# Medicare Part D

Prior Authorization Requirements

The medications in this document have requirements that must be met for coverage on our Medicare plans to be considered.

Contract Year: 2014
Last Updated: 11/2014

## Actemra

**Drugs**
Actemra intravenous

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

**Exclusion Criteria**

**Required Medical Information**
Rheumatoid arthritis(RA)-diagnosis established by a rheumatologist or meets 4 of 7 criteria of the American College of Rheumatology Classification Criteria for Establishing the Diagnosis of Rheumatoid Arthritis AND methotrexate is ineffective after a minimum 6 to 12 week treatment course based on documentation of the American College of Rheumatology Assessment Components for Improvement in Rheumatoid Arthritis except where methotrexate is contraindicated or not tolerated based on clinical documentation AND infliximab(Remicade)was not effective after a minimum 12 week treatment course or has not been tolerated unless contraindicated. Systemic juvenile idiopathic arthritis-a diagnosis of SJIA/Still's disease with disease activity greater than 6 months confirmed by a rheumatologist AND treatment with at least one oral systemic agent for SJIA/Still's disease, such as methotrexate or glucocorticiods (e.g. prednisone), was ineffective or not tolerated.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
6 months initially then annually

**Other Criteria**

## Afinitor

**Drugs**
Afinitor, Afinitor Disperz

**Covered Uses**
All FDA-approved indications not otherwise excluded from Part D,  Waldenstrom's macroglobulinemia.

**Exclusion Criteria**

**Required Medical Information**
Diagnosis of renal cell carcinoma where sunitinib(Sutent) has been ineffective, is contraindicated or was not tolerated OR diagnosis of pancreatic neuroendocrine tumor when prior therapy with sunitinib(Sutent) has been ineffective, is contraindicated or was not tolerated OR a diagnosis of Waldenstrom's macroglobulinemia OR diagnosis of Subependymal Giant Cell Astrocytoma (SEGA) associated with tuberous sclerosis when surgical resection is not an option AND the condition is associated with functional impairment OR a diagnosis of hormone receptor-positive, HER2-negative recurrent or progressive breast cancer when given with exemestane AND prior treatment with anastrozole or letrozole was not effective OR a diagnosis of renal angiomyolipoma and tuberous sclerosis complex.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
12 months

**Other Criteria**

## Alimta

**Drugs**
Alimta

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

**Exclusion Criteria**

**Required Medical Information**
A diagnosis of mesothelioma OR a diagnosis of locally advanced (Stage III or Stage IV) or metastatic non-squamous non-small cell lung cancer.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Aloxi

**Drugs**
Aloxi

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

**Exclusion Criteria**

**Required Medical Information**
Documentation that  granisetron and ondansetron have each been ineffective, not tolerated or contraindicated.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Ampyra

**Drugs**
Ampyra

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

**Exclusion Criteria**

**Required Medical Information**
Documentation that the following criteria have been met: adult with a diagnosis of multiple sclerosis AND dalfampridine is being used for improvement of speed of ambulation.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
Initial-3 months then annually

**Other Criteria**
Continued authorization or re-authorization (after the initial 3-month period) shall be reviewed at least annually. Clinical documentation indicating that the functional impairment resolved as a result of increased speed of ambulation, resulting in the member being able to complete instrumental activities of daily living, must be provided.

## Antidepressants

**Drugs**
Brintellix, Cymbalta, duloxetine, Fetzima, Khedezla, Pristiq, Viibryd

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

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**
Treatment with two generic/preferred medication alternatives have been ineffective, not tolerated or contraindicated.

## Antineoplastics

**Drugs**
Herceptin

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

**Exclusion Criteria**

**Required Medical Information**
Documentation of diagnosis.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Arcalyst

**Drugs**
Arcalyst

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

**Exclusion Criteria**

**Required Medical Information**
There is  laboratory evidence of a genetic mutation in the Cold-Induced Auto-Inflammatory Syndrome 1 (CIAS1, also known as NLRP-3) AND there is clinical documentation that the patient is experiencing the classic symptoms of CAPS in either: Familial Cold Auto-Inflammatory Syndrome (FCAS) including recurrent intermittent episodes of fever and rash that primarily followed natural, artificial or both types of generalized cold exposure OR Muckle-Wells Syndrome (MWS), a syndrome of chronic fever and rash that may wax and wane in intensity, sometimes exacerbated by generalized cold exposure. Clinical documentation of significant functional impairment resulting in significant impairment or limitation of activities of daily living (ADLs).

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
Initial-1 month  then annually with documentation of disease stability or improvement.

**Other Criteria**

## Arzerra

**Drugs**
Arzerra

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

**Exclusion Criteria**

**Required Medical Information**
Diagnosis of chronic lymphocytic leukemia AND fludarabine(Fludara) and alemtuzumab(Campath) have been ineffective, not tolerated or contraindicated.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Atypical Antipsychotics

**Drugs**
Abilify Discmelt, Abilify Maintena, Abilify oral solution, Abilify oral tablet, Fanapt oral tablet 1 mg, 10 mg, 12 mg, 2 mg, 4 mg, 6 mg, 8 mg, Fanapt oral tablets,dose pack, Invega oral tablet extended release 24hr 1.5 mg, 3 mg, 6 mg, 9 mg, Latuda, Saphris (black cherry)

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

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**
Treatment with two generic or preferred atypical antipyschotics have been ineffective, not tolerated or contraindicated.

## Avastin

**Drugs**
Avastin

**Covered Uses**
All FDA-approved indications not otherwise excluded from Part D, age related macular degeneration, branch or central retinal vein occlusion, diabetic retinopathy/macular edema, persistent or recurrent ovarian cancer.

**Exclusion Criteria**

**Required Medical Information**
Use in the eye: Used as an intravitreal(inside the eye) injection for the treatment of ocular conditions such as macular degeneration, retinal vein occlusion and diabetic retinopathy. Use in Cancers: Diagnosis of metastatic colorectal cancer(adenocarcinoma) when given in conjunction with a fluorouracil-based chemotherapy OR diagnosis of glioblastoma or ependymoma that has progressed after at least one prior therapy (such as radiation or temozolomide) OR diagnosis of unresectable, locally advanced, recurrent or metastatic non-small cell lung cancer when: patient has had no prior chemotherapy AND is administered with carboplatin and paclitaxel OR a diagnosis of metastatic renal carcinoma when: tumor has clear cell histology AND treatment with a tyrosine kinase inhibitor[pazopanib(Votrient), sorafenib(Nexavar) or sunitinib(Sutent)] has been ineffective, contraindicated or not tolerated OR a diagnosis of persistent or recurrent ovarian cancer when two prior therapies have been ineffective or are not tolerated.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
6 months

**Other Criteria**

## Beleodaq

**Drugs**
Beleodaq

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

**Exclusion Criteria**

**Required Medical Information**
Documentation of a diagnosis of peripheral T-cell lymphoma (PTCL) AND at least one prior therapy for PTCL was not effective.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Bisphosphonates

**Drugs**
Actonel oral tablet 150 mg, 30 mg, 35 mg, 5 mg, Atelvia, risedronate

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

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**
Treatment with one generic bisphosphonate ineffective, not tolerated or contraindicated.

## Bosulif

**Drugs**
Bosulif oral tablet 100 mg, 500 mg

**Covered Uses**
All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria**

**Required Medical Information**
Documentation of chronic myelogenous leukemia (CML) AND documentation that the patient's CML is Philadelphia chromosone-positive AND one prior tyrosine kinase inhibitor therapy for CML has not been effective or is contraindicated.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Bydureon

**Drugs**
Bydureon

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

**Exclusion Criteria**

**Required Medical Information**
Documentation that the patient's A1C value is over 7%  AND treatment with metformin is contraindicated, not tolerated, or has been inadequate in reducing A1C to goal of 7% or less after 90 days of therapy.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Byetta

**Drugs**
Byetta subcutaneous pen injector 10 mcg/dose(250 mcg/mL) 2.4 mL, 5 mcg/dose (250 mcg/mL) 1.2 mL

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

**Exclusion Criteria**

**Required Medical Information**
Documentation that the patient's hemoglobin A1C value is over 7% AND a 90 day treatment course with metformin did not adequately reduce the hemoglobin A1c to the goal of 7% or less or was not tolerated or is contraindicated.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Caprelsa

**Drugs**
Caprelsa oral tablet 100 mg, 300 mg

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

**Exclusion Criteria**

**Required Medical Information**
Documentation of diagnosis.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Celebrex

**Drugs**
Celebrex oral capsule 100 mg, 200 mg, 400 mg, 50 mg

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

**Exclusion Criteria**

**Required Medical Information**
Used in the treatment of chronic pain and/or inflammation when treatment with at least two generically available prescription nonsteroidal anti-inflammatory drugs (NSAIDs) were ineffective or not tolerated where one of the previously used NSAIDs must be diclofenac, etodolac, nabumetone, or meloxicam.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Cerezyme/VPRIV

**Drugs**
Cerezyme intravenous recon soln 200 unit, VPRIV

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

**Exclusion Criteria**

**Required Medical Information**
Diagnosis of Type 1 Gaucher disease confirmed by: biochemical assay of glucocerebrosidase activity in WBCs or skin fibroblasts is less than or equal to 30% of normal activity (note: laboratory normals may vary) OR genotyping revealing two pathogenic mutations of the glucocerebrosidase gene AND symptomatic manifestations of the disease are present such as anemia, thrombocytopenia, bone disease, hepatomegaly or splenomegaly.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
6 months

**Other Criteria**
For continued authorization, documentation by chart notes of maintenance or improvement in disease must be provided. This may include, but is not limited to, hematologic indices, MRI of spine/femurs, quality of life and/or plain films of skeleton.

## Chorionic Gonadotropin

**Drugs**
chorionic gonadotropin, human, Pregnyl

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

**Exclusion Criteria**

**Required Medical Information**
Documentation of diagnosis.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Cometriq

**Drugs**
Cometriq oral capsule 100 mg/day(80 mg[1]-20 mg[1]), 140 mg/day(80 mg[1]-20 mg[3]), 60 mg/day (20 mg [3]/day)

**Covered Uses**
All FDA approved indications not otherwise excluded from Part D.

**Exclusion Criteria**

**Required Medical Information**
Carbozantinib (Cometriq) may be considered medically necessary in patients with a diagnosis of metastatic medullary thyroid cancer.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Cycloset

**Drugs**
Cycloset

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

**Exclusion Criteria**

**Required Medical Information**
Metformin was ineffective, not tolerated or contraindicated.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
12 months

**Other Criteria**

## Cyramza

**Drugs**
Cyramza

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

**Exclusion Criteria**

**Required Medical Information**
Documentation of a diagnosis of unresectable locally advanced or metastatic gastric cancer, or unresectable or metastatic gastro-esophageal junction adenocarcinoma AND there was disease progression after prior treatment with fluoropyrimidine- or platinum-containing chemotherapy, or therapy with these regimens was not tolerated or is contraindicated.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Daliresp

**Drugs**
Daliresp

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

**Exclusion Criteria**
Moderate to severe liver impairment (Child-Pugh B or C)

**Required Medical Information**
Diagnosis of severe chronic obstructive pulmonary disease (COPD) (defined as FEV1 less than or equal to 50% of predicted and FEV1/forced vital capacity [FVC] less than 0.7) associated with chronic bronchitis AND history of COPD exacerbations which requires the use of systemic corticosteroids, antibiotics, or hospital admission AND Medication will be used with a long-acting inhaled bronchodilator (i.e. long-acting anticholinergic, or long-acting beta agonist in combination with inhaled corticosteroid) or patient is at high-risk of COPD exacerbation and is not a candidate for long-acting inhaled bronchodilator therapy.

