2017 Prior Authorization Criteria

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

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

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

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

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

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

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

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

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

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

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

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

귀하 또는 귀하가 도와드리고 있는 분이**Florida Health Care Plans**에 관한 질문이 있을 경우, 귀하에게는 무료로 본인이 구사하는 언어로 도움과 정보를 받을 권리가 있습니다. 통역으로 전화 연결되려면**1-877-615-4022. (TTY: TRS Relay 711)** 번으로 전화해 주십시오.

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

જો તમને અથવા તમે જેને મદદ કરી રહ્યાં છો તેમને **Florida Health Care Plans** વિશે કોઈ પ્રશ્નો હોય, તો તમને તમારી ભાષામાં કોઇ પણ ખર્ચ વિના મદદ અને માહિતી મેળવવાનો હક છે. દુભાષિયા સાથે વાત કરવા માટે **1-877-615-4022. (TTY: TRS Relay 711)**
પર ફોન કરો.

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

Discrimination is Against the Law

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

Florida Health Care Plans:

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

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

If you need these services, contact Daria Siciliano, RN-BC, CCM.

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

Daria Siciliano, RN-BC, CCM,
Manager of Member Services,
1340 Ridgewood Avenue,
Holly Hill, FL 32117.
1-844-219-6137, TTY: TRS Relay 711, 386-676-7149,
rights@fhcp.com.

You can file grievance in person or by mail, fax, or email. If you need help filing a grievance, Daria Siciliano, RN-BC, CCM Manager of Member Services is available to help you.

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

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

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

H1035_A5228 CMS Accepted (08/11/2016)

ABILIFY MAINTENA

Drugs
Abilify Maintena Intramuscular SUSPENSION RECONSTITUTED 300 MG, 400 MG

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

Exclusion Criteria
Patient has a diagnosis of dementia-related psychosis.

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

ACTIMMUNE

Drugs
Actimmune

Covered Uses
All medically accepted indications not otherwise excluded from part D

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Diagnosis, Bone biopsy if osteopetrosis, Antibiotic failure if chronic granulomatous disease

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Infectious Disease/Hematology-oncology/Orthopedist/rheumatologist

Coverage Duration
12 months

Other Criteria
Sulfamethoxazole/Trimethoprim and/or itraconazole failure for infections secondary to chronic granulomatous disease. Osteopetrosis must be severe malignant

Adcirca Tabs

Drugs
Adcirca

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

Exclusion Criteria

Required Medical Information
Right Heart catheterization, vasoreactivity test.

Age Restriction

Prescriber Restriction
Pulmonology, Cardiology

Coverage Duration
12 months

Other Criteria
Failure of Sildenafil for WHO group 1 PAH

Adempas

Drugs
Adempas

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
pulmonologist/cardiologist

Coverage Duration
12 months

Other Criteria
For PAH must have tried and failed bosentan and sildenafil, CTPH does not require failure of bosentan

Alecensa

Drugs
Alecensa

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Hematology/Oncology

Coverage Duration
12 months

Other Criteria
Approved for ALK+ Non Small Cell Lung Cancer after progression on crizotinib

Alunbrig FHCP

Drugs
Alunbrig

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Hematology/Oncology

Coverage Duration
12 months or until progression

Other Criteria

AMITIZA

Drugs
Amitiza

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

Exclusion Criteria
FDA labeled contraindication

Required Medical Information
Previous Treatment History

Age Restriction
Ages in FDA label

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
Failure of Lactulose and polyethylele glycol 3350 (Miralax)

Ampyra (s)

Drugs
Ampyra

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

Exclusion Criteria
History of seizure. Moderate or severe renal impairment (creatinine clearance less than or equal to 50 mL/minute).

Required Medical Information
Diagnosis of multiple sclerosis AND patient is ambulatory (able to walk at least 25 feet) AND patient has walking impairment

Age Restriction

Prescriber Restriction

Coverage Duration
Initial - 3 months. Renewal - 12 months

Other Criteria
For renewal, walking speed has improved from baseline.

Anti-thymocyte globulin

Drugs
Atgam

Covered Uses
All FDA approved indications not otherwise excluded by part D

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
1 month

Other Criteria
Coverage Criteria Based on current Medicare Part B LCD/NCD

APOKYN

Drugs
Apokyn Subcutaneous Solution Cartridge

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

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Medical notes, previous treatment history

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Neurologist

Coverage Duration
12 months

Other Criteria
Patient must have poorly controlled off time episodes and failed dopamine agonist and COMT inhibitor

Aptiom

Drugs
Aptiom

Covered Uses
All FDA approved indications not otherwise excluded by Part D

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Neurology

Coverage Duration
12 months

Other Criteria
Failure of carbamazepine and Oxcarbazepine

ARANESP

Drugs
Aranesp (Albumin Free) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML, Aranesp (Albumin Free) Injection Solution Prefilled Syringe 10 MCG/0.4ML, 100 MCG/0.5ML, 300 MCG/0.6ML, 40 MCG/0.4ML, 60 MCG/0.3ML

Covered Uses
All medically accepted indications not otherwise excluded from part D

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Medical notes and Scr and HGB and T-sat and Ferritin

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction

Coverage Duration
6 months

Other Criteria
Failure of Procrit. Hemoglobin required to be within FDA approved ranges for initiation and maintenance. Patient must have adequate iron stores to initiate and continue treatment. ESRD would be covered under part B benefit

ARCALYST

Drugs
Arcalyst

Covered Uses
All medically accepted indications not otherwise excluded from part D

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Coverage will be based on a Diagnosis of CAPS, failure of 1 other treatment used for this condition such as cancakinumab, nsaids

Age Restriction

Prescriber Restriction
Immunologist,dermatologist,rheumatologist

Coverage Duration
12 months

Other Criteria

Aubagio Tabs

Drugs
Aubagio

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Neurology

Coverage Duration
12 months

Other Criteria
Failure of Glatopa, Gilenya

AVASTIN

Drugs
Avastin

Covered Uses
All medically accepted indications not otherwise excluded from part D OR Metastatic carcinoma of the colon or rectum when used in combination with intravenous 5-Fluorouracil based chemotherapy for first-line or second-line treatment OR Metastatic human epidermal growth factor receptor 2 (HER2)-negative breast cancer when used in combination with paclitaxel for the treatment of patients who have not received chemotherapy for metastatic HER2-negative breast cancer OR Nonsquamous non-small cell lung cancer in combination with carboplatin and paclitaxel for the first-line treatment of patients with unresectable or locally advanced or recurrent or metastatic non-squamous cell disease OR Central nervous system (CNS) cancers OR Renal cell carcinoma (RCC) OR Ovarian cancer OR Cervical cancer OR wet AMD OR diabetic macular edema OR macular retinal edema

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Medical notes and previous treatment history and associated studies

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
Oncologist, ophthalmologist

Coverage Duration
12 months or until disease progression

Other Criteria

Drugs
Azilect, Rasagiline Mesylate Oral

Covered Uses
All FDA approved indications not otherwise excluded by part D

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
Failure of entacapone or a dopamine agonist

BANZEL

Drugs
Banzel

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

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Diagnosis

Age Restriction

Prescriber Restriction
Neurology

Coverage Duration
12 months

Other Criteria

BOSULIF

Drugs
Bosulif

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
6 months or until disease progression

