- Somatuline Depot Subcutaneous Solution 120 MG/0.5ML, 60 MG/0.2ML, 90 MG/0.3ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, neuroendocrine tumors (NETs) of the gastrointestinal (GI) tract, thymus, lung, pancreas, and adrenal gland.
Exclusion Criteria	
Required Medical Information	For acromegaly: 1) Patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender, and 2) Patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy. For NETs of the GI tract, thymus, and lung: patient has metastatic or unresectable disease.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	For acromegaly continuation of therapy: patient's IGF-1 level has decreased or normalized since initiation of therapy.

SOMAVERT

Products Affected

- Somavert

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Patient meets both of the following criteria: 1) Patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender, and 2) Patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	For continuation of therapy: patient's IGF-1 level has decreased or normalized since initiation of therapy.

SPRYCEL

Products Affected

- Sprycel

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, gastrointestinal stromal tumor (GIST).
Exclusion Criteria	
Required Medical Information	For chronic myelogenous leukemia (CML) or acute lymphoblastic leukemia (ALL), diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, 1) patient has received a hematopoietic stem cell transplant, OR 2) Patient has accelerated or blast phase CML, OR 3) For chronic phase CML, patient has one of the following a) patient is 21 years of age or younger, or b) high or intermediate risk for disease progression, or c) low risk for disease progression and has experienced resistance, intolerance or toxicity to imatinib or an alternative tyrosine kinase inhibitor. If patient experienced resistance to imatinib or an alternative tyrosine kinase inhibitor for CML, patient is negative for T315I mutation. For GIST, patient must have PDGFRA D842V mutation and disease progression on imatinib, sunitinib, or regorafenib.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

STIVARGA

Products Affected

- Stivarga

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, progressive GIST.
Exclusion Criteria	
Required Medical Information	For colorectal cancer: The disease is unresectable advanced or metastatic. The patient has progressed on treatment with EITHER a) FOLFOXIRI (fluorouracil, leucovorin, oxaliplatin, and irinotecan) regimen OR b) irinotecan- AND oxaliplatin-based regimens.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

SUTENT

Products Affected

- Sutent

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, thyroid carcinoma (follicular, papillary, Hurthle cell, or medullary), angiosarcoma, solitary fibrous tumor, hemangiopericytoma, chordoma (bone cancer), thymic carcinoma.
Exclusion Criteria	
Required Medical Information	For renal cell carcinoma: Either 1) The disease is relapsed, metastatic, or unresectable, OR 2) The patient is at high risk of disease recurrence following nephrectomy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

SYLATRON

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, myelofibrosis, polycythemia vera, essential thrombocythemia.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

SYMDEKO

Products Affected

- Symdeko

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	The patient is positive for the F508del mutation on both alleles of the cystic fibrosis transmembrane conductance regulator (CFTR) gene or the patient has a mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to tezacaftor/ivacaftor potentiation based on clinical and/or in vitro assay data. If the patient's genotype is unknown, an FDA-cleared cystic fibrosis mutation test should be used to detect the presence of a CFTR mutation
Age Restrictions	6 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	Symdeko will not be used in combination with Orkambi or Kalydeco.

SYMPAZAN

Products Affected

- Sympazan

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	2 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

SYNRIBO

Products Affected

- Synribo

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For chronic myeloid leukemia (CML), the patient has experienced resistance, toxicity or intolerance to prior therapy with at least two tyrosine kinase inhibitors (TKIs) (eg, imatinib, dasatinib, nilotinib, bosutinib, ponatinib).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

TAFINLAR

Products Affected

- Tafinlar

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, brain metastases from melanoma.
Exclusion Criteria	
Required Medical Information	For melanoma (including brain metastases), tumor is positive for a BRAF V600 activating mutation (e.g., BRAF V600E or BRAF V600K mutation). For NSCLC, tumor is positive for a BRAF V600 activating mutation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

TAGRISSEO

Products Affected

- Tagrisso

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, EGFR mutation-positive recurrent or metastatic non-small cell lung cancer, brain metastases if active against primary tumor (EGFR T790M mutation-positive non-small cell lung cancer).
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