**Age Restriction**
18 years of age or older

**Prescriber Restriction**

**Coverage Duration**
12 months

**Other Criteria**

## Dipeptidyl peptidase-4 (DPP-4) Inhibitors

**Drugs**
Janumet, Janumet XR, Januvia, Juvisync

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

**Exclusion Criteria**

**Required Medical Information**
Documentation that treatment with metformin is contraindicated, not tolerated, or has been ineffective in reducing hemoglobin A1C to goal of 7% or less after 90 days of therapy.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Doxil (doxorubicin liposomal)

**Drugs**
Doxil, doxorubicin, peg-liposomal, Lipodox, Lipodox 50

**Covered Uses**
All FDA-approved indications not otherwise excluded from Part D, cutaneous T-cell lymphoma (CTCL), non-AIDs related Kaposi's sarcoma.

**Exclusion Criteria**

**Required Medical Information**
A diagnosis of ovarian cancer, recurrent or progressive, after treatment with a platinum-based chemotherapy OR a diagnosis of progressive Kaposi's sarcoma (KS) requiring systemic therapy OR a diagnosis of multiple myeloma (MM) after at least one prior therapy has been ineffective or not tolerated OR a diagnosis of cutaneous T-cell lymphoma after treatment with gemcitabine unless ineffective, contraindicated or not tolerated.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Enbrel

**Drugs**
Enbrel subcutaneous kit, Enbrel subcutaneous syringe, Enbrel SureClick

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

**Exclusion Criteria**

**Required Medical Information**
Psoriatic arthritis-diagnosis is established by a rheumatologist or dermatologist. Ankylosing spondylitis-diagnosis is established by a rheumatologist. Rheumatoid arthritis(RA) or juvenile rheumatoid arthritis(JRA, juvenile idiopathic arthritis): diagnosis established by a rheumatologist or for RA meets 4 of 7 criteria of the American College of Rheumatology Classification Criteria for Establishing the Diagnosis of Rheumatoid Arthritis AND methotrexate is ineffective after a minimum 6 to 12 week treatment course based on documentation of the American College of Rheumatology Assessment Components for Improvement in Rheumatoid Arthritis except where methotrexate is contraindicated or not tolerated based on clinical documentation. Chronic plaque psoriasis: Chart notes support a diagnosis of chronic plaque psoriasis involving at least 5% of body surface area or that it causes a significant functional disability AND treatment with at least one oral systemic agent for psoriasis was ineffective or not tolerated, unless all are contraindicated.

**Age Restriction**

**Prescriber Restriction**
Chronic Plaque Psoriasis-dermatologist or rheumatologist

**Coverage Duration**
1 year

**Other Criteria**

## Erbitux

**Drugs**
Erbitux intravenous solution 100 mg/50 mL

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

**Exclusion Criteria**

**Required Medical Information**
A diagnosis of advanced (unresectable) or metastatic colorectal cancer (CRC) when no KRAS mutation is present (for use with KRAS wild type tumors only) OR a diagnosis of advanced (unresectable), metastatic, or recurrent squamous cell carcinoma of the head and neck (SCCHN) OR diagnosis of advanced (stage IIIb or IV) non-small cell lung cancer when documentation is provided that the tumor expresses epidermal growth factor receptor (EGFR).

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Erivedge

**Drugs**
Erivedge

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

**Exclusion Criteria**

**Required Medical Information**
A diagnosis of metastatic basal cell carcinoma OR a diagnosis of locally advanced basal cell carcinoma when the member is not a candidate for radiation AND the disease has recurred following surgery, unless the member is not a candidate for surgery.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Erwinaze

**Drugs**
Erwinaze

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

**Exclusion Criteria**
Member has experienced any of the following with prior asparaginase therapy: serious hypersensitivity reactions, including anaphylaxis, serious pancreatitis, serious thrombosis, serious hemorrhagic events

**Required Medical Information**
Diagnosis of acute lymphoblastic leukemia AND Patient has a hypersensitivity to E. coli-derived asparaginase

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
12 months

**Other Criteria**

## Extavia

**Drugs**
Extavia subcutaneous kit

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

**Exclusion Criteria**

**Required Medical Information**
Diagnosis of multiple sclerosis AND treatment with interferon beta-1a(Avonex) OR interferon beta-1a(Rebif) OR glatiramer acetate(Copaxone) has been ineffective or not tolerated.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Fentanyl

**Drugs**
fentanyl citrate

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

**Exclusion Criteria**

**Required Medical Information**
Documentation that use is for breakthrough cancer pain  AND other generic/preferred formulary short acting strong narcotic analgesic alternatives (other than fentanyl such as, but not limited to, concentrated morphine oral solution, oxycodone or hydromorphone)have been ineffective, not tolerated or contraindicated AND patient is opioid tolerant, taking at least the equivalent of 60mg oral morphine sulfate daily.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
6 months

**Other Criteria**

## Firazyr

**Drugs**
Firazyr

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

**Exclusion Criteria**

**Required Medical Information**
Documented diagnosis of type I, type II, or type III hereditary angioedema (HAE) established by or in conjunction with an allergist, immunologist or hematologist AND clinical documentation of serum C4 and C1-INH (antigenic or functional level) that are below the limits of the laboratory's normal reference range (for type I and type II only) AND clinical documentation of family history of HAE OR normal level of serum C1q antigenic protein based on the laboratory's normal reference range OR FXII mutation (type III only).

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
3 months

**Other Criteria**

## Folotyn

**Drugs**
Folotyn intravenous solution 40 mg/2 mL (20 mg/mL)

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

**Exclusion Criteria**

**Required Medical Information**
Diagnosis of peripheral T-cell lymphoma (PTCL) and at least one prior therapy for PTCL has been ineffective or not tolerated.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Forteo

**Drugs**
Forteo

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

**Exclusion Criteria**

**Required Medical Information**
Patient at high risk for fracture as defined by: having a bone mineral density that is 2.5 or more standard deviations below that of a young, normal adult(T score at or below -2.5) OR having osteopenia with T-score between -1 and -2.5 and a history of previous fractures or glucocorticoid use for at least 3 months at a dose of 5mg per day of prednisone or equivalent AND at least one bisphosphonate has not been effective based on objective documentation except if bisphosphonates are contraindicated based on current medical literature and objective documentation describing the contraindication is provided OR bisphosphonates are not tolerated due to documented clinical side effects.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
One time maximum two years of therapy authorization.

**Other Criteria**

## Gazyva

**Drugs**
Gazyva

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

**Exclusion Criteria**
Diagnosis of chronic lymphocytic leukemia AND Gazyva will be administered in combination with chlorambucil AND patient has had no prior medication therapy for CLL.

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Gilotrif

**Drugs**
Gilotrif

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

**Exclusion Criteria**

**Required Medical Information**
A diagnosis of metastatic non-small cell lung cancer (NSCLC) AND documentation of an EGFR exon 19 deletion or exon 21 (L858R) substitution mutation is provided AND patient has had no prior cytotoxic or targeted chemotherapy for NSCLC.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**
30 tabs per 30 days

## Gleevec

**Drugs**
Gleevec

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

**Exclusion Criteria**

**Required Medical Information**
Documentation of chronic myelogenous leukemia(CML) with the presence of the Philadelphia (Ph-1) chromosome OR gastrointestinal stromal tumor(GIST) OR Philadelphia chromosome positive acute lymphoblastic leukemia(Ph+ALL) OR myelodysplastic /myeloproliferative diseases (MDS/MPD) associated with platelet derived growth factor receptor(PDGFR) gene rearrangements OR aggressive systemic mastocytosis(ASM) without the D816V c-Kit mutation or with c-Kit mutational status unknown OR hypereosinophilic syndrome(HES) and/or chronic eosinophilic leukemia(CEL) who have the FIP1L1-PDGFR alpha fusion kinase(mutational analysis or FISH demonstration of CHIC2 allele deletion) and for patients with hypereosinophilic and/or chronic eosinophilic leukemia(HES/CEL) who are FIP1L1-PDGFR alpha fusion kinase negative or unknown OR unresectable,  recurrent and/or metastatic dermatofibrosarcoma protuberans(DFSP).

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Halaven

**Drugs**
Halaven

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

**Exclusion Criteria**

**Required Medical Information**
Diagnosis of recurrent or metastatic breast cancer AND at least two prior systemic therapies have been part of the prior treatment history unless contraindicated, ineffective or not tolerated. Prior therapies shall include each of the following: A taxane-based chemotherapy regimen [docetaxel (Taxotere) or paclitaxel (Taxol or Abraxane)] AND an anthracycline-based chemotherapy regimen [doxorubicin (Adriamycin, Doxil) or epirubicin (Ellence)].

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## HRM - Analgesics

**Drugs**
Ascomp with Codeine, butalbital-acetaminop-caf-cod oral capsule 50-325-40-30 mg, indomethacin oral, ketorolac injection solution 15 mg/mL, 30 mg/mL (1 mL), ketorolac oral, pentazocine-acetaminophen, pentazocine-naloxone, Talwin

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

**Exclusion Criteria**

**Required Medical Information**
The drug is being prescribed for an FDA-approved indication AND the patient has tried and failed at least one non-HRM alternative (listed in OTHER CRITERIA) AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication .

**Age Restriction**
PA applies to patients 65 years or older.

**Prescriber Restriction**

**Coverage Duration**
12 months

**Other Criteria**
Mild pain: acetaminophen, codeine. Moderate to severe pain: short-term NSAIDs, tramadol, tramadol/APAP, morphine sulfate, hydrocodone/APAP, oxycodone, oxycodone/APAP, fentanyl. Neuropathic pain: duloxetine, pregabalin, gabapentin, desipramine, nortriptyline, topical agents (capsaicin, topical lidocaine).

**Drugs**
Digox oral tablet 250 mcg, digoxin injection solution, digoxin oral solution 50 mcg/mL, digoxin oral tablet 250 mcg, disopyramide phosphate oral capsule, Lanoxin oral tablet 250 mcg

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

**Exclusion Criteria**

**Required Medical Information**
The drug is being prescribed for an FDA-approved indication AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication.

**Age Restriction**
PA applies to patients 65 years or older

**Prescriber Restriction**

**Coverage Duration**
12 months

**Other Criteria**

## HRM - Antidepressants

**Drugs**
amitriptyline, clomipramine, doxepin oral, imipramine HCl, imipramine pamoate, perphenazine-amitriptyline, trimipramine

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

**Exclusion Criteria**

**Required Medical Information**
The drug is being prescribed for an FDA-approved indication AND the patient has tried and failed at least one non-HRM alternative (listed in OTHER CRITERIA) AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication.

**Age Restriction**
PA applies to patients 65 years or older

**Prescriber Restriction**

**Coverage Duration**
12 months

**Other Criteria**
Applies to New Starts only.TCA: nortriptyline, desipramine, low-dose doxepin, trazodone. Depression: SSRI, SNRI, mirtazapine, bupropion. duloxetine, pregabalin, gabapentin. Insomnia: ramelteon (8 mg/d), low-dose doxepin (= 6mg/d).

## HRM - Antihypertensive Agents

**Drugs**
guanfacine, Intuniv ER oral tablet extended release 24 hr 1 mg, 2 mg, 3 mg, 4 mg, methyldopa, methyldopa-hydrochlorothiazide, methyldopate, reserpine

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

**Exclusion Criteria**

**Required Medical Information**
The drug is being prescribed for an FDA-approved indication AND the patient has tried and failed at least one non-HRM alternative (listed in OTHER CRITERIA) AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication.

