

# **2018 Prior Authorization Criteria**

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## ACTIMMUNE

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### **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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## Adcirca Tabs

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### **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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## Adempas

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### **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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## Alecensa

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### **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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## Alunbrig FHCP

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### **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**

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## **Ampyra (s)**

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### **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.

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## APOKYN

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### **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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.



## **Aptiom**

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### **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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## ARANESP

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### **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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## ARCALYST

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### **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 canakinumab, nsaid

### **Age Restriction**

### **Prescriber Restriction**

Immunologist, dermatologist, rheumatologist

### **Coverage Duration**

12 months

### **Other Criteria**

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## Aubagio Tabs

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### 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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## AVASTIN

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### **Drugs**

AVASTIN

### **Covered Uses**

All medically accepted indications not otherwise excluded from Part D.

### **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**

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## Azilect

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### **Drugs**

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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## **BANZEL**

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### **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**

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## BENLYSTA

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### **Drugs**

BENLYSTA

### **Covered Uses**

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

### **Exclusion Criteria**

Member receiving other biologic therapy or intravenous cyclophosphamide.

### **Required Medical Information**

Diagnosis of active, autoantibody-positive, systemic lupus erythematosus (SLE), and member currently receiving one or more of the following standard SLE therapies: Corticosteroids, Antimalarials, Non-steroidal anti-inflammatory drugs (NSAIDs), Immunosuppressants

### **Age Restriction**

Greater or equal to 18 years of age

### **Prescriber Restriction**

Rheumatologist or nephrologist

### **Coverage Duration**

Lifetime

### **Other Criteria**

None

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.



## **BLEOMYCIN SULFATE**

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### **Drugs**

BLEOMYCIN SULFATE INJECTION SOLUTION RECONSTITUTED 30 UNIT

### **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**

Until the end of calendar year

### **Other Criteria**

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## **BOSULIF**

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### **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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## **BOTOX**

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### **Drugs**

BOTOX

### **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**

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## Briviact

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### 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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## BUDESONIDE EC

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### **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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## Cabometyx

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### **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.

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## Calquence FHCP

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### **Drugs**

CALQUENCE

### **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 clinical progression

### **Other Criteria**

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## CARBAGLU

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### **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**

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.



## CEREZYME

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### **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**

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## Cinryze

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### **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

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### **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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## Corlanor FHCP

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### Drugs

CORLANOR

### Covered Uses

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

### Exclusion Criteria

#### Required Medical Information

Documentation of the following: 1. Diagnosis of chronic heart failure with left ventricular ejection fraction less than or equal to 35% AND 2. Patient is in sinus rhythm with resting heart rate greater than or equal to 70 beats per minute AND 3. Patient is on maximally tolerated doses of beta-blockers or has a contraindication to beta-blocker use AND 4. Patient is receiving an ACE inhibitor or ARB or has a contraindication to these agents.

#### Age Restriction

#### Prescriber Restriction

Cardiologist

#### Coverage Duration

12 months

#### Other Criteria

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## Cotellic

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### **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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## CUBICIN

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### **Drugs**

*daptomycin intravenous solution reconstituted 500 mg*

### **Covered Uses**

All medically accepted indications not otherwise excluded from Part D. \*Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI) , and the Drug Package Insert).

### **Exclusion Criteria**

Cubicin is contraindicated in patients with known hypersensitivity to daptomycin or any other component of the product.

### **Required Medical Information**

Documentation of a consultation with an infectious disease specialist. If being used to treat a condition caused by end-stage renal disease(ESRD) and member is on dialysis, please bill to Medicare Part B.

### **Age Restriction**

### **Prescriber Restriction**

### **Coverage Duration**

If all conditions are met, the request will be authorized until the end of the contract year.

### **Other Criteria**

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

## Cuprimine

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### **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

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### **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.

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.



## DRONABINOL

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### **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**

12 months

### **Other Criteria**

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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## ELAPRASE

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### **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**

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## ELITEK

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### **Drugs**

ELITEK

### **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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## EMEND

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### **Drugs**

APREPITANT, EMEND ORAL SUSPENSION RECONSTITUTED

### **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)

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## EMSAM

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### **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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## ENBREL

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### **Drugs**

ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE, ENBREL SUBCUTANEOUS SOLUTION RECONSTITUTED, 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.