Other Criteria
Requires failure of another Tyrosine Kinase inhibitor for CML

BOTOX

Drugs
Botox Injection SOLUTION RECONSTITUTED 100 UNIT

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

Exclusion Criteria
FDA labeled contraindications OR cosmetic conditions

Required Medical Information
Diagnosis, supporting notes

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction

Coverage Duration
12 months

Other Criteria

Briviact

Drugs
Briviact ORAL

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
failed trial or contraindication or intolerance of Levetiracetam

BUDESONIDE EC

Drugs
Budesonide ORAL

Covered Uses
All medically accepted indications not otherwise excluded from part D

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Medical notes, previous treatment history

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
Gastroenterologist

Coverage Duration
3 months

Other Criteria
Covered for Short term use in mild to moderate Crohn's

BUPRENORPHINE

Drugs
Buprenorphine HCl Sublingual, Buprenorphine HCl-Naloxone HCl

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

Exclusion Criteria
FDA labeled contraindications, Not covered for pain management

Required Medical Information
Diagnosis

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction

Coverage Duration
12 months

Other Criteria

BYDUREON

Drugs
Bydureon Subcutaneous Pen-injector

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
Patient must be on maximal metformin unless contraindicated and failure of Tanzeum. Not covered for combination use outside of FDA label.

BYETTA

Drugs
Byetta 10 MCG Pen Subcutaneous Solution Pen-injector, Byetta 5 MCG Pen Subcutaneous Solution Pen-injector

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

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Medical notes, previous treatment history, HA1c BG

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
none

Coverage Duration
12 months

Other Criteria
Patient must be on maximal tolerated doses of sulfonylurea and Metformin and failure of Tanzeum, unless contraindicated

Cabometyx

Drugs
Cabometyx

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Hematology/Oncology

Coverage Duration
12 months

Other Criteria
Covered until disease progression.

CARBAGLU

Drugs
Carbaglu

Covered Uses
All FDA approved indications not otherwise excluded from part D

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria

CEREZYME

Drugs
Cerezyme Intravenous SOLUTION RECONSTITUTED 400 UNIT

Covered Uses
All FDA-approved indications not otherwise excluded from Part D. Approved for treatment of type 1 Gauchers with a history of Thrombocytopenia OR splenomegaly OR bone disease OR hepatomegaly

Exclusion Criteria

Required Medical Information
Medical notes

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
Medical Geneticist, hematologist, metabolic specialist

Coverage Duration
12 months

Other Criteria

Cinryze

Drugs
Cinryze

Covered Uses
All Medically acceptable indications not otherwise excluded by part D

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
Patient must have two or more angioedema attacks per month and has failed danazol

Cometriq

Drugs
Cometriq (100 mg Daily Dose), Cometriq (140 mg Daily Dose), Cometriq (60 mg Daily Dose)

Covered Uses
All FDA approved indications not otherwise excluded by part D

Exclusion Criteria
combination use with other tyrosine Kinase inhibitors.

Required Medical Information
Diagnosis

Age Restriction

Prescriber Restriction
oncology/hematology

Coverage Duration
6 months or until disease progression

Other Criteria
Covered for Metastatic Thyroid Medullary Cancer

Drugs
Cotellic

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Hematology/Oncology

Coverage Duration
12 months

Other Criteria
Covered for BRAF+ metastatic melanoma for combination use in with Zelboraf

Cuprimine

Drugs
Cuprimine ORAL CAPSULE 250 MG

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

Exclusion Criteria

Required Medical Information
serum ceruloplasmin if used for wilson's disease

Age Restriction

Prescriber Restriction
rheumatology/hepatology/neurology/urology

Coverage Duration
12 months

Other Criteria
Coverage for RA requires failure of a TNF-Agent and JAK inhibitor or abatacept.

DALIRESP

Drugs
Daliresp

Covered Uses
All medically acceptable indications not otherwise excluded by Part D

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
Failure or intolerance of combination inhaled corticosteroid/Long Acting Beta Agonist and long acting muscarinic antagonist.

DRONABINOL

Drugs
Dronabinol

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

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Previous Treatment History

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
Infectious disease/oncologist/gastroenterologist

Coverage Duration
up to 12 months

Other Criteria
For HIV/Cancer related cachexia patient must fail megestrol, For Chemotherapy induced nausea, patient must fail Emend and Ondansetron.

ELAPRASE

Drugs
Elaprase

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

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Previous Treatment History, medical notes supporting diagnosis

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
Medical Geneticist, Endocrinologist, metabolic specialist

Coverage Duration
12 months

Other Criteria

ELITEK

Drugs
Elitek Intravenous SOLUTION RECONSTITUTED 1.5 MG

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

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Previous Treatment History

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
oncologist

Coverage Duration
12 months

Other Criteria
Patient must fail xanthine oxidase inhibitor

EMEND

Drugs
Aprepitant, Emend ORAL CAPSULE 40 MG, Emend Oral CAPSULE 80 MG, Emend ORAL SUSPENSION RECONSTITUTED, Emend Tri-Pack

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

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Previous treatment history

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
Hematologist/oncologist/Surgeon

Coverage Duration
12 months

Other Criteria
Patient must fail treatment with ondansetron (PA not applicable for PONV)

EMSAM

Drugs
Emsam Transdermal Patch 24 Hour 6 MG/24HR, 9 MG/24HR

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

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Medical notes, prior medication failures

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
Patient must fail 6 week trial with two formulary anti-depressants

ENBREL

Drugs
Enbrel Subcutaneous Solution Prefilled Syringe, Enbrel SureClick Subcutaneous Solution Auto-injector

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

Exclusion Criteria
FDA labeled contraindications combination with other biologic

Required Medical Information
Medical notes

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
Rheumatology/Dermatology or Specialist trained in management of prescribed condition

Coverage Duration
12 months

Other Criteria
For RA Patient must fail adequate trial of MTX in combination with a DMARD If MTX contraindicated, must try combination of 2-nonbiologic DMARDS. For Ankylosing Spondylitis PT must fail 2 NSAIDS within past 6 months. For Plaque Psoriasis patient must fail MTX or Soriatane and Topical Therapy(ie. high potency steroids Vit D analogs). for Psoriatic Arthritis Patient must fail adequate trial of MTX or LEF in past 6 months.

Esbriet

Drugs
Esbriet

Covered Uses
All FDA approved indications not otherwise excluded from part D

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
Confirmed Diagnosis of idiopathic pulmonary fibrosis (IPF) through exclusion of other fibrosing conditions/causes and definitive High resolution CT IPF pattern or Biopsy proven IPF. FVC of at least 50% of predicted value DLCO of at least 30%

Exelon

Drugs
Exelon Transdermal

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
Failure of memantine and donepezil for Alzheimer's disease. no prequisite medications for dementia due to parkinson's disease

EXJADE

Drugs
Exjade

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

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Medical notes, previous treatment history, iron indices

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
Hematologist/oncologist

Coverage Duration
12 months

Other Criteria
Patient must fail or have contraindication to deferoximine

FABRAZYME

Drugs
Fabrazyme Intravenous SOLUTION RECONSTITUTED 35 MG

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

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Medical notes, previous treatment history

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
Medical Geneticist, metabolic specialist

Coverage Duration
12 months

Other Criteria
Patient must have a diagnosis of Fabry's disease with significant cardiac or renal manifestations.