**Age Restriction**
PA applies to patients 65 years or older

**Prescriber Restriction**

**Coverage Duration**
12 months

**Other Criteria**
Low dose thiazide or a second generation calcium channel blocker OR ACE inhibitor, ARB, beta-blocker or combination product based on specific chronic conditions

## HRM - Antiparkinson Agents

**Drugs**
benztropine oral, trihexyphenidyl

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

**Exclusion Criteria**

**Required Medical Information**
The drug is being prescribed for an FDA-approved indication AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication.

**Age Restriction**
PA applies to patients 65 years or older

**Prescriber Restriction**

**Coverage Duration**
12 months

**Other Criteria**

**Drugs**
thioridazine

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

**Exclusion Criteria**

**Required Medical Information**
The drug is being prescribed for an FDA-approved indication AND the patient has tried and failed at least one non-HRM alternative (listed in OTHER CRITERIA) AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication.

**Age Restriction**
PA applies to patients 65 years or older

**Prescriber Restriction**

**Coverage Duration**
12 months

**Other Criteria**
Applies to New Starts only. haloperidol, quetiapine, risperidone, aripiprazole, asenapine, iloperidone, lurasidone, olanzapine, paliperidone, ziprasidone

## HRM - Benzodiazepines

**Drugs**
alprazolam oral tablet 0.25 mg, 0.5 mg, 1 mg

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

**Exclusion Criteria**

**Required Medical Information**
Verify the medication is being used for an FDA-approved diagnosis. Provider was notified this is a high risk medication and that the provider wishes to prescribe medication

**Age Restriction**
PA applies to patients 65 years or older

**Prescriber Restriction**

**Coverage Duration**
12 months

**Other Criteria**

## HRM - Calcium Channel Blockers, Dihydropyridine

**Drugs**
nifedipine oral capsule

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

**Exclusion Criteria**

**Required Medical Information**
The drug is being prescribed for an FDA-approved indication AND the patient has tried and failed at least one non-HRM alternative (listed in OTHER CRITERIA) AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication.

**Age Restriction**
PA applies to patients 65 years or older

**Prescriber Restriction**

**Coverage Duration**
12 months

**Other Criteria**
extended-release nifedipine, nicardipine, amlodipine

## HRM - Dementia Agents

**Drugs**
ergoloid

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

**Exclusion Criteria**

**Required Medical Information**
The drug is being prescribed for an FDA-approved indication AND the patient has tried and failed at least one non-HRM alternative (listed in OTHER CRITERIA) AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication.

**Age Restriction**
PA applies to patients 65 years or older

**Prescriber Restriction**

**Coverage Duration**
12 months

**Other Criteria**
donepezil, galantamine, rivastigmine, memantine

**Drugs**
Megace ES, megestrol oral suspension 400 mg/10 mL (40 mg/mL), megestrol oral tablet

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

**Exclusion Criteria**

**Required Medical Information**
The drug is being prescribed for an FDA-approved indication AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication.

**Age Restriction**
PA applies to patients 65 years or older

**Prescriber Restriction**

**Coverage Duration**
12 months

**Other Criteria**
Applies to New Starts only.

## HRM - Oral and Transdermal Estrogens and Progestins

**Drugs**
Alora, Angeliq oral tablet 0.5-1 mg, Climara Pro, CombiPatch, Divigel transdermal gel in packet 1 (0.1) mg (%), Elestrin, Enjuvia, estradiol oral, estradiol transdermal, estradiol-norethindrone acet, estropipate, Evamist, Jinteli, Menest, Menostar, Mimvey, Mimvey Lo, Prefest, Premarin oral, Premphase, Prempro, Vivelle-Dot

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

**Exclusion Criteria**

**Required Medical Information**
The drug is being prescribed for an FDA-approved indication AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication.

**Age Restriction**
PA applies to patients 65 years or older

**Prescriber Restriction**

**Coverage Duration**
12 months

**Other Criteria**

## HRM - Platelet Inhibitors

**Drugs**
ticlopidine

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

**Exclusion Criteria**

**Required Medical Information**
The drug is being prescribed for an FDA-approved indication AND the patient has tried and failed at least one non-HRM alternative (listed in OTHER CRITERIA) AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication.

**Age Restriction**
PA applies to patients 65 years or older

**Prescriber Restriction**

**Coverage Duration**
12 months

**Other Criteria**
clopidogrel

## HRM - Sedative Hypnotic Agents

**Drugs**
zolpidem

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

**Exclusion Criteria**

**Required Medical Information**
The drug is being prescribed for an FDA-approved indication AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) when used longer than 90 days and wishes to proceed with the originally prescribed medication AND intended duration of therapy will be verified.

**Age Restriction**
PA applies to patients 65 years or older

**Prescriber Restriction**

**Coverage Duration**
12 months

**Other Criteria**

## HRM - Skeletal Muscle Relaxants

**Drugs**
chlorzoxazone, methocarbamol, orphenadrine citrate injection, orphenadrine citrate oral

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

**Exclusion Criteria**

**Required Medical Information**
The drug is being prescribed for an FDA-approved indication AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication.

**Age Restriction**
PA applies to patients 65 years or older

**Prescriber Restriction**

**Coverage Duration**
12 months

**Other Criteria**

## HRM - Sulfonylureas

**Drugs**
chlorpropamide, glyburide, glyburide micronized, glyburide-metformin

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

**Exclusion Criteria**

**Required Medical Information**
The drug is being prescribed for an FDA-approved indication AND the patient has tried and failed at least one non-HRM alternative (listed in OTHER CRITERIA) AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication.

**Age Restriction**
PA applies to patients 65 years or older

**Prescriber Restriction**

**Coverage Duration**
12 months

**Other Criteria**
glimepiride, glipizide

## HRM - Vasodilators

**Drugs**
dipyridamole oral

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

**Exclusion Criteria**

**Required Medical Information**
The drug is being prescribed for an FDA-approved indication AND the patient has tried and failed at least one non-HRM alternative (listed in OTHER CRITERIA) AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication.

**Age Restriction**
PA applies to patients 65 years or older

**Prescriber Restriction**

**Coverage Duration**
12 months

**Other Criteria**
clopidogrel, dipyridamole

## Humira

**Drugs**
Humira Crohn's Dis Start Pck, Humira Ped Crohn's Starter Pk, Humira subcutaneous syringe kit 20 mg/0.4 mL, 40 mg/0.8 mL

**Covered Uses**
All FDA-approved indications not otherwise excluded from Part D, ulcerative colitis

**Exclusion Criteria**

**Required Medical Information**
Psoriatic arthritis-when the diagnosis established by a rheumatologist or dermatologist. Ankylosing spondylitis-diagnosis established by a rheumatologist. Rheumatoid arthritis(RA) or juvenile idiopathic arthritis (JIA)-diagnosis established by a rheumatologist or for RA meets 4 of 7 criteria of the American College of Rheumatology Classification Criteria for Establishing the Diagnosis of Rheumatoid Arthritis AND 6-12 week course of methotrexate was ineffective based on documentation which includes one or more of the American College of Rheumatology Assessment Components for improvement in Rheumatoid Arthritis unless methotrexate is contraindicated or not tolerated based on clinical documentation. Crohn's Disease-Fistulizing Crohn's Disease OR acute treatment of an exacerbation when at least one of the three following criteria is met: treatment with an adequate course of systemic corticosteroids(such as, but not limited to, 40-60mg prednisone per day for 7-14 days) has been ineffective or is contraindicated OR patient has been unable to taper off an adequate course of systemic corticosteroids without experiencing worsening of disease OR patient is experiencing breakthrough disease while stabilized for at least 2 months on an immune-modulatory medication(such as, but not limited to, azathioprine, mercaptopurine, cyclosporine or methotrexate) OR acute and/or maintenance of Crohn's Disease when infliximab(Remicade) has been ineffective or not tolerated. Chronic plaque psoriasis-Chart notes support a diagnosis of chronic plaque psoriasis involving at least 5% of body surface area or causes significant functional disability AND treatment with at least one oral systemic agent(such as, but not limited to, cyclosporine, methotrexate or acitretin) for psoriasis was ineffective or not tolerated, unless all are contraindicated.

**Age Restriction**

**Prescriber Restriction**
Chronic Plaque Psoriasis-dermatologist or rheumatologist. Ulcerative colitis-gastroenterologist.

**Coverage Duration**
Rheumatologic conditions, plaque psoriasis-annually. UC and Crohn's Disease-3 months then annually

**Other Criteria**
Ulcerative colitis - acute treatment of an exacerbation of moderately to severely active ulcerative colitis where an adequate course of systemic corticosteroids was ineffective or is contraindicated AND treatment with an oral aminosalicylate (such as balasazide, mesalamine or sulfasalazine) for ulcerative colitis was ineffective or not tolerated.

## Iclusig

**Drugs**
Iclusig oral tablet 15 mg, 45 mg

**Covered Uses**
All FDA approved indications not otherwise excluded from Part D.

**Exclusion Criteria**

**Required Medical Information**
Documentation of Philadelphia chromosome-positive chronic myelogenous leukemia (CML) when treatment with at least two tyrosine kinase inhibitors (TKIs) for CML is not effective or not tolerated, unless all TKIs are contraindicated OR documentation of Philadelphia chromosome-positive acute lymphoblastic leukemia (ALL) when treatment with both imatinib (Gleevec) and dasatinib (Sprycel) is ineffective, not tolerated, or contraindicated.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Imbruvica

**Drugs**
Imbruvica

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

**Exclusion Criteria**

**Required Medical Information**
Diagnosis of mantle cell lymphoma (MCL) AND at least one prior therapy for MCL has been ineffective or a diagnosis of chronic lymphocytic leukemia (CLL) when at least one prior therapy has been ineffective.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**
120 caps per 30 days

## Incivek

**Drugs**
Incivek

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

**Exclusion Criteria**

**Required Medical Information**
A diagnosis of chronic genotype 1 hepatitis C virus (HCV) infection AND peginterferon and ribavirin will be used in combination with telaprevir AND liver biopsy results are obtained unless liver biopsy is contraindicated or there is documentation of compensated cirrhosis based on imaging studies AND there is documentation that indicates patient has not previously been treated with a protease inhibitor for chronic hepatitis C.

**Age Restriction**
Minimum 18 years of age

**Prescriber Restriction**

**Coverage Duration**
Initial=8 wks

**Other Criteria**
Continued Authorization: If HCV RNA is greater than 1,000 IU/mL at week 4 then no additional authorization as treatment is not effective. If HCV RNA less than 1,000 IU/mL at week 4 then 4 additional weeks.

## Increlex

**Drugs**
Increlex

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

**Exclusion Criteria**

**Required Medical Information**
Diagnosis of severe primary IGF-1 deficiency OR growth hormone deletion OR genetic mutation of growth hormone receptor(Laron Syndrome) AND current high measurement at less than 3rd percentile for age and sex AND IGF-1 level greater than or equal to 3 standard deviations below normal (based on at least one growth hormone stimulation test) AND normal or elevated growth hormone levels based upon at least one growth hormone stimulation test AND open growth plates.