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## Entresto FHCP

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### **Drugs**

ENTRESTO

### **Covered Uses**

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

### **Exclusion Criteria**

### **Required Medical Information**

Documentation of chronic heart failure (NYHA Class II-IV) and reduced ejection fraction (less than or equal to 40%).

### **Age Restriction**

### **Prescriber Restriction**

Cardiologist

### **Coverage Duration**

12 months

### **Other Criteria**

Entresto will be used in place of an ACE inhibitor or other ARB.

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## ErivedgeFHCP

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### **Drugs**

ERIVEDGE

### **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 progression

### **Other Criteria**

Diagnosis of metastatic basal cell carcinoma OR Diagnosis of locally advanced basal cell carcinoma that has recurred following surgery or when the patient is not a candidate for surgery and radiation

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.



## ERLEADA-FHCP

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### **Drugs**

ERLEADA

### **Covered Uses**

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

### **Exclusion Criteria**

### **Required Medical Information**

### **Age Restriction**

### **Prescriber Restriction**

Urologist, Oncologist

### **Coverage Duration**

12 months or until PSA progression

### **Other Criteria**

Failure of abiraterone (only applies to overlapping indications)

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## **Esbriet**

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### **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%

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## Exelon

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### Drugs

RIVASTIGMINE

### 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 prerequisite medications for dementia due to parkinson's disease

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## EXJADE

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### **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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## FABRAZYME

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### **Drugs**

FABRAZYME

### **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.

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## FANAPT

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### **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**

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## FANAPT TITRATION PACK

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### **Drugs**

FANAPT TITRATION PACK

### **Covered Uses**

All FDA approved indications not otherwise excluded from Part D.

### **Exclusion Criteria**

### **Required Medical Information**

#### **Age Restriction**

NOT APPROVED IF LESS THAN 18 YEARS OF AGE

#### **Prescriber Restriction**

PSYCHIATRIST

#### **Coverage Duration**

Until the end of calendar year

#### **Other Criteria**

For schizophrenia: Must use formulary alternatives risperidone, or olanzapine, quetiapine, or ziprasidone within previous 12 months.

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## Farydak

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### **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**

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.



## Fentanyl

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### **Drugs**

*fentanyl transdermal patch 72 hour 100 mcg/hr*

### **Covered Uses**

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

### **Exclusion Criteria**

### **Required Medical Information**

Medical notes, previous treatment history

### **Age Restriction**

### **Prescriber Restriction**

### **Coverage Duration**

6 months

### **Other Criteria**

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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.

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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**

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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 past 12 months

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## **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**

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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, *lanthanum carbonate*

### **Covered Uses**

All medically accepted indications not otherwise excluded from part D

### **Exclusion Criteria**

FDA labeled contraindications

### **Required Medical Information**

Previous treatment history, CA, PO<sub>4</sub>, 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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

**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**

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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.

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## Gilenya

---

### **Drugs**

GILENYA ORAL CAPSULE 0.5 MG

### **Covered Uses**

All medically accepted indications not otherwise excluded from Part D.

### **Exclusion Criteria**

### **Required Medical Information**

### **Age Restriction**

### **Prescriber Restriction**

Neurology

### **Coverage Duration**

12 months

### **Other Criteria**

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## GLYBURIDE

---

### **Drugs**

*glyburide micronized, glyburide oral*

### **Covered Uses**

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

### **Exclusion Criteria**

### **Required Medical Information**

failure or contraindication to preferred glipizide and glimeperide

### **Age Restriction**

Prior authorization required for members 65 years or older. Automatic approval for members less than 65 years of age.

### **Prescriber Restriction**

### **Coverage Duration**

Through benefit year

### **Other Criteria**

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.