FANAPT

Drugs
Fanapt

Covered Uses
All medically accepted indications not otherwise excluded from part D

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Diagnosis

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
Neurology/Psychiatry

Coverage Duration
12 months

Other Criteria

Farydak

Drugs
Farydak

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Hematologist/oncologist

Coverage Duration
12months

Other Criteria

FENTANYL LOZENGE

Drugs
FentaNYL Citrate Buccal

Covered Uses
All medically accepted indications not otherwise excluded from part D

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Previous treatment history

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
Pain management physician/oncologist

Coverage Duration
12 months

Other Criteria
Covered for breakthrough pain in patients receiving long acting opioid treatment and are opioid tolerant. Patient must fail two immediate release C-II opioid such as hydromorphone, morphine, oxycodone.

FENTANYL PATCH

Drugs
FentaNYL Transdermal Patch 72 Hour 12 MCG/HR, 25 MCG/HR, 50 MCG/HR, 75 MCG/HR

Covered Uses
All medically accepted indications not otherwise excluded from part D

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Medical notes, previous treatment history

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
Pain management physician/oncologist

Coverage Duration
12 months

Other Criteria

Ferriprox

Drugs
Ferriprox ORAL TABLET

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
oncologist/hematologist

Coverage Duration
12 months

Other Criteria
Failure of Exjade and Desferal

Fetzima

Drugs
Fetzima

Covered Uses
All FDA approved indications not otherwise excluded by part D

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
Must fail two generically available anti-depressants in past12 months

FIRAZYR

Drugs
Firazyr

Covered Uses
All FDA approved indications not otherwise excluded by part D.

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria

FONDAPARINUX

Drugs
Fondaparinux Sodium

Covered Uses
All medically accepted indications not otherwise excluded from part D

Exclusion Criteria
FDA labeled contraindications

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
none

Coverage Duration
12 months

Other Criteria
Coverage will be based on allergy to Lovenox or other condition where Lovenox use is not appropriate

FORTEO

Drugs
Forteo Subcutaneous SOLUTION 600 MCG/2.4ML

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

Exclusion Criteria
FDA labeled contraindications/ cumulative tx more than 24month

Required Medical Information
Medical notes, previous treatment history, BMD, PTH, VITD

Age Restriction
Late adolescents and Adults only

Prescriber Restriction
none

Coverage Duration
12 months

Other Criteria
Patient must fail or have contraindication to bisphosphonates, Vitamin D (25,OH), PTH must be WNL

FOSRENOL

Drugs
Fosrenol ORAL PACKET, Fosrenol Oral TABLET CHEWABLE 1000 MG, 500 MG, 750 MG

Covered Uses
All medically accepted indications not otherwise excluded from part D

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Previous treatment history, CA, PO4, IPTH

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
Nephrologist

Coverage Duration
12 months

Other Criteria
Patient must fail or not be a candidate for calcium based phosphate binders based on KDOQI guidelines for use

fycompa

Drugs
Fycompa

Covered Uses
All FDA approved indications not otherwise excluded by Part D

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Neurology

Coverage Duration
12 months

Other Criteria
Covered for use as an adjunctive agent for partial onset seizures

GAMMAGARD

Drugs
Gammagard INJECTION SOLUTION 2.5 GM/25ML

Covered Uses
All FDA approved indications not otherwise excluded by part D

Exclusion Criteria

Required Medical Information
Medical notes, immunoglobulin studies

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction

Coverage Duration
12 months

Other Criteria

Gattex

Drugs
Gattex

Covered Uses
All FDA approved indications not otherwise excluded by part D

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Gastroenterologist

Coverage Duration
6 months initially

Other Criteria
Diagnosis of Short Bowel Syndrome Dependent on Parenteral Support Baseline Records of parenteral hydration After 6 month trial of Gattex, patient must demonstrate clinical improvement and or reduction in weekly parenteral fluid volume for continuation.

Drugs
Geodon Intramuscular

Covered Uses
All medically accepted indications not otherwise excluded from part D

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Diagnosis

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Psychiatry/ Neurology

Coverage Duration
12 months

Other Criteria

Gilenya

Drugs
Gilenya

Covered Uses
All Medically Acceptable indications not otherwise covered by Part D

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Neurology

Coverage Duration
12 months

Other Criteria

Gilotrif

Drugs
Gilotrif

Covered Uses
All medically accepted indications not otherwise excluded from Part D

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Oncology/Hematology

Coverage Duration
12 months

Other Criteria
Off label use must be supported by NCCN criteria with evidence rating of 2a or 1

Hetlioz

Drugs
Hetlioz

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
Confirmed Diagnosis of non-24 hour sleep-Wake disorder Sleep study to rule out Sleep/apnea or other contributory sleep disorders Patient must be totally Blind

Drugs
Cyclobenzaprine HCl Oral TABLET 10 MG, GlyBURIDE Micronized Oral TABLET 3 MG, GlyBURIDE Oral

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

Exclusion Criteria
FDA Labeled contraindications

Required Medical Information

Age Restriction
No authorization needed for patients less than 65 years old

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
For patients 65 years of age or older prescriber attests that side effects related to the use of this medication in older adults: Will be monitored periodicallyOverall benefit outweighs riskPatient/caretaker has been informed of special considerations related to use in patients over 65 years of age For Nitrofurantoin, Zolpidem, Zaleplon no authorization is needed if patients will use less than 90 days of medication in a year.

HUMIRA

Drugs
Humira Pediatric Crohns Start Subcutaneous Prefilled Syringe Kit 40 MG/0.8ML, Humira Pen Subcutaneous Pen-injector Kit, Humira Subcutaneous Prefilled Syringe Kit 10 MG/0.2ML, 40 MG/0.8ML

Covered Uses
All medically accepted indications not otherwise excluded from part D

Exclusion Criteria
FDA labeled contraindications combination with other biologic

Required Medical Information
Medical notes

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
Dermatologist/rheumatologist/ Gastroenterologist/Ophthalmologist

Coverage Duration
12 months

Other Criteria
For RA Patient must fail adequate trial of MTX in combination with a DMARD If MTX contraindicated, must try combination of 2-nonbiologic DMARDS. For Ankylosing Spondylitis PT must fail 2 NSAIDS within past 6 months. For Plaque Psoriasis patient must fail MTX or Soriatane and Topical Therapy(ie. high potency steroids Vit D analogs). for Psoriatic Arthritis Patient must fail adequate trial of MTX or LEF in past 6 months. For Inflammatory Bowel disease patient must fail recent 3 month trial of immunosupressive (MTX, azathioprine, 6-mp) and anti-inflammatory (such as 5-ASA, olsalazine/balsalazide) in past 6 months

Ibrance

Drugs
Ibrance

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Hematology/Oncology

Coverage Duration
12 months

Other Criteria

Iclusig

Drugs
Iclusig

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

Exclusion Criteria

Required Medical Information
Diagnosis

Age Restriction

Prescriber Restriction
Hematology/Oncology

Coverage Duration
12 months

Other Criteria

IDHIFA FHCP

Drugs
IDHIFA

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

Exclusion Criteria

Required Medical Information
Evidence of IDH-1 mutation

Age Restriction

Prescriber Restriction
Hematology/Oncology

Coverage Duration
12 months or until disease progression

Other Criteria

Ilaris

Drugs
Ilaris (150mg Delivered)

Covered Uses
All FDA approved indications not otherwise excluded by partD

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
For JRA patient must fail Enbrel and Humira

Imbruvica

Drugs
Imbruvica

Covered Uses
All medically accepted indications not otherwise excluded from Part D

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Hematology/Oncology

Coverage Duration
12 months

Other Criteria
Off Label and combination use must be supported by NCCN guidelines with evidence rating of 2a or 1

INCRELEX

Drugs
Increlex

Covered Uses
All medically accepted indications not otherwise excluded from part D

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Medical notes, previous treatment history

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
Endocrinologist

Coverage Duration
12 months

Other Criteria

INVEGA SUSTENNA

Drugs
Invega Sustenna

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

Exclusion Criteria
A. Diagnosis of dementia-related psychosis. B. Prior use of risperidone demonstrated a hypersensitivity reaction.