**Age Restriction**

**Prescriber Restriction**
Pediatric Endocrinologist

**Coverage Duration**
1 year

**Other Criteria**

## Inlyta

**Drugs**
Inlyta

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

**Exclusion Criteria**

**Required Medical Information**
Documentation of a diagnosis of renal cell carcinoma (RCC) AND sunitinib (Sutent) or sorafenib (Nexavar) or pazopanib (Votrient) has been ineffective or was not tolerated.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
12 months

**Other Criteria**

## Istodax

**Drugs**
Istodax

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

**Exclusion Criteria**

**Required Medical Information**
Diagnosis of cutaneous T-cell lymphoma (CTCL) AND at least two prior systemic therapies for CTCL have been ineffective or not tolerated. Systemic therapies include all-trans retinoic acid (Vesanoid), bexarotene (Targretin), bortezomib (Velcade), chlorambucil (Leukeran), cyclophosphamide (Cytoxan), denileukin diftitox (Ontak), doxorubicin liposomal (Doxil), etoposide (VePesid), gemcitabine (Gemzar), interferon alfa (Intron A), isotretinoin, methotrexate, pentostatin, pralatrexate (Folotyn), temozolomide (Temodar) and vorinostat (Zolinza) OR a diagnosis of peripheral T-cell lymphoma (PTCL) when at least two prior systemic therapies have been ineffective or not tolerated.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Jakafi

**Drugs**
Jakafi

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

**Exclusion Criteria**

**Required Medical Information**
A diagnosis of myelofibrosis, including but not limited to primary myelofibrosis, post-polycythemia vera myelofibrosis and post-essential thrombocythemia myelofibrosis.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Jevtana

**Drugs**
Jevtana

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

**Exclusion Criteria**

**Required Medical Information**
Diagnosis of metastatic hormone-resistant prostate cancer(mHRPC) AND prior treatment with docetaxel (Taxotere) has been ineffective or not tolerated.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Kadcyla

**Drugs**
Kadcyla

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

**Exclusion Criteria**

**Required Medical Information**
Diagnosis of HER2-positive metastatic breast cancer AND disease progression after treatment with trastuzumab and a taxane (separately or in combination).

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Kalydeco

**Drugs**
Kalydeco

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

**Exclusion Criteria**

**Required Medical Information**
A diagnosis of cystic fibrosis (CF)AND confirmation that the patient has one of the following specific mutations in either CFTR gene: G551D, G1244E, G1349D, G178R, G551S, S1251N, S1255P, S549N, or S549R.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Kineret

**Drugs**
Kineret

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

**Exclusion Criteria**

**Required Medical Information**
The diagnosis of Rheumatoid Arthritis (RA) has been established by a rheumatologist or meets 4 of 7 criteria of the American College of Rheumatology Classification Criteria for Establishing the Diagnosis of Rheumatoid Arthritis AND methotrexate alone is not effective after at least a 6 to 12 week treatment course based on documentation which includes one or more of the American College of Rheumatology Assessment Components for Improvement in Rheumatoid Arthritis except if documentation is submitted that methotrexate is relatively or absolutely contraindicated based on current literature OR methotexate is not tolerated due to documented clinical side effects AND either etanercept(Enbrel) or adalimumab(Humira)or golimumab(Simponi) is not effective after at least a 12 week treatment course unless not tolerated due to documented clinical side effects.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**
The diagnosis of Systemic Juvenile Idiopathic Arthritis (SJIA or Still's disease) is established by a Rheumatologist AND the duration of disease is greater than 6 months AND at least one systemic oral agent for SJIA was ineffective or not tolerated. A diagnosis of Cryopyrin-Associated Periodic Syndromes (CAPS) (including Neonatal-Onset Multisystem Inflammatory Disease [NOMID]) is established by a rheumatologist and the following criteria (1 and 2) below, are met - 1) There is laboratory evidence of a genetic mutation in the Cold-Induced Auto-inflammatory Syndrome 1 (CIAS1 - sometimes referred to as the NLRP-3) AND 2) There is clinical documentation that the patient is experiencing the classic symptoms of CAPS, defined as meeting any of criteria i through iii below - i) NOMID - Urticaria-like rash, CNS involvement (papilledema, cerebrospinal fluid [CSF] pleocytosis, or sensorineural hearing loss), elevated C-reactive protein, or epiphyseal and/or patellar overgrowth on radiographs. OR ii) Familial Cold Auto-Inflammatory Syndrome (FCAS) - Recurrent intermittent episodes of fever and rash that primarily followed natural, artificial (e.g., air conditioning) or both types of generalized cold exposure. OR iii) Muckle-Wells Syndrome (MWS) - Syndrome of chronic fever and rash that may wax and wane in intensity, sometimes exacerbated by generalized cold exposure. This syndrome may be associated with deafness or amyloidosis.

## Lyrica

**Drugs**
Lyrica

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

**Exclusion Criteria**

**Required Medical Information**
Documentation of diagnosis

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Mekinist

**Drugs**
Mekinist

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

**Exclusion Criteria**

**Required Medical Information**
A definitive diagnosis of unresectable or metastatic melanoma AND there is documentation of a BRAF V600E or V600K mutation as detected by a Food and Drug Administration (FDA) approved test.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**
QLL: 30 per month

## Modafinil

**Drugs**
modafinil oral tablet 100 mg, 200 mg

**Covered Uses**
All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria**

**Required Medical Information**
Excessive sleepiness associated with narcolepsy(diagnosed by the criteria of DSM-IV-TR, Appendix 1) when at least one generic or preferred brand medication, such as, but not limited to, methylphenidate or dextroamphetamine, has been ineffective or not tolerated OR documentation of residual excessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome AND there is documentation that the patient has been compliant with CPAP or BiPAP for at least 2 months OR excessive sleepiness associated with shift-work disorder when diagnosis is made using the criteria from International Classification of Sleep Disorders(ICSD, Appendix 2) AND sleep disturbance causes measurable functional impairment in social, occupational or other important areas of functioning that has persisted for at least three months AND sleep disturbance is not due to otherwise reversible conditions AND non-pharmacologic therapies have been inadequate in improving functional impairments.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
Narcolepsy and shift work disorder-1 year. Obstructive sleep apnea/hypoapnea-6 months then annually

**Other Criteria**

## Namenda

**Drugs**
Namenda oral solution, Namenda oral tablet 10 mg, 5 mg, Namenda Titration Pak

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

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**
Treatment with galantamine(Razadyne), oral or transdermal rivastigmine (Exelon) or donepezil(Aricept) ineffective, not tolerated or contraindicated.

## Nexavar

**Drugs**
Nexavar

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

**Exclusion Criteria**

**Required Medical Information**
Documented diagnosis of renal cell carcinoma and when sunitinib(Sutent) has been ineffective, not tolerated or contraindicated OR documented diagnosis of  hepatocellular carcinoma.

**Age Restriction**

**Prescriber Restriction**
Oncologist or hematologist

**Coverage Duration**
1 year

**Other Criteria**

## Nutropin/Omnitrope

**Drugs**
Nutropin AQ Nuspin subcutaneous cartridge 10 mg/2 mL (5 mg/mL), 5 mg/2 mL (2.5 mg/mL), Nutropin AQ subcutaneous cartridge, Nutropin subcutaneous recon soln 10 mg, Omnitrope

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

**Exclusion Criteria**

**Required Medical Information**
Pediatric-Documented GHD defined as two GH stimulation tests below 10ng/ml OR at least one GH stimulation test less than 15ng/ml and IGF-1 and IGF-BP3 levels below normal for bone age and sex OR one GH stimulation test below 10ng/ml for those with defined CNS pathology, history of irradiation, or genetic condition associated with GHD OR growth stimulation hormone tests, IGF-1 or IGF-BP3 levels are not needed for GHD if multiple pituitary hormone deficiencies exist OR for congential GHD. Open growth plates-an initial bone age, demonstration of open growth plates. Short Stature/Growth failure-Height is less than the minimum percentile specified for age/sex OR when the height is below the minimum percentile specified for age/sex and untreated growth velocity with a minimum of 1 year of growth data is below the 25th percentile OR if GHD defined as GH stimulation tests, IGF-1 or IGF-BP3 levels not needed for cogential GHD, growth failure/short stature is not needed.

**Age Restriction**

**Prescriber Restriction**
Pediatrics-pediatric endocrinologist, pediatric nephrologist, trauma/burn surgeon

**Coverage Duration**
Short bowel syndrome-up to 4 weeks. All other indications-up to1 year

**Other Criteria**

## Olysio

**Drugs**
Olysio

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

**Exclusion Criteria**

**Required Medical Information**
CHRONIC HEPATITIS C GENOTYPE 1A: A diagnosis of chronic genotype 1a hepatitis C virus (HCV) infection AND the member does not have the Q80K polymorphism AND peginterferon and ribavirin will be used in combination with simeprevir AND there is documentation that indicates member has not been previously treated with a direct-acting oral antiviral (e.g. boceprevir, simeprevir, sofosbuvir, or telaprevir) for chronic hepatitis C. CHRONIC HEPATITIS C GENOTYPE 1B: A diagnosis of chronic genotype 1b HCV infection AND peginterferon and ribavirin will be used in combination with simeprevir AND there is documentation that indicates member has not been previously treated with a direct-acting oral antiviral (e.g. boceprevir, simeprevir, sofosbuvir, or telaprevir) for chronic hepatitis C. IN COMBINATION WITH SOFOSBUVIR (SOVALDI): A diagnosis of chronic genotype 1 HCV infection AND simeprevir will be given in combination with sofosbuvir AND the member was a partial responder or null responder to prior treatment with peginterferon and ribavirin OR the member is treatment-naive or relapsed following prior treatment with peginterferon and ribavirin and peginterferon is contraindicated or is not a treatment option.

**Age Restriction**
18 years

**Prescriber Restriction**

**Coverage Duration**
12 weeks

**Other Criteria**
30 per 30 days

## Orencia

**Drugs**
Orencia, Orencia (with maltose)

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

**Exclusion Criteria**

**Required Medical Information**
Juvenile idiopathic arthritis (JIA) or rheumatoid arthritis(RA)-diagnosis established by a rheumatologist or for RA meets 4 of 7 criteria of the American College of Rheumatology Classification Criteria for Establishing the Diagnosis of Rheumatoid Arthritis for RA AND treatment with methotrexate has been ineffective after at least a 6-12 week treatment course based on documentation which includes one or more of the components of the American College of Rheumatology Assessment Components for Improvement in Rheumatoid Arthritis except if methotrexate is contraindicated or not tolerated based on clinical documentation AND infliximab (Remicade) is not effective after at least a 12 week treatment course of therapy except if not tolerated due to documented clinical side effects.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
6 months initially then 1 year

**Other Criteria**

## Pegasys

**Drugs**
Pegasys ProClick subcutaneous pen injector 135 mcg/0.5 mL, Pegasys subcutaneous solution, Pegasys subcutaneous syringe