## HUMIRA

---

### **Drugs**

HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT, HUMIRA PEN SUBCUTANEOUS PEN-INJECTOR KIT, HUMIRA PEN-CD/UC/HS STARTER, HUMIRA PEN-PS/UV STARTER, HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT

### **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 a preferred TNF (Enbrel/Simponi)and Xeljanz. For Psoriatic Arthritis, Ankylosing spondylitis Patient must fail Enbrel and Simponi. For ulcerative colitis patient must fail Simponi and conventional agents. For plaque psoriasis patients must fail Enbrel

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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**

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## IDH1FA FHCP

---

### **Drugs**

IDH1FA

### **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**

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## Ilaris

---

### **Drugs**

ILARIS SUBCUTANEOUS SOLUTION

### **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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## Imbruvica

---

### **Drugs**

IMBRUVICA ORAL CAPSULE 140 MG, 70 MG, IMBRUVICA ORAL TABLET

### **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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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**

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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.

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.



## isotretinoin

---

### Drugs

ZENATANE ORAL CAPSULE 10 MG, 20 MG, 40 MG, *zenatane oral capsule 30 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 tetracycline and topical retinoid must have been tried in most recent 6 months.

## ITRACONAZOLE

---

### **Drugs**

*itraconazole oral capsule*, 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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## IVIG

---

### **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).

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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.

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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.

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## KADCYLA

---

### **Drugs**

KADCYLA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG, 160 MG

### **Covered Uses**

All medically accepted indications not otherwise excluded from Part D.

### **Exclusion Criteria**

### **Required Medical Information**

Tumor(s) have been evaluated with an assay validated to predict HER2 protein overexpression. Individuals are considered HER2 positive whose tumors have HER2 protein overexpression documented by one of the following, immunohistochemistry (IHC) 3+ or fluorescent in situ hybridization (FISH) HER2 gene copy is greater than 6 OR FISH ratio of HER2 gene/chromosome 17 ratio is greater than or equal to 2.0.

### **Age Restriction**

### **Prescriber Restriction**

### **Coverage Duration**

1 year

### **Other Criteria**

For metastatic breast cancer, individual has previously received trastuzumab and a taxane, separately or in combination. AND has either received prior therapy for metastatic disease OR developed disease recurrence during or within six (6) months of completing adjuvant therapy. Kadcyla is only used in one line of therapy.

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

**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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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**

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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**

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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.

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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**

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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**

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.



## 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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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**

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## LOTRONEX

---

### **Drugs**

*alosetron hcl*

### **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**

Gastroenterologist

### **Coverage Duration**

up to 12 months

### **Other Criteria**

Failure of loperimide and cholestyramine. Approved initially for 3 months continuation up to 12 months if patient has improvement in symptoms.

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## LUMIZYME

---

### **Drugs**

LUMIZYME

### **Covered Uses**

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

### **Exclusion Criteria**

### **Required Medical Information**

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

### **Age Restriction**

### **Prescriber Restriction**

### **Coverage Duration**

Authorization will be for 12 months

### **Other Criteria**

Appropriate medical support is readily available when Lumizyme is administered in the event of anaphylaxis, severe allergic reaction, or acute cardiorespiratory failure.

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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**

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## Mavyret

---

### **Drugs**

MAVYRET

### **Covered Uses**

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

### **Exclusion Criteria**

### **Required Medical Information**

### **Age Restriction**

### **Prescriber Restriction**

Gastroenterology, infectious disease, Hepatology

### **Coverage Duration**

8 weeks to 16 weeks

### **Other Criteria**

Information supporting diagnosis,genotype,and Metavir score.

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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.

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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 require failure of formulary estrogens which do not have utilization management (ie. premarin, estradiol, estropipate)

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.



## 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)

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## multaq

---

### **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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## NAGLAZYME

---

### **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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## Natpara

---

### **Drugs**

NATPARA

### **Covered Uses**

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

### **Exclusion Criteria**

### **Required Medical Information**

iPTH, Calcium

### **Age Restriction**

### **Prescriber Restriction**

endocrinologist

### **Coverage Duration**

12 months

### **Other Criteria**

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## Nerlynx FHCP

---

### **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**

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## Ninlaro

---

### **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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.



## 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 prerequisite drugs required for Dopamine-Beta-Hydroxylase deficiency

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## Nuedexta

---

### **Drugs**

NUDEXTA

### **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**

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## Nuplazid

---

### Drugs

NUPLAZID ORAL TABLET 17 MG

### Covered Uses

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

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

Neurology Psychiatry

### 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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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%

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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**

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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**

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.