Required Medical Information
Diagnosis of acute and maintenance treatment of schizophrenia AND The patient has received at least ONE of the following: a. three test doses of oral Risperdal (risperidone) b. three test doses of oral Invega c. previous use of Invega Sustenna.

Age Restriction
Patient must be 18 years old or older.

Prescriber Restriction

Coverage Duration
Authorization will be for 12 months

Other Criteria
Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

IRESSA

Drugs
Iressa

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

Exclusion Criteria
Iressa is contraindicated in patients with severe hypersensitivity to gefitinib or other components.

Required Medical Information
Diagnosis

Age Restriction
Patient must be at least 18 years old or older.

Prescriber Restriction
Hematology/Oncology

Coverage Duration
12 months

Other Criteria
Approved for Non Small Cell Lung Cancer with Egfr exon 19 deletion or Exon 21 substitution.

Drugs
Claravis ORAL CAPSULE 30 MG, Myorisan ORAL CAPSULE 10 MG, Zenatane ORAL CAPSULE 20 MG, 40 MG

Covered Uses
All medically acceptable indications not otherwise excluded by part D

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
5 months

Other Criteria
For cystic, nodular or scarring acne, must be refractory to oral antibiotics and topical retinoids. Trial of combination oral teracycline and topical retinoid most have been tried in most recent 6 months.

ITRACONAZOLE

Drugs
Itraconazole Oral, Sporanox ORAL SOLUTION

Covered Uses
All medically accepted indications not otherwise excluded from part D

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Medical notes, previous treatment history, fungal culture and sensitivity

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction

Coverage Duration
minimum of 12 week up to 12 months

Other Criteria
Failure of terbinafine for onychomycosis

Drugs
Gamunex-C INJECTION SOLUTION 1 GM/10ML

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

Exclusion Criteria

Required Medical Information
Diagnosis, immunoglobulin studies

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
For ITP Must fail corticosteroids and Anti-D immunoglobulin (if indicated).

JAKAFI

Drugs
Jakafi

Covered Uses
All FDA approved indications not otherwise excluded from part D

Exclusion Criteria
FDA labeled contraindications, Low risk Disease

Required Medical Information
Diagnosis

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
Hematology-oncology

Coverage Duration
3 months

Other Criteria
Continuation will be based on reduction in spleen size from baseline or symptomatic improvement. Not covered when used in combination with antiproliferative drugs (i.e lenalidomide), or other JAK or Tyrosine Kinase inhibitors.

JANUVIA

Drugs
Januvia

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

Exclusion Criteria
FDA labeled contraindications, Non FDA approved combinations

Required Medical Information
Medical notes, previous treatment history, HA1c BG

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
Patient must be on maximal tolerated doses of sulfonylurea and Metformin unless contraindicated

Juxtapid

Drugs
Juxtapid

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
3 months initially, 12 months for continuation

Other Criteria
Clinical confirmation that patient has HoFH and failure of Statin and PCSK-9 therapy. Continuation of Juxtapid after 3 month trial based on LDL reduction while on therapy.

Drugs
Kalydeco ORAL TABLET

Covered Uses
All FDA approved indications not otherwise excluded by part D

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
Genotyping supportive of mutation status in the FDA label

KINERET

Drugs
Kineret Subcutaneous Solution Prefilled Syringe

Covered Uses
All medically accepted indications not otherwise excluded from Part D

Exclusion Criteria
FDA labeled contraindications combination with other biologic

Required Medical Information
Medical notes

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
For RA failure of Enbrel and Humira

Kisqali

Drugs
Kisqali 200 Dose, Kisqali 400 Dose, Kisqali 600 Dose

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Hematology/Oncology

Coverage Duration
12 months

Other Criteria

Kisqali FHCP

Drugs
Kisqali Femara 200 Dose, Kisqali Femara 400 Dose, Kisqali Femara 600 Dose

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Hematology/Oncology

Coverage Duration
12 months or until progression

Other Criteria

Korlym

Drugs
Korlym

Covered Uses
All FDA approved indications not otherwise excluded from part D

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
endocrinologist

Coverage Duration
12 months

Other Criteria
Diagnosis of Cushings syndrome , Type 2 diabetes mellitus , Failed surgery OR not a candidate for surgery , Failure of ketoconazole

KUVAN

Drugs
Kuvan ORAL PACKET 500 MG, Kuvan ORAL TABLET SOLUBLE

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

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Medical notes, previous treatment history

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
Medical Geneticist, neurologist, hepatologist,Metabolic specialist

Coverage Duration
12 months

Other Criteria
Coverage will be based on medical history/status, response to previous treatments, and the consideration of other therapeutic options

Kynamro

Drugs
Kynamro Subcutaneous Solution Prefilled Syringe

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
3 months initially, 12 months after response

Other Criteria
Clinical confirmation that patient has HoFH AND failure of Statin AND PCSK-9 therapy. Continuation of Kynamro after 3 month trial based on LDL reduction.

LATUDA

Drugs
Latuda

Covered Uses
All medically accepted indications not otherwise excluded from part D

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Diagnosis

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction

Coverage Duration
12 months

Other Criteria

Lenvima

Drugs
Lenvima 10 MG Daily Dose, Lenvima 14 MG Daily Dose, Lenvima 20 MG Daily Dose, Lenvima 24 MG Daily Dose

Covered Uses
All FDA approved indications not otherwise excluded by part D

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Hematology Oncology

Coverage Duration
12 months or until disease progression

Other Criteria

LIDODERM

Drugs
Lidocaine EXTERNAL PATCH 5 %

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

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Medical notes

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
Covered for PHN, patient must fail gabapentin

Drugs
Linzess

Covered Uses
All FDA approved indications not otherwise excluded by part D

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Gastroenterology

Coverage Duration
12 month

Other Criteria
Failure of Lactulose and polyethylele glycol 3350 (Miralax)

Lonsurf

Drugs
Lonsurf

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Hematology/Oncology

Coverage Duration
12 months

Other Criteria

Lynparza

Drugs
Lynparza

Covered Uses
All FDA approved indications not otherwise excluded from part D

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Hematology/Oncology

Coverage Duration
12 months

Other Criteria

Mavyret FHCP

Drugs
Mavyret

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

Exclusion Criteria

Required Medical Information
Genotype, Viral Load, stage of liver fibrosis, previous treatment history

Age Restriction

Prescriber Restriction

Coverage Duration
8-16 weeks depending on patient characterstics

Other Criteria

Mekinist

Drugs
Mekinist

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
12 months or until disease progression

Other Criteria
Mutation analysis showing BRAF V600E or V600K positive, not covered for combination use with other anti-neoplastics unless FDA indication or NCCN recommended with a class 2A or greater evidence rating.