TALZENNA

Products Affected

- Talzenna

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	Plan Year
Other Criteria	

TARCEVA

Products Affected

- Erlotinib HCl
- Tarceva

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, chordoma, renal cell carcinoma (RCC).
Exclusion Criteria	
Required Medical Information	For non-small cell lung cancer, patient has a known sensitizing EGFR mutation. For pancreatic cancer, the disease is locally advanced, unresectable, or metastatic.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

TASIGNA

Products Affected

- Tasigna

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), gastrointestinal stromal tumor (GIST).
Exclusion Criteria	
Required Medical Information	For CML or ALL, diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, 1) patient has received a hematopoietic stem cell transplant, OR 2) patient has accelerated or blast phase CML, OR 3) For chronic phase CML, the patient has one of the following: a) patient is 18 years of age or younger, b) high or intermediate risk for disease progression, or c) low risk for disease progression and has experienced resistance, intolerance or toxicity to imatinib or an alternative tyrosine kinase inhibitor. If patient experienced resistance to imatinib or an alternative tyrosine kinase inhibitor for CML, patient is negative for T315I mutation. For GIST, patient must have progressed on imatinib, sunitinib or regorafenib.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

TAZAROTENE

Products Affected

- Tazarotene External
- Tazorac External Cream 0.05 %

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For plaque psoriasis, the requested drug is being prescribed to treat less than 20 percent of the patient's body surface area.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

TECENTRIQ

Products Affected

- Tecentriq

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	Plan Year
Other Criteria	

TETRABENAZINE

Products Affected

- Tetrabenazine

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, chronic tics, tardive dyskinesia, hemiballismus, chorea not associated with Huntington's disease.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

THALOMID

Products Affected

- Thalomid

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, myelofibrosis-related anemia, systemic light chain amyloidosis, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, recurrent aphthous stomatitis, recurrent HIV-associated aphthous ulcers, cachexia, HIV-associated diarrhea, Kaposi's sarcoma, Behcet's syndrome, chronic graft-versus-host disease, Crohn's disease, multicentric Castleman's disease.
Exclusion Criteria	
Required Medical Information	Cachexia: Cachexia must be due to cancer or HIV infection. Kaposi's sarcoma: The patient has HIV infection.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

TIBSOVO

Products Affected

- Tibsovo

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	Plan Year
Other Criteria	

TOBRAMYCIN

Products Affected

- Tobramycin Inhalation

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, non-cystic fibrosis bronchiectasis.
Exclusion Criteria	
Required Medical Information	Pseudomonas aeruginosa is present in the patient's airway cultures OR the patient has a history of pseudomonas aeruginosa infection or colonization in the airways.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

TOPICAL LIDOCAINE

Products Affected

- Glydo External Gel
- Lidocaine External Ointment
- Lidocaine HCl External Gel
- Lidocaine HCl External Solution
- Lidocaine HCl Urethral/Mucosal External Gel
- Lidocaine-Prilocaine External Cream

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	1) The requested drug is being used for topical anesthesia, 2) If the requested drug will be used as part of a compounded product, then all the active ingredients in the compounded product are FDA-approved for topical use
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Months
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

TOPICAL TESTOSTERONES

Products Affected

- Androderm Transdermal Patch 24 Hour
- Testosterone Transdermal Gel 12.5 MG/ACT (1%), 25 MG/2.5GM (1%), 50 MG/5GM (1%)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	1) Request is for continuation of testosterone therapy and requested drug is being prescribed for hypogonadism in a male patient or a patient that self-identifies as male who had a confirmed low testosterone level according to current practice guidelines or your standard male lab reference values before starting testosterone therapy OR 2) Request is not for continuation of testosterone therapy and requested drug is being prescribed for hypogonadism in a male patient or a patient that self-identifies as male who has at least two confirmed low testosterone levels according to current practice guidelines or your standard male lab reference values.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

TOPICAL TRETINOIN

Products Affected

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

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	Plan Year
Other Criteria	

TRELSTAR

Products Affected

- Trelstar Mixject Intramuscular Suspension
Reconstituted 11.25 MG, 3.75 MG

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	Plan Year
Other Criteria	Use as neoadjuvant therapy prior to radical prostatectomy is not approvable.