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

**Exclusion Criteria**

**Required Medical Information**
ADMINISTERED WITH A HCV PROTEASE INHIBITOR-Peginterferon alfa-2a will be used in combination with a hepatitis C virus protease inhibitor (e.g. boceprevir or telaprevir) for the initial treatment or re-treatment of chronic hepatitis C when there is a diagnosis of chronic genotype 1 hepatitis C virus (HCV) infection AND prior authorization has been approved for either boceprevir (Victrelis) or telaprevir (Incivek) AND there is documentation of member's treatment history. ADMINISTERED WITHOUT A HCV PROTEASE INHIBITOR-Peginterferon alfa-2a will be used without a hepatitis C protease inhibitor (e.g. boceprevir or telaprevir) for the initial treatment of chronic hepatitis C (any genotype) AND detectable HCV RNA levels are higher than 50 IU/ml AND Peginterferon alfa-2a will be used in combination with ribavirin, unless ribavirin is contraindicated AND patient has not received previous treatment with peginterferon alfa-2a or peginterferon alfa-2b AND there is documentation that peginterferon alfa-2a will not be used with a hepatitis C protease inhibitor (e.g. boceprevir or telaprevir) OR Peginterferon alfa-2a will be used for the treatment of chronic hepatitis B AND there is a confirmed diagnosis of compensated chronic hepatitis B AND patient has not received previous treatment with peginterferon alfa-2a or peginterferon alfa-2b.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
Genotype 2,3-24 weeks, not 2,3 -12wks then 36wks, ribavirin contraindicated/HIV+-48wks, hep B-48wks

**Other Criteria**
DURATION OF COVERAGE WITH HCV PROTEASE INHIBITOR: Initial coverage duration with telapravir-8 weeks initially and if HCV RNA is greater than 1000u/ml at week 4 then no additional authorization as treatment is not effective. If HCV RNA is less than 1,000IU/ml at week 4 then 4 additional week. Initial coverage duration with boceprevir-12 weeks initially then based upon HCV RNA levels at weeks 4, 8 and 20 of boceprevir. Continued authorization: TREATMENT-NAÏVE-If HCV RNA is greater than 100 IU/mL at week 8 of boceprevir then no additional authorization as treatment is not effective. If HCV RNA is less than 100 IU/mL at week 8 of boceprevir then 12 additional weeks. If HCV RNA is greater than 10 IU/mL at week 20 of boceprevir no additional authorization as treatment is not effective. If HCV RNA is less than 10 IU/mL at week 20 of boceprevir and HCV RNA was less than 10IU/ml(undetectable) at week 4 of boceprevir then no additional authorization as treatment is complete or if HCV RNA at week 4 of boceprevir was greater than 10IU/ml(detectable) then 8 additional weeks. PRIOR RELAPSERS OR PRIOR PARTIAL RESPONDERS-If HCV RNA greater than 100 IU/mL at week 8 of boceprevir then no additional authorization as treatment is not effective. If HCV RNA less than 100 IU/mL at week 8 of boceprevir then 12 additional weeks. If HCV RNA is greater than 10 IU/mL at week 20 of boceprevir no additional authorization as treatment is not effective. If HCV RNA is less than 10 IU/mL at week 20 of boceprevir 8 additional weeks . COMPENSATED CIRRHOSIS OR PRIOR NULL-RESPONDERS-If HCV RNA greater than 100 IU/mL at week 8 of boceprevir no additional authorization as treatment is not effective. If HCV RNA less than 100 IU/mL at week 8 of boceprevir then 12 additional weeks then if HCV RNA greater than 10 IU/mL at week 20 of boceprevir no additional authorization as treatment not effective or if HCV RNA is less than 10 IU/mL at week 20 of boceprevir then 20 additional weeks.

## PEGIntron

**Drugs**
PegIntron Redipen, PegIntron subcutaneous kit 120 mcg/0.5 mL, 150 mcg/0.5 mL, 50 mcg/0.5 mL, 80 mcg/0.5 mL

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

**Exclusion Criteria**

**Required Medical Information**
ADMINISTERED WITH A HCV PROTEASE INHIBITOR-Peginterferon alfa-2b will be used in combination with a hepatitis C virus protease inhibitor (e.g. boceprevir or telaprevir) for the initial treatment or retreatment of chronic hepatitis C AND there is a confirmed diagnosis of chronic hepatitis C genotype 1 AND prior authorization has been approved for either boceprevir (Victrelis) or telaprevir (Incivek) AND there is documentation of the patient's treatment history. ADMINISTERED WITHOUT A HCV PROTEASE INHIBITOR-Peginterferon alfa-2b will be used without a hepatitis C protease inhibitor (e.g. boceprevir or telaprevir) for the initial treatment of chronic hepatitis C (any genotype) AND detectable HCV RNA levels are higher than 50 IU/ml AND Peginterferon alfa-2b will be used in combination with ribavirin, unless ribavirin is contraindicated AND patient has not received previous treatment with peginterferon alfa-2a or peginterferon alfa-2b AND there is documentation that peginterferon alfa-2b will not be used with a hepatitis C protease inhibitor (e.g. boceprevir or telaprevir).

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
Genotype 2,3-24 weeks,genotype not 2,3-12 weeks then 36 wks,ribavirin contraindicated/HIV+-48 wks

**Other Criteria**
DURATION OF COVERAGE WITH HCV PROTEASE INHIBITOR-Initial coverage duration with telapravir-8 weeks initially and if HCV RNA is greater than 1000u/ml at week 4 then no additional authorization as treatment is not effective. If HCV RNA is less than 1,000IU/ml at week 4 then 4 additional week. Initial coverage duration with boceprevir-12 weeks initially then based upon HCV RNA levels at weeks 4, 8 and 20 of boceprevir. Continued authorization-TREATMENT-NAÏVE-If HCV RNA is greater than 100 IU/mL at week 8 of boceprevir then no additional authorization as treatment is not effective. If HCV RNA is less than 100 IU/mL at week 8 of boceprevir then 12 additional weeks. If HCV RNA is greater than 10 IU/mL at week 20 of boceprevir no additional authorization as treatment is not effective. If HCV RNA is less than 10 IU/mL at week 20 of boceprevir and HCV RNA was less than 10IU/ml(undetectable) at week 4 of boceprevir then no additional authorization as treatment is complete or if HCV RNA at week 4 of boceprevir was greater than 10IU/ml(detectable) then 8 additional weeks. PRIOR RELAPSERS OR PRIOR PARTIAL RESPONDERS-If HCV RNA greater than 100 IU/mL at week 8 of boceprevir then no additional authorization as treatment is not effective. If HCV RNA less than 100 IU/mL at week 8 of boceprevir then 12 additional weeks. If HCV RNA is greater than 10 IU/mL at week 20 of boceprevir no additional authorization as treatment is not effective. If HCV RNA is less than 10 IU/mL at week 20 of boceprevir 8 additional weeks. COMPENSATED CIRRHOSIS OR PRIOR NULL-RESPONDERS-If HCV RNA greater than 100 IU/mL at week 8 of boceprevir no additional authorization as treatment is not effective. If HCV RNA less than 100 IU/mL at week 8 of boceprevir then 12 additional weeks then if HCV RNA greater than 10 IU/mL at week 20 of boceprevir no additional authorization as treatment not effective or if HCV RNA is less than 10 IU/mL at week 20 of boceprevir then 20 additional weeks.

## Perjeta

**Drugs**
Perjeta

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

**Exclusion Criteria**

**Required Medical Information**
A diagnosis of HER2-positive metastatic breast cancer AND pertuzumab is used concomitantly with trastuzumab and chemotherapy AND pertuzumab is used in one of the following settings: Patient with no prior treatment for metastatic breast cancer, or patient received one prior therapy for metastatic breast cancer that included trastuzumab plus chemotherapy in the absence of pertuzumab.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Pituitary

### Drugs
Genotropin, Genotropin MiniQuick, Humatrope, Norditropin FlexPro, Norditropin Nordiflex, Saizen click.easy, Saizen subcutaneous recon soln 5 mg, Serostim subcutaneous recon soln 4 mg, 5 mg, 6 mg, Tev-Tropin, Zorbtive

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

### Exclusion Criteria

### Required Medical Information
Adult and Pediatric-Omnitrope OR Nutropin products have not been tolerated AND documented AND Pediatrics-Documented GHD defined as two GH stimulation tests below 10ng/ml OR at least one GH stimulation test less than 15ng/ml and IGF-1 and IGF-BP3 levels below normal for bone age and sex OR one GH stimulation test below 10ng/ml for those with defined CNS pathology, history of irradiation, or genetic condition associated with GHD OR growth stimulation hormone tests, IGF-1 or IGF-BP3 levels are not needed for GHD if multiple pituitary hormone deficiencies exist OR for congential GHD. Open growth plates-an initial bone age, demonstration of open growth plates. Short Stature/Growth failure-Height is less than the minimum percentile specified for age/sex OR when the height is below the minimum percentile specified for age/sex and untreated growth velocity with a minimum of 1 year of growth data is below the 25th percentile OR if GHD defined as GH stimulation tests, IGF-1 or IGF-BP3 levels not needed for cogential GHD, growth failure/short stature is not needed. Chronic Renal Insufficiency-requires weekly dialysis OR chronic renal insufficiency defined as glomerular filtration rate (GFR) less than 75ml/min/1.73m2. Adults-Diagnosis of growth hormone deficiency with panhypopituitarism-One pituitary hormone deficiency other than growth hormone requiring hormone replacement AND at least one known cause for pituitary disease or condition affecting pituitary function is documented AND one provocative stimulation test less than 5ng/ml OR three pituitary hormone deficiencies other than growth hormone requiring hormone replacement AND an IGF-1 below 80ng/ml. Short bowel syndrome (SBS)-ability to ingest solid food AND dependent on parenteral nutrition at least five days per week to provide at least 3000 calories per week AND chart notes indicate dietary needs and goals have been addressed.

### Age Restriction

### Prescriber Restriction

### Coverage Duration
Short bowel syndrome-up to 4 weeks. All other indications- up to 1 year.

### Other Criteria

## Pomalyst

**Drugs**
Pomalyst

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

**Exclusion Criteria**

**Required Medical Information**
Documentation of recurrent multiple myeloma AND at least two prior therapies for multiple myeloma have been ineffective or not tolerated and these prior therapy regimens must have included both bortezomib, and an immunomodulator, unless contraindicated.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Promacta

**Drugs**
Promacta

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

**Exclusion Criteria**

**Required Medical Information**
Diagnosis of chronic ITP made by or in consultation with a hematologist AND patient is at risk of spontaneous bleeding as demonstrated in chart notes by either platelet count less than 20,000mm3 or platelet count less than 30,000/mm3 accompanied by symptoms of bleeding AND treatment with at least one of the following ITP treatments was ineffective or not tolerated: adequate course of systemic corticosteroids or immunoglobulin replacement therapy or splenectomy OR diagnosis of hepatitis C with thrombocytopenia and is unable to initiate or maintain interferon therapy due to platelet count less than 75,000/mm3.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
Initial-3 months then every 6 months

**Other Criteria**

## Pulmonary Antihypertensives

**Drugs**
Letairis, Remodulin, Revatio intravenous, sildenafil, Tracleer, Ventavis

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

**Exclusion Criteria**

**Required Medical Information**
Diagnosis of World Health Organization (WHO) Group 1 pulmonary aterial hypertension (PAH) confirmed with right heart catheterization (RHC) AND patient is non-responsive to vasodilator therapy defined as: calcium channel blockers are ineffective, not tolerated or contraindicated OR negative response to acute vasoreactivity testing (such as IV epoprostenol or nitric oxide) OR vasoreactivity testing is contraindicated.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Quinine Sulfate

**Drugs**
quinine sulfate

**Covered Uses**
All FDA-approved indications not otherwise excluded from Part D, babesiosis.

**Exclusion Criteria**

**Required Medical Information**
Documented diagnosis of uncomplicated malaria due to Plasmodium falciparum or babesiosis.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
up to 10 days