Menest

Drugs
Menest ORAL TABLET 0.3 MG, 0.625 MG, 1.25 MG

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

Exclusion Criteria
FDA contraindications

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
Covered for palliative treatment of breast cancer. Coverage for Hormone replacement therapy would required failure of formulary estrogens which do not have utilization management (ie. premarin, estradiol, estropipate)

MODAFINIL

Drugs
Armodafinil, Modafinil

Covered Uses
All medically accepted indications not otherwise excluded from part D

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Medical notes, Sleep study or MSLT when appropriate

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
None

Coverage Duration
12 months

Other Criteria

Movantik

Drugs
Movantik

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
12months

Other Criteria
Failure of Lactulose and polyethylele glycol 3350 (Miralax)

Drugs
Multaq

Covered Uses
All FDA approved indications not otherwise excluded by part D

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
Failure of sotalol and amiodarone

Myrbetriq

Drugs
Myrbetriq

Covered Uses
All medically accepted indications not otherwise excluded from part D

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
Failure of Toviaz and Oxybutynin

Drugs
Naglazyme

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

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Medical notes

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
medical geneticist, endocrinologist, metabolic specialist.

Coverage Duration
12 months

Other Criteria
Must demonstrate improvement in 3 minute stair climb or 12 minute walk distance for continuation at 24 weeks

Natpara

Drugs
Natpara

Covered Uses
All FDA approved uses not otherwise excluded from part D

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
endocrinologist

Coverage Duration
12 months

Other Criteria
Uncontrolled hypocalcemia on adequate doses of calcium and vitamin D.

Drugs
Nerlynx

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Hematologist/Oncologist

Coverage Duration
12 months or until disease progression

Other Criteria

Neupro

Drugs
Neupro

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
Failure of Ropinirole and Pramipexole

Drugs
Ninlaro

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Hematology/Oncology

Coverage Duration
12 months

Other Criteria
Failure of Velcade and Revlimid required for coverage

Northera

Drugs
Northera

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
Documented orthostatic hypotension, failure of midodrine or Fludrocortisone. No perquisite drugs required for Dopamine-Beta-Hydroxylase deficiency

Noxafil

Drugs
Noxafil ORAL

Covered Uses
All FDA approved indications not otherwise excluded by part D

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
3 months

Other Criteria
Failure, resistance or contraindication to itraconazole,voriconazole

Nuedexta

Drugs
Nuedexta

Covered Uses
All FDA approved indications not otherwise excluded by part D

Exclusion Criteria

Required Medical Information
Diagnosis

Age Restriction

Prescriber Restriction
neurology

Coverage Duration
12 months

Other Criteria

Drugs
Nulojix

Covered Uses
All medically accepted indications not otherwise excluded from part D

Exclusion Criteria
Seronegative for Epstein Barr-Virus exposure, Liver Transplantation

Required Medical Information
Diagnosis, previous treatment history, EBV titers

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
Transplant/nephrology

Coverage Duration
12 months

Other Criteria
Documentation of failure or intolerance to calcineurin inhibitor

Nuplazid

Drugs
Nuplazid

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Neurology

Coverage Duration
12 months

Other Criteria
Notes supporting dementia with hallucinations or delusions secondary to parkinsons dementia.

ODOMZO

Drugs
Odomzo

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Hematology/Oncology

Coverage Duration
3 - 12 months

Other Criteria
Approval will initially be for three months, if patient has a response to therapy will be renewed for 12 months

Ofev

Drugs
Ofev

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
pulmonologist

Coverage Duration
12 months

Other Criteria
Confirmed Diagnosis of idiopathic pulmonary fibrosis (IPF) through exclusion of other fibrosing conditions/causes and definitive High resolution CT IPF pattern or Biopsy proven IPF. FVC of at least 50% of predicted value DLCO of at least 30%

OMNITROPE

Drugs
Omnitrope

Covered Uses
All medically accepted indications not otherwise excluded from part D

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Medical notes, studies establishing diagnosis of indication.

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
Endocrinologist

Coverage Duration
12 months

Other Criteria

ONFI

Drugs
Onfi ORAL SUSPENSION, Onfi ORAL TABLET 10 MG, 20 MG

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

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Diagnosis

Age Restriction
FDA approved Ages

Prescriber Restriction
Restricted to Neurology

Coverage Duration
12 Months

Other Criteria

ONGLYZA

Drugs
Onglyza ORAL TABLET 2.5 MG, 5 MG

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

Exclusion Criteria
FDA labeled contraindications, Non FDA approved combinations

Required Medical Information
Medical notes, previous treatment history, HA1c BG

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
Patient must be on maximal tolerated doses of sulfonylurea and Metformin unless contraindicated

Opsumit

Drugs
Opsumit

Covered Uses
All FDA approved uses not otherwise excluded from Part D

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
pulmonologist/cardiologist

Coverage Duration
12 months

Other Criteria
Failure of sildenafil and Bosentan

ORENCIA

Drugs
Orencia Intravenous

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

Exclusion Criteria
FDA labeled contraindications, combination therapy with other biologics

Required Medical Information
Medical notes, previous treatment history

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
Rheumatologist

Coverage Duration
12 months

Other Criteria
Patient must fail an ANTI-TNF, and xeljanz

Orkambi

Drugs
Orkambi ORAL TABLET 200-125 MG

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

Exclusion Criteria

Required Medical Information
CFTR mutation analysis, spirometry

Age Restriction
Ages approved in FDA label

Prescriber Restriction
pulmonologist

Coverage Duration
12 months

Other Criteria
CFTR mutation must be supported by FDA approved label such as homozygous F508-deletion

OXANDROLONE

Drugs
Oxandrolone ORAL TABLET 2.5 MG

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria

PEGASYS

Drugs
Pegasys Subcutaneous SOLUTION 180 MCG/0.5ML

Covered Uses
All medically accepted indications not otherwise excluded from part D

Exclusion Criteria
FDA labeled contraindications, HCV Retreatment for Peg INF+RBV Non-responders

Required Medical Information
Medical notes, Viral Load

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
Gastroenterologist/ Infectious Disease

Coverage Duration
up to 12 months

Other Criteria
For HCV patient must have allergy of contraindication to Peg-Intron. For HBV Patient must be Pegasys naive, with chronic HBV infection with chronically elevated transaminases.

POMALYST

Drugs
Pomalyst

Covered Uses
All FDA approved indications not otherwise excluded by PartD

Exclusion Criteria
FDA contraindications

Required Medical Information

Age Restriction

Prescriber Restriction
Hematology/Oncology

Coverage Duration
12 months

Other Criteria
Approve for patients with multiple myeloma who have received at least two prior therapies including lenalidomide and bortezomib and have demonstrated disease progression on or within 60 days of completion of the last therapy

PROCRIT

Drugs
Procrit

Covered Uses
All medically accepted indications not otherwise excluded from part D

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Medical notes, Scr, HGB, T-sat, Ferritin

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction

Coverage Duration
6 months

Other Criteria
Hemoglobin must be within FDA approved ranges for initiation and maintenance. Patient must have adequate iron stores to initiate and continue treatment. ESRD will be covered under Medicare Part B

Drugs
Prolia

Covered Uses
All FDA approved indications not otherwise excluded by Part D

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
Intolerance or contraindication to injectable bisphosphonate required for coverage of prolia

PROMACTA

Drugs
Promacta

Covered Uses
All medically accepted indications not otherwise excluded from part D