TREPROSTINIL INJ

Products Affected

- Remodulin Injection Solution 1 MG/ML, 10 MG/ML, 2.5 MG/ML, 5 MG/ML
- Treprostinil

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Pulmonary arterial hypertension (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

TRIENTINE

Products Affected

- Trientine HCl

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	Plan Year
Other Criteria	

TURALIO

Products Affected

- Turalio

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	Plan Year
Other Criteria	

TYKERB

Products Affected

- Tykerb

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, metastatic CNS lesions from HER2-positive breast cancer.
Exclusion Criteria	
Required Medical Information	For HER2-positive breast cancer, the requested drug will be used in combination with: 1) aromatase inhibitor (e.g., anastrozole, letrozole, exemestane), or 2) capecitabine, or 3) trastuzumab.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

TYMLOS

Products Affected

- Tymlos

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For postmenopausal osteoporosis: patient has ONE of the following (1. or 2.): 1) A history of fragility fractures, OR 2) A pre-treatment T-score of less than or equal to -2.5 or osteopenia with a high pre-treatment FRAX fracture probability and patient has ANY of the following: a) Indicators for higher fracture risk (e.g., advanced age, frailty, glucocorticoid therapy, very low T-scores, or increased fall risk), OR b) Patient has failed prior treatment with or is intolerant to a previous osteoporosis therapy (i.e., oral bisphosphonates or injectable antiresorptive agents)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 months lifetime total for parathyroid hormone analogs (e.g., abaloparatide or teriparatide)
Other Criteria	Patient has high FRAX fracture probability if the 10 year probability is either greater than or equal to 20% for any major osteoporotic fracture or greater than or equal to 3% for hip fracture

VALCHLOR

Products Affected

- Valchlor

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, chronic or smoldering adult T-cell leukemia/lymphoma, mycosis fungoides, primary cutaneous marginal zone lymphoma, primary cutaneous follicle center lymphoma, lymphomatoid papulosis.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

VELCADE

Products Affected

- Bortezomib
- Velcade Injection

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, systemic light chain amyloidosis, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, multicentric Castleman's disease.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

VENCLEXTA

Products Affected

- Venclexta
- Venclexta Starting Pack

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, small lymphocytic lymphoma, mantle cell lymphoma.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

VENTAVIS

Products Affected

- Ventavis

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Pulmonary arterial hypertension (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

VERSACLOZ

Products Affected

- Versacloz

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	Plan Year
Other Criteria	

VERZENIO

Products Affected

- Verzenio

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	Plan Year
Other Criteria	

VIGABATRIN

Products Affected

- Vigabatrin
- Vigadrone

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For complex partial seizures (CPS): patient had an inadequate response to at least 2 alternative therapies for CPS (e.g., carbamazepine, phenytoin, levetiracetam, topiramate, oxcarbazepine or lamotrigine).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

VITRAKVI

Products Affected

- Vitrakvi

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	Plan Year
Other Criteria	

VIZIMPRO

Products Affected

- Vizimpro

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	Plan Year
Other Criteria	

VOSEVI

Products Affected

- Vosevi

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Decompensated cirrhosis/moderate or severe hepatic impairment (Child Turcotte Pugh class B or C)
Required Medical Information	Chronic hepatitis C infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions where applicable, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Criteria will be applied consistent with current AASLD-IDSA guidance.
Other Criteria	