**Other Criteria**

## Relistor

**Drugs**
Relistor subcutaneous kit

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

**Exclusion Criteria**

**Required Medical Information**
Diagnosis of opioid-induced constipation AND Patient has used opioid medication for a minimum of 2 weeks AND Patient is experiencing fewer than 3 bowel movements in a week or no bowel movement for longer than 2 days AND Patient is diagnosed with an advanced illness (e.g., incurable cancer, end-stage chronic obstructive pulmonary disease/emphysema, cardiovascular disease/heart failure, Alzheimer's disease/dementia, HIV/AIDS, etc.) AND Patient is receiving palliative care AND Patient has tried and had an insufficient response to laxative (e.g., lactulose and or polyethylene glycol) therapy.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
Up to 4 months

**Other Criteria**

## Remicade

**Drugs**
Remicade

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

**Exclusion Criteria**

**Required Medical Information**
Rheumatoid Arthritis (RA)-diagnosis of RA or meets 4 of 7 criteria of the American College of Rheumatology Classification Criteria for Establishing the Diagnosis of RA AND methotrexate has been ineffective after at least a 6-12 week treatment course based on documentation which includes one or more of the components of the American College of Rheumatology Assessment Components for Improvement in RA except if methotrexate is contraindicated or not tolerated based on clinical documentation AND infliximab administered with an oral DMARD (such as, but not limited to, methotrexate). Ankylosing spondylitis-diagnosis of ankylosing spondylitis. Crohn's Disease and Ulcerative Colitis-fistulizing Crohn's disease OR acute treatment of an exacerbation of Crohn's disease or ulcerative colitis where adequate course of systemic corticosteroids(such as, but not limited to, 40-60mg prednisone per day for 10-14 days) has been ineffective or contraindicated OR unable to taper off an adequate course of systemic corticosteroids without worsening or symptoms OR patient is experiencing breakthrough disease while stabilized for at least 2 months on an immunomodulatory medication (such as, but not limited to, azathioprine, mercaptopurine, cyclosporine or methotrexate). Plaque psoriasis-chart notes support a diagnosis of chronic plaque psoriasis involving at least 10% of the body surface area or causes significant functional impairment disability AND treatment with at least one oral systemic agent for psoriasis (such as, but not limited to, cyclosporine, methotrexate or acitretin) was ineffective or not tolerated, unless all are contraindicated.

**Age Restriction**

**Prescriber Restriction**
Plaque psoriasis-dermatologist or rheumatologist

**Coverage Duration**
Initial authorization-6 months then continued authorization 1 year

**Other Criteria**

## Revlimid

**Drugs**
Revlimid

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

**Exclusion Criteria**

**Required Medical Information**
Diagnosis of myelodysplastic syndrome(MDS) when patient is transfusion dependent (defined as administration of 2 or more units of red blood cells (RBCs) in the previous 8 weeks) AND patient has an absolute neutrophil count of at least 500/mm3 AND patient has a platelet count of at least 50,000/mm3. Diagnosis of multiple Myeloma (MM)-when lenalidomide is used in combination with corticosteroid (such as, but not limited to, dexamethasone) unless used as maintenance or documentation is provided that a corticosteroid is contraindicated or is not tolerated AND patient has an absolute neutrophil count(ANC) of at least 1,000/mm3 AND patient has a platelet count of at least 30,000/mm3. Diagnosis of Mantle cell lymphoma (MCL) when prior two prior therapies, one of which must have been bortezomib, have been ineffective or not tolerated AND patients has an AND of at least 500 cells/mm3 AND patient has a platelet count of at least 50,000/mm3.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
MDS-Initially 3 months then yearly. All other -1 year

**Other Criteria**

## Rituxan

**Drugs**
Rituxan

**Covered Uses**
All FDA-approved indications not otherwise excluded from Part D, Refractory autoimmune hemolytic anemia (AIHA), Multicentric Castleman's disease (angiofollicular lymph node hyperplasia), Refractory Evan's syndrome, Relapsed or refractory hairy cell leukemia, Primary central nervous system (CNS) lymphoma, CD20-positive B-cell post-transplant lymphoproliferative disorder (B-PTLD), Waldenström's macroglobulinemia.

**Exclusion Criteria**

**Required Medical Information**
A diagnosis of B-cell mediated cancer OR a diagnosis of refractory autoimmune hemolytic anemia (AIHA) when an adequate course of corticosteroids (such as, but not limited to, prednisone 1mg/kg/day for 3 weeks) is ineffective, unless contraindicated or not tolerated OR a diagnosis of multicentric Castleman's disease (angiofollicular lymph node hyperplasia) OR patients with refractory chronic immune (idiopathic) thrombocytopenic purpura (ITP) when a diagnosis of chronic ITP is made by, or in consultation with, a hematologist AND patient is at risk of spontaneous bleeding as demonstrated in chart notes by either one of the following criteria: platelet count is less than 20,000/mm3 OR platelet count is less than 30,000/mm3 accompanied by symptoms of bleeding AND prior treatment with a corticosteroid (unless contraindicated), is ineffective or not tolerated OR a diagnosis of dermatomyositis documented with EMG abnormalities and/or increased CPK levels, with associated functional impairment when corticosteroids have been ineffective, are contraindicated, or are not tolerated OR a diagnosis of refractory Evan's syndrome when at least two prior therapies have been ineffective, contraindicated, or not tolerated OR a diagnosis of polymyositis documented with EMG abnormalities and/or increased CPK levels, with associated functional impairment when corticosteroids have been ineffective, are contraindicated, or are not tolerated OR a diagnosis of CD20-positive B-cell post-transplant lymphoproliferative disorder when tapering of immunosuppressive medications is not effective or is contraindicated.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**
OR a diagnosis  of moderately to severely active rheumatoid arthritis (RA) when: the diagnosis has been established by a rheumatologist or meets 4 of 7 criteria of the American College of Rheumatology Classification Criteria for Establishing the Diagnosis of RA AND treatment with two biologic treatments for RA have been ineffective after at least a 12-week treatment course or have not been tolerated unless all are contraindicated AND rituximab is given in combination with methotrexate unless contraindicated or not tolerated OR a diagnosis of Waldenström's macroglobulinemia OR a diagnosis of Wegener's granulomatosis when prior therapy with cyclophosphamide plus corticosteroids has been ineffective, is contraindicated, or is not tolerated.

## Serum immunoglobulins gamma

**Drugs**
Bivigam, Carimune NF Nanofiltered intravenous recon soln 6 gram, Gammagard Liquid, Gammaplex, Gamunex-C injection solution 1 gram/10 mL (10 %), Privigen

**Covered Uses**
All FDA-approved indications not otherwise excluded from Part D, Acquired Factor VIII inhibitor,Acute inflammatory demyelinating polyneuropathy, Allogeneic bone marrow transplant recipients, Autoimmune hemolytic anemia, dermatomyositis, Fetal alloimmune thrombocytopenia, HIV infected children with T4 count greater than 200/mm3, Hypogammaglobulinemic neonates, Lambert-Eaton myasthenic syndrome, Multifocal motor neuropathy, Multiple myeloma, Myasthenia gravis, Intractable pediatric epilepsy, Polymyositis, Post transfusion purpura, Pure red cell aplasia, Refactory pemphigus foliaceus, Solid organ transplant, Stiff-Person syndrome, Systemic lupus erythematosus.

**Exclusion Criteria**

**Required Medical Information**
Acquired Factor VIII inhibitor-when conventional therapy (such as cyclophosphamide, corticosteroids or azathioprine) is ineffective or not tolerated. Allogeneic bone marrow transplant recipients who are 20 years of age or older for up to 4 months following transplantation. Autoimmune hemolytic anemia- warm type AIHA that does not respond to alternative therapies(such as corticosteroids, immunosuppressive agents, plasmapheresis, or splenectomy). Dermatomyositis-documented EMG abnormalities and/or increased CPK levels with associated severe disability when corticosteroid therapy is ineffective or not tolerated. Fetal alloimmune thrombocytopenia-documented diagnosis. HIV infected children(less than 13 years of age) when T4 cell count is greater than 200/mm3. Hypogammaglobulinemia(acquired) associated with either chronic B-cell lymphocytic leukemia or post allogeneic bone marrow transplant and documented with laboratory findings. Hypogammaglobulinemic neonates-low birth weight(less than 1500g) or in a setting with high baseline infection rate or morbidity. Inflammatory demyelinating polyneuropathy(acute) including Guillain-Barre' syndrome with deteriorating pulmonary function tests OR rapid deterioration with symptoms for less than 2 weeks OR rapidly deteriorating ability to ambulate OR inability to walk independently for 10 meters. Inflammatory demyelinating polyneuropathy(chronic, CIDP) with significant functional disability AND documentation of slowing of nerve conduction velocity on EMG/NCS AND documentation of elevated spinal fluid protein on lumbar puncture or a nerve biopsy confirming diagnosis. Acute idiopathic thrombocytopenia purpura (ITP)-when rapid increase in platelet count is necessary. Chronic ITP-platelets less than 30,000/mm3 in children or less than 20,000/mm3 in adults.ITP in pregnancy-refractory to steroids with platelet counts less than 10,000/mm3 in the 3rd trimester OR platelet less than 30,000/mm3 associated with bleeding before delivery

**Age Restriction**
Allogeneic bone marrow transplant recipients- 20 years of age or older. HIV infected children-less than 13 years of age

**Prescriber Restriction**

**Coverage Duration**
90 days to 1 year depending on diagnosis

**Other Criteria**
OR history of autoimmune thrombocytopenia with previous pregnancy OR platelets less than 50,000/mm3 during current pregnancy OR past history of splenectomy. Kawasaki syndrome-during first 10 days of diagnosis. Lambert-Eaton myasthenic syndrome-other treatment options (such as pyridostigmine bromide, azathioprine or prednisone) are ineffective or not tolerated. Multifocal motor neuropathy-in patient with anti-GM1 antibodies and conduction block. Multiple myeloma-patients with stable disease and high risk of recurrent infections despite prophylactic antibiotic therapy, patients with poor IgG response to the pneumococcal vaccine or have low normal IgG levels during acute sepsis episodes. Myasthenia gravis-treatment of acute severe decompensation or chronic decompensation when other treatments (such as

plasmapheresis, pyridostigmine, azathioprine, cyclosporine, or cyclophosphamide) are ineffective or not tolerated. Pediatric intractable epilepsy in candidates for surgical resection or when other interventions(such as anticonvulsant medications, ketogenic diets, or corticosteroids) are ineffective or not tolerated. Polymyositis-patients with severe active illness when other interventions (such as corticosteroid therapy, azathioprine, methotrexate, or cyclophosphamide) have been ineffective or not tolerated. Post transfusion purpura-severly affected patients. Primary humoral immunodeficiency diseases-Baseline IgG level along with documented laboratory findings including X-linked agammaglobulinemia diagnosis accompanied by marked deficits or absence of all five immunoglobulin classes, decreased circulating B lymphocytes and normal numbers of functioning T lymphocytes OR hypogammaglobulinemia OR common variable immunodeficiency documented with low to normal IgG levels and inability to produce an antibody response to protein or carbohydrate antigens OR immunoglobulin subclass deficiency accompanied by very low serum IgG, IgA and IgE with normal or elevated polyclonal IgM OR combined immunodeficiency syndromes including Wiskott-Aldrich accompanied by marked deficits in IgG, IgA, IgM, low lymphocyte counts and absent or below normal levels of both B and T lymphocytes. Pure red cell aplasia with documented parvovirus B19 infection and severe anemia. Refractory pemphigus foliaceus resistant to conventional treatment (such as immunosuppressive agents or plasmapheresis). Solid organ transplant in treatment of antibody-mediated rejection and prior to transplant patient at high risk for anti-body mediated rejection and those receiving an ABO incompatible organ OR following a solid organ transplant. Stiff-Person Syndrome-when treatment with other agents (such as diazepam, baclofen, clonazepam, valproic acid, or clonidine) is ineffective or not tolerated. Systemic lupus erythematosus-severe active disease when other interventions (such as corticosteroids, cyclophosphamide or azathioprine) are ineffective or not tolerated.