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Medical Notes, CBC ,Platelet count less than 50,000

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
Hematologist/oncologist, Hepatologist, Infectious Disease

Coverage Duration
12 months

Other Criteria
Chronic ITP Refractory to IVIG, corticosteroids or splenectomy as per FDA approval studies not applicable to HCV related thrombocytopenia

PULMOZYME

Drugs
Pulmozyme

Covered Uses
All medically accepted indications not otherwise excluded from part D

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Medical notes, Spirometry

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
Pulmonologist

Coverage Duration
12 months

Other Criteria
For Patients with Cystic Fibrosis who have had recurrent pulmonary infections

Quinine

Drugs
QuiNINE Sulfate Oral

Covered Uses
All FDA approved indications not otherwise excluded by part D

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
Notes supporting diagnosis of malaria

RANEXA

Drugs
Ranexa

Covered Uses
All medically accepted indications not otherwise excluded from part D

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Recent Cardiology notes, previous treatment history for angina

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
Pt must fail one agent in two of the three following medication classes used for angina- Long acting nitrates including isosorbide dinitrate or isosorbide mononitrate, CCB including amlodipine and nifedapine and a Beta blocker metoprolol, atenolol, carvedilol, propranolol, labetalol.

Ravicti

Drugs
Ravicti

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
hepatologist or metabolic specialist such as a endocrinologist or geneticist

Coverage Duration
12 months

Other Criteria
Clinical Failure of Buphenyl

RELISTOR

Drugs
Relistor Subcutaneous SOLUTION 12 MG/0.6ML, 8 MG/0.4ML

Covered Uses
All medically accepted indications not otherwise excluded from part D

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Previous treatment history

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
Pain management physician, gastroenterologist, oncologist

Coverage Duration
12 months

Other Criteria
Covered for patients with advanced illness receiving palliative opioid treatment who fail Movantik, Lactulose, and metoclopramide

REMICADE

Drugs
Remicade

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

Exclusion Criteria
FDA labeled contraindications, combination therapy with other biologics

Required Medical Information
Medical notes

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
Rheumatology/Dermatology or Specialist trained in management of prescribed condition

Coverage Duration
12 months

Other Criteria
For RA, Plaque Psoriasis, or Psoriatic Arthritis patient must fail Humira. For Inflammatory Bowel Disease must have moderate to severe disease refractory to conventional therapies or steroid dependency despite use of adequate doses of immunosuppressive agents. Conventional therapies includes adequate doses of anti-inflammatories and immunosuppressive agents supported by current peer reviewed guidelines (American Gastroenterology Association).

REMODULIN

Drugs
Remodulin

Covered Uses
All medically accepted indications not otherwise excluded from part D

Exclusion Criteria
FDA labeled contraindications, combination therapy with other PAH medications

Required Medical Information
Medical notes, previous treatment history, 6 min walk, diffusion studies,Rt Heart Cath

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
Pulmonologist/Cardiologist

Coverage Duration
12 months

Other Criteria
Pulmonary hypertension must be diagnosed by heart catheterization ,Evaluation, EKG, diffusion studies, catheterization results and an objective test of exercise ability (6 minute walk) must be submitted with referral, Patient must fail Tracleer.

Repatha

Drugs
Repatha, Repatha Pushtronex System, Repatha SureClick

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
Failure of rosuvastatin 40mg and ezetimibe 10mg in combination. Not currently approved for monotherapy or for patients who are not on maximally tolerated statin dose. Diagnosis of HeFH must be supported by Dutch Lipid Clinic Network criteria. Statin intolerant patients must have had myositis or elevated transaminases while on statin therapy which resolved after discontinuation of statin.

REVATIO

Drugs
Sildenafil Citrate Oral

Covered Uses
All medically accepted indications not otherwise excluded from part D

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Medical notes, previous treatment history, 6 min walk, diffusion studies,Rt Heart Cath

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
Pulmonologist/Cardiologist

Coverage Duration
12 months

Other Criteria
Pulmonary hypertension must be diagnosed by heart catheterization ,Evaluation, EKG, diffusion studies, catheterization results and an objective test of exercise ability (6 minute walk) must be submitted with referral ,Coverage will be based on medical history/status, vasoreactivity tests.

REVLIMID

Drugs
Revlimid

Covered Uses
All medically accepted indications not otherwise excluded from part D

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Medical notes, CBC, Bone Marrow Biopsy, Karyotype

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
Hematologist/oncologist

Coverage Duration
12 months

Other Criteria
Patient must fail Thalidomide for Multiple Myeloma.

Rexulti

Drugs
Rexulti

Covered Uses
All medically accepted indications not otherwise excluded from part D

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
12months

Other Criteria
Failure of aripiprazole and risperidone for schizophrenia or failure of combination SSRI and aripiprazole for major depressive disorder.

RILUTEK

Drugs
Riluzole

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

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Medical notes, previous treatment history, associated studies

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
Neurologist

Coverage Duration
12 months

Other Criteria
Diagnosis is definite or probable ALS by Neurology, symptoms present for less than 5 years, Vital Capacity is 60% or more of predicted, patient does not have a tracheotomy

Drugs
Rituxan Intravenous SOLUTION 500 MG/50ML

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

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Medical notes, immunohistopathy

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
Hematologist/oncologist, rheumatologist

Coverage Duration
12 months

Other Criteria
For Rheumatoid Arthritis coverage patient must fail 2 TNF antagonists. Patient must also be on methotrexate unless contraindicated or intolerant.

Rozerem

Drugs
Rozerem

Covered Uses
All FDA approved indications not otherwise excluded by part D

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
failure of Zolpidem and one other medication used for insomnia, such as temazepam, zaleplon, doxepin, trazodone.

Rubraca

Drugs
Rubraca Oral TABLET 200 MG, 300 MG

Covered Uses
All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Oncology/Hematology

Coverage Duration
12 months or until disease progression

Other Criteria
Notes and labs supporting presences of BRCA mutation.

Rydapt FHCP

Drugs
Rydapt

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Hematology/Oncology

Coverage Duration
12 months or until progression

Other Criteria
Labs supporting FLT3 mutation

Drugs
Sabril, Vigabatrin

Covered Uses
All medically accepted indications not otherwise excluded from part D

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Medical notes

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
Neurologist

Coverage Duration
12 months

Other Criteria
Patient must fail treat with adjunctive treatment combination (applies to Refractory Partial Complex only)

SAPHRIS

Drugs
Saphris

Covered Uses
All medically accepted indications not otherwise excluded from part D

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Diagnosis

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
Psychiatry/ Neurology

Coverage Duration
12 months

Other Criteria

SENSIPAR

Drugs
Sensipar

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

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Medical notes, previous treatment history, associated studies

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
Nephrologist/endocrinologist/oncologist

Coverage Duration
12 months

Other Criteria
For secondary hyperparathyroidism related to CKD, patient must fail active vit-D therapy/phosphate binders, iPTH must be greater than 300 in ESRD

Signifor

Drugs
Signifor, Signifor LAR Intramuscular Suspension Reconstituted ER

Covered Uses
All FDA approved uses not excluded form part D

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Endocrinologist

Coverage Duration
12 months

Other Criteria
For Cushings Disease Failed or poor surgical candidate for pituitary resection For Acromegaly Failed or poor surgical candidate for pituitary resection Failure of octreotide