VOTRIENT

Products Affected

- Votrient

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, thyroid carcinoma (follicular, papillary, Hurthle cell, or medullary), uterine sarcoma, ovarian cancer (epithelial ovarian, fallopian tube, or primary peritoneal).
Exclusion Criteria	
Required Medical Information	For renal cell carcinoma: The disease is relapsed, metastatic, or unresectable. For soft tissue sarcoma (STS): 1) The patient does not have an adipocytic soft tissue sarcoma, AND 2) The patient has one of the following subtypes of STS: a) gastrointestinal stromal tumor (GIST), b) angiosarcoma, c) pleomorphic rhabdomyosarcoma, d) retroperitoneal/intra-abdominal sarcoma, or e) extremity/superficial trunk, head/neck sarcoma.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

VRAYLAR

Products Affected

- Vraylar

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following: lurasidone, aripiprazole, olanzapine, paliperidone, quetiapine, risperidone, or ziprasidone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

XALKORI

Products Affected

- Xalkori

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, non-small cell lung cancer (NSCLC) with high-level MET amplification or MET exon 14 skipping mutation, inflammatory myofibroblastic tumors (IMT).
Exclusion Criteria	
Required Medical Information	For IMT, the tumor is ALK-positive.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

XELJANZ

Products Affected

- Xeljanz
- Xeljanz XR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): Patient meets at least one of the following criteria: 1) Inadequate response, intolerance or contraindication to methotrexate (MTX), OR 2) Inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) (e.g., adalimumab). For active psoriatic arthritis (new starts only): Patient meets BOTH of the following criteria: 1) Inadequate response to methotrexate (MTX) or other nonbiologic disease-modifying antirheumatic drugs (DMARDs) (e.g., leflunomide, sulfasalazine, etc.) OR a prior biologic DMARD (e.g., adalimumab), AND 2) The requested drug is used in combination with a nonbiologic DMARD (e.g., methotrexate, leflunomide, sulfasalazine, etc.). For moderately to severely active ulcerative colitis (new starts only): Patient meets at least one of the following criteria: 1) Inadequate response, intolerance or contraindication to at least one conventional therapy option (e.g., oral aminosalicylates, corticosteroids), or 2) Inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) (e.g., adalimumab)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

XGEVA

Products Affected

- Xgeva

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For hypercalcemia of malignancy, condition is refractory to intravenous (IV) bisphosphonate therapy (eg, zoledronic acid, pamidronate) or there is a clinical reason to avoid IV bisphosphonate therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

XIFAXAN

Products Affected

- Xifaxan Oral Tablet 550 MG

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	Reduction in risk of overt hepatic encephalopathy recurrence-6 Months, IBS-D - Plan Year
Other Criteria	

XOLAIR

Products Affected

- Xolair

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For allergic asthma initial therapy: 1) Patient has positive skin test (or blood test) to at least 1 perennial aeroallergen, 2) Patient has baseline IgE level greater than or equal to 30 IU/mL, 3) Patient has inadequate asthma control despite current treatment with both of the following medications at optimized doses: a) Inhaled corticosteroid, b) Additional controller (long acting beta2-agonist, leukotriene modifier, or sustained-release theophylline) unless patient has an intolerance or contraindication to such therapies. For allergic asthma continuation therapy only: Patient's asthma control has improved on the requested drug since initiation of therapy. Chronic idiopathic urticaria (CIU) initial therapy: 1) Patient has been evaluated for other causes of urticaria, including bradykinin-related angioedema and IL-1-associated urticarial syndromes (auto-inflammatory disorders, urticarial vasculitis), 2) Patient has experienced a spontaneous onset of wheals, angioedema, or both, for at least 6 weeks. For CIU continuation therapy: Patient has experienced a response (e.g., improved symptoms) since initiation of therapy.
Age Restrictions	For CIU: 12 years of age or older. For allergic asthma: 6 years of age or older.
Prescriber Restrictions	
Coverage Duration	Allergic asthma: Plan Year. CIU initial: 6 months. CIU continuation: Plan Year.
Other Criteria	

XOSPATA

Products Affected

- Xospata

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

XPOVIO

Products Affected

- Xpovio (100 MG Once Weekly)
- Xpovio (60 MG Once Weekly)
- Xpovio (80 MG Once Weekly)
- Xpovio (80 MG Twice Weekly)