## Simponi

**Drugs**
Simponi subcutaneous pen injector 100 mg/mL, Simponi subcutaneous syringe

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

**Exclusion Criteria**

**Required Medical Information**
Diagnosis of ankylosing spondylitis or psoriatic arthritis when the diagnosis has been established by a rheumatologist or dermatologist. Diagnosis of rheumatoid arthritis when the diagnosis has been established by a rheumatologist or meets 4 of 7 criteria of the American College of Rheumatology Classification Criteria for Establishing the Diagnosis of Rheumatoid Arthritis AND methotrexate is ineffective after a minimum 6 to 12 week treatment course based on documentation of the American College of Rheumatology Assessment Components for Improvement in Rheumatoid Arthritis except where methotrexate is contraindicated or not tolerated based on clinical documentation AND golimumab(Simponi) is administered with an oral DMARD.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Simponi Aria

**Drugs**
Simponi ARIA

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

**Exclusion Criteria**

**Required Medical Information**
Diagnosis of rheumatoid arthritis when the diagnosis has been established by a rheumatologist or meets 4 of 7 criteria of the American College of Rheumatology Classification Criteria for Establishing the Diagnosis of Rheumatoid Arthritis AND methotrexate is ineffective after a minimum 6 to 12 week treatment course based on documentation of the American College of Rheumatology Assessment Components for Improvement in Rheumatoid Arthritis except where methotrexate is contraindicated or not tolerated based on clinical documentation AND golimumab(Simponi) is administered with an oral DMARD.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Sovaldi

**Drugs**
Sovaldi

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

**Exclusion Criteria**

**Required Medical Information**
CHRONIC HEPATITIS C GENOTYPE 1: A diagnosis of chronic genotype 1 hepatitis C virus (HCV) infection AND ribavirin will be used in combination with sofosbuvir AND peginterferon will be used in combination with sofosbuvir and ribavirin, unless peginterferon is contraindicated or is not a treatment option AND the member has not been previously treated with sofosbuvir (Sovaldi) CHRONIC HEPATITIS C GENOTYPE 2 OR 3: A diagnosis of chronic HCV genotype 2 or 3 HCV infection AND ribavirin will be used in combination with sofosbuvir AND the member has not been previously treated with sofosbuvir (Sovaldi). CHRONIC HEPATITIS C GENOTYPE 4: A diagnosis of chronic genotype 4 HCV infection AND peginterferon and ribavirin will be used in combination with sofosbuvir AND the member has not been previously treated with sofosbuvir (Sovaldi)

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
GT1(+PEG+RIBA),GT1(+simeprevir),GT2, GT4:12wks. GT1(+RIBA),GT3: 24wks. HCC/pre-liver trnsplnt: 48wks

**Other Criteria**
IN COMBINATION WITH SIMEPREVIR (OLSYIO): A diagnosis of chronic genotype 1 HCV infection AND sofosbuvir will be given in combination with simeprevir AND the member was a partial responder or null responder to prior treatment with peginterferon and ribavirin OR the member is treatment-naive or relapsed following prior treatment with peginterferon and ribavirin and peginterferon is contraindicated or is not a treatment option AND the member has not been previously treated with sofosbuvir (Sovaldi) HEPATOCELLULAR CARCINOMA / PRE-LIVER TRANSPLANT: A diagnosis of chronic HCV infection AND a diagnosis of hepatocellular carcinoma AND the member is awaiting liver transplantation AND sofosbuvir will be given in combination with ribavirin.

## Sprycel

**Drugs**
Sprycel

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

**Exclusion Criteria**

**Required Medical Information**
Documentation of chronic or accelerated phase chronic myelogenous leukemia (CML) when there is documentation that the patient's CML is Philadelphia chromosome-positive (PH+) AND treatment with nilotinib(Tasigna) has been ineffective, not tolerated or contraindicated  OR documentation of blast phase CML when there is documentation that the patients CML is Philadelphia chromosome-positive (PH+) AND treatment with imatinib(Gleevec) has been ineffective, not tolerated or contraindicated OR documentation of acute lymphoblastic leukemia (ALL) when there is documentation that the patient's ALL is Philadelphia chromosome-positive (PH+) AND treatment wtih imatinib (Gleevec) has been ineffective, not tolerated or contraindicated.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Stelara

**Drugs**
Stelara subcutaneous syringe

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

**Exclusion Criteria**

**Required Medical Information**
Diagnosis of moderate to severe psoriasis where chart notes support a diagnosis of chronic plaque psoriasis involving at least 10% of the body surface area or causes significant functional disability AND treatment with at least one oral systemic agent for psoriasis was ineffective or not tolerated, unless all are contraindicated.

**Age Restriction**

**Prescriber Restriction**
Dermatologist or rheumatologist

**Coverage Duration**
1 year

**Other Criteria**

## Stivarga

**Drugs**
Stivarga

**Covered Uses**
All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria**

**Required Medical Information**
A diagnosis of metastatic colorectal cancer AND prior treatment with bevacizumab (Avastin) has been ineffective, contraindicated or not tolerated AND prior treatment with and anti-EGFR therapy [i.e. cetuximab (Erbitux) or panitumumab (Vectibix)] has been ineffective, contraindicated or not tolerated when no KRAS mutation is present (for use with KRAS wild type tumors only) OR a diagnosis of locally advanced, unresectable or metastatic gastrointestinal stromal tumor (GIST) AND prior treatment with imatinib (Gleevec) and sunitinib (Sutent) have been ineffective, contraindicated, or not tolerated.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Sutent

**Drugs**
Sutent oral capsule 12.5 mg, 25 mg, 37.5 mg, 50 mg

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

**Exclusion Criteria**

**Required Medical Information**
Documentation of one the following diagnoses: gastrointestinal stromal tumor(GIST) OR renal cell carcinoma(RCC) OR pancreatic neuroendocrine tumors.

**Age Restriction**

**Prescriber Restriction**
Hematologist or oncologist

**Coverage Duration**
1 year

**Other Criteria**

## Sylatron

**Drugs**
Sylatron

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

**Exclusion Criteria**

**Required Medical Information**
Documentation Sylatron is being used for the adjuvant treatment (after surgery) of malignant melanoma.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Sylvant

**Drugs**
Sylvant

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

**Exclusion Criteria**

**Required Medical Information**
A diagnosis of multicentric Castleman's disease (MCD) AND the patient is negative for human immunodeficiency virus (HIV) AND the patient is negative for human herpesvirus-8 (HHV-8).

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Synagis

**Drugs**
Synagis intramuscular solution 50 mg/0.5 mL

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

**Exclusion Criteria**

**Required Medical Information**
Infants with bronchopulmonary dysplasia who are less than 2 years of age at the start of the current RSV season and who have required medical therapy for bronchopulmonary dysplasia within 6 months of or during the RSV season or infants with bronchopulmonary dysplasia that required treatment with supplemental oxygen as neonates for at least 28 days OR infants less than or equal to 3 months of chronological age (post-natal age) at the onset of RSV season and with a history of premature birth between 32 0/7 weeks to 34 6/7 weeks gestation who have at least one of the following risk factors: childcare attendance or school aged siblings or siblings in the household who are less than 5 years of age OR infants less than or equal to 12 months of chronological age(post-natal age) with congenital abnormalities of the airway or neuromuscular disease OR infants less than or equal to 6 months chronological age(post-natal) at the onset of RSV season with a history of premature birth between 29 0/7 to 31 6/7 weeks with or without the presence of additional risk factors OR infants less than or equal to 12 months chronological age(post-natal) at the onset of RSV season and born at 28 6/7 weeks of gestation or earlier OR infants or children with hemodynamically significant congenital heart disease who are 24 months of age or younger at the onset of RSV season who: receive medication to control congestive heart failure OR have moderate to severe pulmonary hypertension OR have cyanotic heart disease.

**Age Restriction**
24 months or younger

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Synribo

**Drugs**
Synribo

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

**Exclusion Criteria**

**Required Medical Information**
Diagnosis of chronic myelogenous leukemia (CML) AND prior therapy with at least two tyrosine kinase inhibitors (TKIs) for CML is not effective or is not tolerated, unless all TKIs are contraindicated.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Tafinlar

**Drugs**
Tafinlar

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

**Exclusion Criteria**

**Required Medical Information**
A definitive diagnosis of unresectable or metastatic melanoma AND there is documentation of a BRAF V600E mutation as detected by a Food and Drug Administration (FDA) approved test.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**
QLL: 120 per month

## Tarceva

**Drugs**
Tarceva

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

**Exclusion Criteria**

**Required Medical Information**
A diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC) when at least one prior chemotherapy regimen prescribed for non-small cell lung cancer was not effective (documented disease progression either during or after treatment)or used as a single maintenance chemotherapy after four cycles of platinum-based chemotherapy or used as first-line therapy when an EGFR mutation is present OR a diagnosis of locally advanced, unresectable or metastatic pancreatic cancer when given in combination with gemcitabine.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Tasigna

**Drugs**
Tasigna

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

**Exclusion Criteria**

**Required Medical Information**
Documentation of diagnosis of chronic or accelerated phase Philadelphia chromosome positive chronic myelogenous leukemia(Ph+ CML).

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Testosterone topical gel 1% (Testim Gel)

**Drugs**
Testim

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

**Exclusion Criteria**

**Required Medical Information**
Prior treatment with testosterone topical gel (AndroGel or AndroGel Pump) has been ineffective, contraindicated, or not tolerated.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Tretinoin topical products

**Drugs**
Atralin, Retin-A Micro, TRETIN-X topical cream 0.0375 %, tretinoin microspheres topical gel, tretinoin microspheres topical gel with pump 0.1 %, tretinoin topical

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

**Exclusion Criteria**

**Required Medical Information**
Documentation of diagnosis.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Tykerb

**Drugs**
Tykerb

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

**Exclusion Criteria**

**Required Medical Information**
Documentation of diagnosis of HER 2 positive breast cancer.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Tysabri

**Drugs**
Tysabri

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

**Exclusion Criteria**

**Required Medical Information**
Multiple Sclerosis- A definitive diagnosis of a relapsing form of multiple sclerosis (relapsing-remitting or secondary progressing multiple sclerosis) AND interferon beta product (Avonex, Rebif, Betaseron or Extavia) OR glatiramer acetate (Copaxone) was documented in clinical notes to be ineffective, contraindicated or not tolerated with ineffectiveness defined as meeting two of the following criteria: patient continues to have clinical relapses(at least two clinical relapses within the past 12 months) or patient continues to have CNS lesion progression as measured by MRI or patient continues to have worsening disability. Crohn's Disease-A diagnosis of Crohn's disease AND infliximab (Remicade) is not effective after at least an initial induction period (5mg/kg on weeks 0,2,6) except if not tolerated due to documented clinical side effects AND adalimumab(Humira) is not effective after at least an initial 3-dose induction period except if not tolerated due to documented clinical side effects.

**Age Restriction**

**Prescriber Restriction**
Multiple Sclerosis-Prescribed by or in consultation with a neurologist or multiple sclerosis physician specialist. Crohn's Disease- Prescribed by or in consultation with a gastro-enterologist.