SOLARAZE

Drugs
Diclofenac Sodium Transdermal GEL 3 %

Covered Uses
All medically accepted indications not otherwise excluded from part D

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Diagnosis

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
Dermatologist, oncologist

Coverage Duration
12 months

Other Criteria

Somatuline

Drugs
Somatuline Depot Subcutaneous SOLUTION 120 MG/0.5ML, 60 MG/0.2ML, 90 MG/0.3ML

Covered Uses
All FDA approved indications not otherwise excluded by Part D

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
endocrinologist, oncologist , medical geneticist

Coverage Duration
12 Months

Other Criteria
Need clinical notes and labs supporting diagnosis of Acromegaly GH, IGF-1

SOMAVERT

Drugs
Somavert Subcutaneous SOLUTION RECONSTITUTED 10 MG

Covered Uses
All medically accepted indications not otherwise excluded from part D

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Medical notes

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
Endocrinologist

Coverage Duration
12 months

Other Criteria

Soriatane

Drugs
Acitretin

Covered Uses
All FDA approved indications not otherwise excluded by part D

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Dermatologist

Coverage Duration
12 months

Other Criteria
Must have severe psoriasis and failed one other systemic therapy and one topical therapy.

Sovaldi Tabs

Drugs
Sovaldi

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

Exclusion Criteria

Required Medical Information
Genotype, Viral Load, Liver Biopsy or Fibrosure/Fibroscan

Age Restriction

Prescriber Restriction
Infectious Disease, Gastroenterology/Hepatology

Coverage Duration
Duration Supported by current AASLD based on patient characteristics

Other Criteria
Zepatier will be the preferred and exclusive treatment for genotype 1 or 4 unless contraindicated or unsupported by current AASLD guidelines.

SUBOXONE

Drugs
Suboxone SUBLINGUAL FILM

Covered Uses
All medically accepted indications not otherwise excluded from part D

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Diagnosis

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction

Coverage Duration
12 months

Other Criteria

SYLATRON

Drugs
Sylatron Subcutaneous KIT 200 MCG, 300 MCG, 600 MCG

Covered Uses
All medically accepted indications not otherwise excluded from part D

Exclusion Criteria
FDA labeled contraindications

Required Medical Information

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
oncology

Coverage Duration
12 months

Other Criteria
Must be used as adjuvant treatment within 84 days of surgical resection in patients with metastatic melanoma with nodal involvement

Sylvant

Drugs
Sylvant Intravenous SOLUTION RECONSTITUTED 100 MG

Covered Uses
All FDA approved indications not otherwise excluded by part D

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Hematology Oncology

Coverage Duration
12months

Other Criteria

Drugs
SymlinPen 120 Subcutaneous Solution Pen-injector, SymlinPen 60 Subcutaneous Solution Pen-injector

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

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Medical notes, previous treatment history, HA1c BG

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
Endocrinologist, Internist

Coverage Duration
12 months

Other Criteria
Patient BG must be non-controlled on optimal doses of insulin

SYNAREL

Drugs
Synarel

Covered Uses
All medically accepted indications not otherwise excluded from part D

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Diagnosis, Notes, Previous treatment history

Age Restriction
Ages approved in FDA Label

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
Covered after patient fails treatment with Lupron for endometriosis or precocious puberty

Tafinlar

Drugs
Tafinlar

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
12 months or until disease progression

Other Criteria
Mutation analysis showing BRAF V600E or V600K positive, not covered for combination use with other anti-neoplastics unless FDA indication or NCCN recommended with a class 2A or greater evidence rating.

Tagrisso

Drugs
Tagrisso

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Hematology/Oncology

Coverage Duration
12 months

Other Criteria
Coverage requires Diagnosis of Non Small Cell Lung cancer, progression on an EGRF TKI inhibitor, and confirmation of T790M mutation

TASIGNA

Drugs
Tasigna

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

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Medical notes

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
Hematologist/oncologist

Coverage Duration
12 months

Other Criteria
Covered for failure or relapse of CML when previously treated with imatinib. Covered for newly diagnosed CML patients who are Philadelphia chromosome +. Will also be covered for intolerance or adverse reaction to imatinib. Combination therapy with other tyrosine kinase inhibitors or MTOR inhibitors for CML is not supported.

TAZORAC

Drugs
Tazarotene External, Tazorac EXTERNAL CREAM, Tazorac EXTERNAL GEL 0.1 %

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

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Previous treatment history

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
For Psoriasis patient must have failed medium to high potency topical corticosteroid, For acne patient must have failed Tretinoin and oral antibiotic

Tecfidara

Drugs
Tecfidera

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Neurology

Coverage Duration
12 months

Other Criteria
Failure of Gilenya

THALOMID

Drugs
Thalomid

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

Exclusion Criteria
FDA labeled contraindications

Required Medical Information

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
Hematologist/oncologist/infectious disease

Coverage Duration
12 months

Other Criteria

TRACLEER

Drugs
Tracleer

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

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Medical notes, Right heart Catheterization, 6 Minute Walk time

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
Pulmonologist or cardiologist

Coverage Duration
12 months

Other Criteria
Pulmonary hypertension must be diagnosed by heart catheterization ,Evaluation, EKG, diffusion studies, catheterization results and an objective test of exercise ability (6 minute walk) must be submitted with referral ,Coverage will be based on medical history/status, vasoreactivity tests, failure of sildenafil

Transderm-Scop

Drugs
Transderm-Scop (1.5 MG)

Covered Uses
All FDA approved indications not otherwise excluded from part D

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
4 weeks

Other Criteria
Failure of two oral anti-emetics

TRETINOIN CAPSULE

Drugs
Tretinoin Oral

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

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Diagnosis

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
Hematologist/oncologist

Coverage Duration
12 months

Other Criteria

TRETINOIN TOPICAL

Drugs
Tretinoin EXTERNAL CREAM, Tretinoin External GEL 0.01 %, 0.025 %

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

Exclusion Criteria
FDA labeled contraindications, treatment of photoaging, wrinkles

Required Medical Information
Diagnosis

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction

Coverage Duration
12 months

Other Criteria

Drugs
Trintellix

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
Failure of two generically available anti-depressants within past 6 months

TYKERB

Drugs
Tykerb

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

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Medical notes, previous treatment history, associated studies

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
Oncologist/hematologist

Coverage Duration
12 months

Other Criteria
Patient is using in combination with capecitabine for HER/NEU + Metastatic breast CA, having failed an anthracycline, Herceptin and a taxane, or Patient must be using in combination with an aromatase inhibitor and have HER/NEU+ HR+ metastatic breast CA

Tysabri

Drugs
Tysabri

Covered Uses
All FDA approved indications not otherwise excluded by part D

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
neurologist/Gastroenterologist

Coverage Duration
12 months

Other Criteria
Requires failure of first line Multiple Sclerosis agent or Tumor Necrosis Factor inhibitor for Crohn's Disease, and a negative JC antibody test.