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	Plan Year
Other Criteria	

XTANDI

Products Affected

- Xtandi

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	The requested drug will be used to treat prostate cancer.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

XYREM

Products Affected

- Xyrem

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	1) The drug is being prescribed for the treatment of excessive daytime sleepiness in a patient with narcolepsy AND 2) The patient experienced an inadequate treatment response or intolerance to at least one CNS stimulant drug and one CNS promoting wakefulness drug OR 3) the patient has a contraindication to at least one CNS stimulant drug and one CNS wakefulness promoting drug (NOTE: Examples of a CNS stimulant drug are amphetamine, dextroamphetamine, or methylphenidate. Example of a CNS wakefulness promoting drug is armodafinil. Coverage of armodafinil or amphetamines or methylphenidates may require prior authorization). OR 4) The drug is being prescribed for the treatment of cataplexy in a patient with narcolepsy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	If the request is for the continuation of Xyrem (sodium oxybate), then the patient experienced a decrease in daytime sleepiness with narcolepsy or a decrease in cataplexy episodes with narcolepsy.

ZAVESCA

Products Affected

- Miglustat

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of Gaucher disease was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

ZEJULA

Products Affected

- Zejula

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	Plan Year
Other Criteria	Treatment is being started or was started no later than 8 weeks after the most recent platinum-based chemotherapy.

ZELBORAF

Products Affected

- Zelboraf

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, brain metastases from melanoma, non-small cell lung cancer, hairy cell leukemia, and thyroid carcinoma (papillary, follicular, and Hurthle).
Exclusion Criteria	
Required Medical Information	For melanoma (including brain metastases), tumor is positive for BRAF V600 activating mutation (e.g., BRAF V600E or BRAF V600K mutation). For non-small cell lung cancer, tumor is positive for the BRAF V600E mutation. For thyroid carcinoma the tumor is positive for BRAF mutation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

ZEPATIER

Products Affected

- Zepatier

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Decompensated cirrhosis/moderate or severe hepatic impairment (Child Turcotte Pugh class B or C)
Required Medical Information	Chronic hepatitis C infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions (eg, NS5A polymorphisms) where applicable, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD-IDSA treatment guidelines.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Criteria will be applied consistent with current AASLD-IDSA guidance.
Other Criteria	

ZOLINZA

Products Affected

- Zolinza

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, mycosis fungoides, Sezary syndrome.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

ZYDELIG

Products Affected

- Zydelig

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, relapsed or refractory chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL), refractory, relapsed or progressive follicular lymphoma, and marginal zone lymphomas [nodal marginal zone lymphoma, gastric mucosa associated lymphoid tissue (MALT) lymphoma, non-gastric MALT lymphoma, and splenic marginal zone lymphoma].
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

ZYKADIA

Products Affected

- Zykadia

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, anaplastic lymphoma kinase (ALK)-positive inflammatory myofibroblastic tumor.
Exclusion Criteria	
Required Medical Information	For non-small cell lung cancer (NSCLC), the requested medication is used for the treatment of recurrent or metastatic ALK-positive NSCLC. For inflammatory myofibroblastic tumor, the tumor is ALK-positive.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

ZYPREXA RELPREVV

Products Affected

- ZyPREXA Relprevv

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Tolerability with oral olanzapine has been established.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

ZYTIGA

Products Affected

- Abiraterone Acetate
- Zytiga Oral Tablet 500 MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D and newly diagnosed metastatic or high-risk locally advanced prostate cancer.
Exclusion Criteria	
Required Medical Information	For metastatic castration-resistant prostate cancer: The requested drug will be used in combination with prednisone. For castration-sensitive metastatic or locally advanced prostate cancer: 1) The requested drug will be used in combination with prednisone and concurrent androgen-deprivation therapy. Androgen deprivation therapy is not required in patients who have had bilateral orchiectomy, 2) Disease is newly diagnosed and metastatic, node-positive, high-risk locally advanced, or was previously treated with radical surgery or radiotherapy and is now relapsing with high risk features.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