**Coverage Duration**
MS-1 year, Crohn's-initially 12 weeks then every 6 months

**Other Criteria**

## Velcade

**Drugs**
Velcade

**Covered Uses**
All FDA-approved indications not otherwise excluded from Part D, Waldenstrom macroglobulinemia.

**Exclusion Criteria**

**Required Medical Information**
A diagnosis of multiple myeloma OR a diagnosis of mantle cell lymphoma in patients who have received at least one prior therapy OR a diagnosis of Waldenstrom macroglobulinemia.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Victoza

**Drugs**
Victoza 3-Pak

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

**Exclusion Criteria**

**Required Medical Information**
Documentation that a 90-day treatment course with each metformin AND exenatide (Byetta, Bydureon) did not adequately reduce hemoglobin A1C to goal of 7% or less, were not tolerated, or are contraindicated.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Victrelis

**Drugs**
Victrelis

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

**Exclusion Criteria**

**Required Medical Information**
A diagnosis of chronic genotype 1 hepatitis C virus (HCV) infection AND peginterferon and ribavirin will be administered for four weeks immediately preceding initiation of boceprevir AND boceprevir will be given concomitantly with peginterferon and ribavirin for the appropriate treatment course based upon member treatment history and HCV RNA level AND liver biopsy results are obtained unless liver biopsy is contraindicated or there is documentation of compensated cirrhosis based on imaging studies AND treatment with telaprevir (Incivek) is contraindicated or not recommended AND there is documentation of any one of the four that indicates the patient is: 1) treatment-naïve who has never received therapy for the treatment for hepatitis C or 2) a relapser who had an undetectable HCV RNA level at the end of prior therapy with peginterferon and ribavirin but had a subsequent detectable HCV RNA level during the follow-up period or 3) a partial responder who had a HCV RNA reduction of greater than or equal to 2 log10 after 12 weeks of prior therapy with peginterferon and ribavirin, but still had a detectable HCV RNA level during the treatment period or 4) a null responder who had a less than 2 log10 reduction in HCV RNA after 12 weeks of prior therapy with peginterferon and ribavirin.

**Age Restriction**
Minimum 18 years of age

**Prescriber Restriction**

**Coverage Duration**
8 weeks initially then based upon HCV RNA levels at weeks 4, 8, and 20 of boceprevir

**Other Criteria**
Continued authorization: TREATMENT-NAÏVE-If HCV RNA is greater than 100 IU/mL at week 8 of boceprevir then no additional authorization as treatment is not effective. If HCV RNA is less than 100 IU/mL at week 8 of boceprevir then 12 additional weeks. If HCV RNA is greater than 10 IU/mL at week 20 of boceprevir no additional authorization as treatment is not effective. If HCV RNA is less than 10 IU/mL at week 20 of boceprevir and HCV RNA was less than 10IU/ml(undetectable) at week 4 of boceprevir then no additional authorization as treatment is complete or if HCV RNA at week 4 of boceprevir was greater than 10IU/ml(detectable) then 8 additional weeks. PRIOR RELAPSERS OR PRIOR PARTIAL RESPONDERS-If HCV RNA greater than 100 IU/mL at week 8 of boceprevir then no additional authorization as treatment is not effective. If HCV RNA less than 100 IU/mL at week 8 of boceprevir then 12 additional weeks. If HCV RNA is greater than 10 IU/mL at week 20 of boceprevir no additional authorization as treatment is not effective. If HCV RNA is less than 10 IU/mL at week 20 of boceprevir 8 additional weeks . COMPENSATED CIRRHOSIS OR PRIOR NULL-RESPONDERS-If HCV RNA greater than 100 IU/mL at week 8 of boceprevir no additional authorization as treatment is not effective. If HCV RNA less than 100 IU/mL at week 8 of boceprevir then 12 additional weeks then if HCV RNA greater than 10 IU/mL at week 20 of boceprevir no additional authorization as treatment not effective or if HCV RNA is less than 10 IU/mL at week 20 of boceprevir then 20 additional weeks.

## Votrient

**Drugs**
Votrient

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

**Exclusion Criteria**

**Required Medical Information**
Diagnosis of renal cell carcinoma and sunitinib(Sutent)has been ineffective, not tolerated or contraindicated.

**Age Restriction**

**Prescriber Restriction**
Oncologist

**Coverage Duration**
1 year

**Other Criteria**

## Xalkori

**Drugs**
Xalkori

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

**Exclusion Criteria**

**Required Medical Information**
A diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC) AND there is documentation that the tumor expresses anaplastic lymphoma kinase (ALK), meaning that it is an ALK positive tumor.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Xenazine

**Drugs**
Xenazine

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

**Exclusion Criteria**

**Required Medical Information**
Diagnosis of Huntington's disease with presence of chorea symptoms as confirmed by a neurologist AND chart notes document that the patient is being monitored for symptoms of depression and if depression present that it is being addressed.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
Initially 3 months then every 6 months

**Other Criteria**

## Xgeva

**Drugs**
Xgeva

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

**Exclusion Criteria**
Hypocalcemia (calcium less than 8.0 mg/dL).

**Required Medical Information**
For the prevention of skeletal-related events: Diagnosis of a solid tumor (e.g., breast cancer, castrate-resistant prostate cancer, thyroid carcinoma, kidney, or non-small cell lung cancer) AND patient has bone metastases AND Medication will be used for the prevention of skeletal-related events (e.g., spinal cord compression, hypercalcemia, bone pain or lesions requiring radiation or surgery) AND patient will receive supplementation with calcium and vitamin D AND patient has tried and had an inadequate response to pamidronate or zoledronic acid, or both pamidronate and zoledronic acid are contraindicated. For the treatment of giant cell tumor of the bone: diagnosis of giant cell tumor of the bone AND the tumor is unresectable OR the tumor is resectable, but surgical resection is contraindicated.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
12 months

**Other Criteria**

## Xolair

**Drugs**
Xolair

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

**Exclusion Criteria**

**Required Medical Information**
Patient is followed by an asthma specialist (allergist, immunologist or pulmonologist) AND positive skin prick test or in-vitro specific IgE test to one or more allergens which supports the patient's clinical history AND total serum IgE level is greater than or equal to 30IU/ml and less than or equal to 700IU/ml AND clinical documentation of poor asthma control or recurrent exacerbation requiring additional medical treatment with recurrent exacerbation defined as 2 or more acute exacerbations in a 12 month period AND clinical documentation that the patient is compliant with high dose inhaled corticosteroids and long-acting beta-2 agonists and use of oral corticosteroids for exacerbation unless contraindicated AND underlying conditions or triggers for asthma or pulmonary disease are being maximally managed.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
6 months

**Other Criteria**

**Drugs**
Xtandi

**Covered Uses**
All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria**

**Required Medical Information**
A diagnosis of metastatic castration-resistant prostate cancer AND prior treatment with taxane chemotherapy has been ineffective, contraindicated or not tolerated AND prior treatment with abiraterone (Zytiga) has been ineffective, contraindicated or not tolerated.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Xyrem

**Drugs**
Xyrem

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

**Exclusion Criteria**

**Required Medical Information**
Narcolepsy with cataplexy(a sudden loss in muscle tone and deep tendon reflexes) OR narcolepsy with excessive daytime sleepiness when modafinil(Provigil) in doses up to 400mg daily has been ineffective, not tolerated or contraindicated AND at least one other generic stimulant drug or preferred brand stimulant drug (Adderall-XR or Metadate-CD) has been ineffective, not tolerated or contraindicated.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Yervoy

**Drugs**
Yervoy intravenous solution 50 mg/10 mL (5 mg/mL)

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

**Exclusion Criteria**

**Required Medical Information**
Diagnosis of unresectable or metastatic melanoma.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
4 infusions(one treatment course) then annually.

**Other Criteria**

## Zaltrap

**Drugs**
Zaltrap intravenous solution 100 mg/4 mL (25 mg/mL)

**Covered Uses**
All FDA approved indications not otherwise excluded from Part D.

**Exclusion Criteria**

**Required Medical Information**
Ziv-aflibercept (Zaltrap) may be considered medically when criteria A, B and C below are met: A. A diagnosis of metastatic colorectal cancer AND B. Prior treatment with an oxaliplatin (Eloxatin)-containing regimen has been ineffective or not tolerated AND C. Prior treatment with bevacizumab (Avastin) has been ineffective or not tolerated.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Zavesca

**Drugs**
Zavesca

**Covered Uses**
All FDA-approved indications not otherwise excluded from Part D

**Exclusion Criteria**

**Required Medical Information**
A diagnosis of type 1 Guacher disease.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Zelboraf

**Drugs**
Zelboraf

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

**Exclusion Criteria**

**Required Medical Information**
A diagnosis of unresectable or metastatic melanoma AND there is documentation of a BRAFV600 genetic mutation as detected by a Food and Drug Administration (FDA) approved test.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Zoledronic Acid

**Drugs**
zoledronic acid, zoledronic acid-mannitol-water intravenous solution, Zometa intravenous solution 4 mg/100 mL

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

**Exclusion Criteria**

**Required Medical Information**
Treatment of osteoporosis when an oral bisphosphonate (such as alendronate, ibandronate or risedronate) has been ineffective, not tolerated or contraindicated OR for the treatment of Paget's disease OR for the treatment of multiple myeloma and breast cancer when pamidronate has been ineffective, not tolerated or contraindicated OR for the treatment bone metastases from solid tumor cancers other than breast cancer s OR treatment of hypercalcemia of malignancy.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Zolinza

**Drugs**
Zolinza

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

**Exclusion Criteria**

**Required Medical Information**
A diagnosis of cutaneous T-cell lymphoma (CTCL) AND at least two prior system therapies [such as, but not limited to, all-trans retinoic acid (Vesanoid®), bexarotene (Targretin®), bortezomib (Velcade®), chlorambucil (Leukeran®), cyclophosphamide (Cytoxan®), denileukin diftitox (Ontak®), doxorubicin, liposomal (Doxil®), etoposide (VePesid®), gemcitabine (Gemzar®), interferon alfa (Intron® A), isotretinoin, methotrexate, pentostatin, pralatrexate (Folotyn®) or temozolomide (Temodar®)] have been ineffective or not tolerated.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
6 months

**Other Criteria**

## Zydelig

**Drugs**
Zydelig

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

**Exclusion Criteria**

**Required Medical Information**
Diagnosis of chronic lymphocytic leukemia (CLL) when at least one prior therapy for CLL has been ineffective and idelalisib will be administered in combination with rituximab OR diagnosis of follicular B-cell non-Hodgkin lymphoma (FL) when at least two prior therapies for FL have been ineffective and idelalisib will be used as monotherapy OR diagnosis of small lymphocytic lymphoma (SLL) when at least two prior therapies for SLL have been ineffective and idelalisib will be used as monotherapy.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Zykadia

**Drugs**
Zykadia

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

**Exclusion Criteria**

**Required Medical Information**
A diagnosis of locally advanced or metastatic (stage III or IV) non-small cell lung cancer (NSCLC) AND documentation that the tumor expresses an anaplastic lymphoma kinase (ALK) rearrangement (ALK-positive) AND prior therapy with crizotinib was not effective of not tolerated.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

## Zytiga

**Drugs**
Zytiga

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

**Exclusion Criteria**

**Required Medical Information**
A diagnosis of metastatic castration-resistant prostate cancer AND Zytiga will be used in combination with prednisone.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**
1 year

**Other Criteria**

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