Uptravi

Drugs
Uptravi

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

Exclusion Criteria

Required Medical Information
Right heart catheterization supporting diagnosis of PAH

Age Restriction

Prescriber Restriction
Pulmonology or Cardiology

Coverage Duration
12 months

Other Criteria
diagnosis of WHO group 1 PAH, failure of bosentan and sildenafil,

Vancomycin Capsules

Drugs
Vancomycin HCl Oral

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

Exclusion Criteria

Required Medical Information
Diagnostic confirmation of clostridium difficile diarrhea

Age Restriction

Prescriber Restriction
Gastroenterology, infectious disease, oncology

Coverage Duration
10 days

Other Criteria
Failure or contraindication to oral metronidazole

Venclexta

Drugs
Venclexta, Venclexta Starting Pack

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

Exclusion Criteria

Required Medical Information
Notes supporting Diagnosis and documentation of 17p deletion

Age Restriction

Prescriber Restriction
Hematology/Oncology

Coverage Duration
12 months

Other Criteria

VIMPAT

Drugs
Vimpat ORAL

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

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Diagnosis

Age Restriction
17 and older

Prescriber Restriction
Neurology

Coverage Duration
12 months

Other Criteria

Voriconazole

Drugs
Voriconazole ORAL SUSPENSION RECONSTITUTED, Voriconazole Oral TABLET 200 MG

Covered Uses
All FDA approved indications not otherwise excluded by Part D

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
3 months

Other Criteria
Covered when two of the following medications have been tried, unless resistance or contraindication precludes use, Itraconazole, fluconazole, ketoconazole. Exclusions to prerequisite medications are Invasive pulmonary aspergillosis, Scedosporium apiospermum, Fusarium

Vraylar

Drugs
Vraylar

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Psychiatry or Neurology

Coverage Duration
12 months

Other Criteria
Requires failure of aripiprazole and risperidone.

Welchol

Drugs
Welchol Oral TABLET

Covered Uses
All FDA approved indications not otherwise excluded by Part D

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
For diabetes must fail Metformin and DPP-IV inhibitor, For Hyperlipidemia must fail cholestyramine

XALKORI

Drugs
Xalkori

Covered Uses
All FDA approved indications not otherwise excluded from part D, locally advanced or metastatic ALK+ NSCLC

Exclusion Criteria
FDA labeled contraindications, NCLC which is Anaplastic Lymphoma Kinase negative, combination therapy with other tyrosine kinase inhibitors or EGRf inhibitors.

Required Medical Information
Diagnosis, documentation support ALK+ NSLC

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
Hematology-oncology

Coverage Duration
6 months

Other Criteria
Continuation will be based on lack of disease progression

XELJANZ

Drugs
Xeljanz, Xeljanz XR

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Rheumatology

Coverage Duration
12 months

Other Criteria
3 month trial of Combination DMARD therapy in past 6 months.

Drugs
Xgeva

Covered Uses
All Medically Acceptable indications not otherwise excluded by PART D

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
oncology/endocrinology

Coverage Duration
12 months

Other Criteria
Failure or contraindication to bisphosphonate for osteolytic cancer indications other than giant cell tumor of the bone.

XOLAIR

Drugs
Xolair

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

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Medical Notes, Previous treatment history, For asthma please submit RAST, aeroallergens results, IgE values

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
Pulmonologist, allergist, Dermatologist

Coverage Duration
12 months

Other Criteria
For Asthma patient Must Fail Combination LABA/ICS. For chronic ideopathic urticaria failure of hydroxyzine and H-2 antagonist.

Drugs
Xtandi

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
6 months or until disease progression

Other Criteria
Failure of docetaxel and Abiraterone

XYREM

Drugs
Xyrem

Covered Uses
All FDA approved indications not otherwise excluded by part D

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Physician Board certified in Sleep Medicine or neurologist

Coverage Duration
12 months

Other Criteria
Failure of Modafanil and amphetamine/dextroamphetamine or failure of fluoxetine for narcolepsy with cataplexy

YERVOY

Drugs
Yervoy Intravenous SOLUTION 50 MG/10ML

Covered Uses
All FDA approved indications not otherwise excluded from part D

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Diagnosis, medical notes

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
Hematology-oncology

Coverage Duration
6 months

Other Criteria
Approval will be for up to 4 doses at 3mg/kg. Not covered for combination therapy with BRAF inhibitors, MEK inhibitors, Adjuvant agents (Interferon), Interleukins subject to FDA approval changes or Listings within Medicare Approved compendia. Not covered for patients who previously experienced a severe immune mediated reaction related to ipilimumab.

Zaltrap

Drugs
Zaltrap Intravenous SOLUTION 100 MG/4ML

Covered Uses
All FDA Approved indications not otherwise excluded by Part D

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Hematology/oncology

Coverage Duration
6 months or until disease progression

Other Criteria
Failure Allergy or contraindication to Avastin.

ZAVESCA

Drugs
Zavesca

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

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Medical notes, previous treatment history, associated studies

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
Oncologist/Hematologist, Neurologist, Medical Geneticist, Metabolic Specialist.

Coverage Duration
12 months

Other Criteria
Coverage will be based on medical history/status, response to previous treatments, and the consideration of other therapeutic options

Zejula FHCP

Drugs
Zejula

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Hematology/Oncology

Coverage Duration
12 months or until progression

Other Criteria
Supporting BRCA results

Drugs
Zelboraf

Covered Uses
All medically accepted indications not otherwise excluded from part D, Metastatic Melanoma Stage IIIC unresectable or Stage IV

Exclusion Criteria
Absence of Braf V600E mutation, Combination therapy with other antineoplastic agents

Required Medical Information
Diagnosis, verification of a positive Braf V600e Mutation

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
Oncology

Coverage Duration
3 months

Other Criteria
Authorization for continuation past 90 days will be based on absence of disease progression.

ZEMPLAR

Drugs
Paricalcitol Oral

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

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Medical notes, previous treatment history, CA PO4, iPTH

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
Nephrologist/endocrinologist

Coverage Duration
12 months

Other Criteria
Patient must fail or have contraindication to Calcitriol or phosphate binder if appropriate

Zepatier

Drugs
Zepatier

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

Exclusion Criteria

Required Medical Information
Gentotype, Viral Load, Fibroscan/Fibrosure or liver biopsy, RAV NS5A panel

Age Restriction

Prescriber Restriction
Infectious disease, Gastroenterology/Hepatology

Coverage Duration
12 or 16 weeks depending on RAV profile as supported by current AASLD guidelines

Other Criteria
Zepatier is the exclusive treatment for indicated Genotype-1 and 4 patients with chronic HCV

ZOLINZA

Drugs
Zolinza

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

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Medical Notes

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
Oncologist/hematologist/dermatologist

Coverage Duration
12 months

Other Criteria
Failed minimum of two systemic treatments, one of which must be Targretin, unless contraindicated

Zydelig

Drugs
Zydelig

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Hematology/Oncology

Coverage Duration
12 months or until disease progression

Other Criteria

ZYKADIA

Drugs
Zykadia

Covered Uses
All FDA approved indications not otherwise excluded by Part D

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Hematology/Oncology

Coverage Duration
12 months or until disease progression

Other Criteria
Restricted to use in ALK+ Non Small Cell Lung Cancer in patients who have failed crizotinib.

Drugs
OLANZapine Intramuscular

Covered Uses
All medically accepted indications not otherwise excluded from part D

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Diagnosis

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction

Coverage Duration
12 months

Other Criteria

ZYTIGA

Drugs
Zytiga

Covered Uses
All medically accepted indications not otherwise excluded from part D

Exclusion Criteria
FDA labeled contraindications

Required Medical Information
Diagnosis

Age Restriction
Ages approved in FDA labeling

Prescriber Restriction
Oncology/urology

Coverage Duration
12 months

Other Criteria
Patient Must have castrate resistant metastatic prostate cancer and have failed docetaxel

Index