## 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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

**opdivo**

---

**Drugs**

OPDIVO INTRAVENOUS SOLUTION 100 MG/10ML, 40 MG/4ML

**Covered Uses**

All medically accepted indications not otherwise excluded from Part D.

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**

1 year

**Other Criteria**

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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 a preferred ANTI-TNF(Simponi/Enbrel)and xeljanz (where applicable, only applies to overlapping indications such as Rheumatoid Arthritis)

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## Otezla FHCP

---

### **Drugs**

OTEZLA ORAL TABLET, OTEZLA ORAL TABLET THERAPY PACK

### **Covered Uses**

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

### **Exclusion Criteria**

### **Required Medical Information**

Documentation of active psoriatic arthritis or moderate-to-severe plaque psoriasis.

### **Age Restriction**

### **Prescriber Restriction**

Rheumatologist, Dermatologist

### **Coverage Duration**

12 months

### **Other Criteria**

For Plaque Psoriasis patient must fail MTX or Soriatane and must fail 2 preferred TNF inhibitors or have a contraindication to TNF inhibitors. For Psoriatic Arthritis patient must fail adequate trial of MTX or LEF and must fail 2 preferred TNF inhibitors or have a contraindication to TNF inhibitors.

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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**

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## PA Applies

---

### Drugs

*phenoxybenzamine hcl 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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.



## 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 contraindication

### **Required Medical Information**

Medical notes, Viral Load

### **Age Restriction**

Ages approved in FDA labeling

### **Prescriber Restriction**

Gastroenterologist/ Infectious Disease

### **Coverage Duration**

48 weeks

### **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.

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## POMALYST

---

### **Drugs**

POMALYST

### **Covered Uses**

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

### **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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## PROCRIT

---

### **Drugs**

PROCRIT INJECTION SOLUTION 10000 UNIT/ML, 20000 UNIT/ML, 40000 UNIT/ML

### **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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## **PROLASTIN-C**

---

### **Drugs**

PROLASTIN-C INTRAVENOUS SOLUTION RECONSTITUTED 1000 MG

### **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**

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## prolia

---

### **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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.



## 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.

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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**

### **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).

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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.

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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

For patients with HoFH, HeFH, or with established atherosclerotic cardiovascular disease who require additional LDL lowering: Failure of rosuvastatin 40mg or Atorvastatin 80 combined with ezetimibe 10mg. Diagnosis of must be HeFH supported by Dutch Lipid Clinic Network criteria. Diagnosis of HOFH must be confirmed by genetic testing. Patients who are intolerant to rosuvastatin/ atorvastatin can use an alternative statin + Ezetimibe 10mg. For statin intolerant patients who required additional LDL lowering and have established cardiovascular disease, HoFH, or HeFH: History of statin intolerance to a hydrophilic statin such as fluvastatin, pravastatin, rosuvastatin in the absence of fibrates or other combinations which can increase risk of myopathy or myalgia when used in combination with a statin.

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## REVATIO

---

### **Drugs**

*sildenafil citrate oral tablet 20 mg*

### **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.

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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**

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.



## 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.

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## RITUXAN

---

### **Drugs**

RITUXAN INTRAVENOUS SOLUTION

### **Covered Uses**

All FDA-approved indications not otherwise excluded from Part D

### **Exclusion Criteria**

FDA labeled contraindications

### **Required Medical Information**

Medical notes, immunohistopathology

### **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.

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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.

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## Rubraca

---

### **Drugs**

RUBRACA

### **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.

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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 if being used for AML, not required for systemic mastocytosis

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## SABRIL

---

### **Drugs**

SABRIL

### **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)

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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**

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.



## 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. ESRD use is excluded from medicare Part D and this authorization will include a determination of Part D vs Part B coverage based indication

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## Signifor

---

### Drugs

SIGNIFOR

### Covered Uses

All FDA approved uses not excluded from part D

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

Endocrinologist

### Coverage Duration

12 months

### Other Criteria

For Cushing's Disease Failed or poor surgical candidate for pituitary resection For Acromegaly  
Failed or poor surgical candidate for pituitary resection Failure of octreotide

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## SimponiFHCP

---

### **Drugs**

SIMPONI ARIA, SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR, SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.5ML

### **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**

For RA Patient must fail 3 month trial of MTX in combination with a DMARD in past 6 months. If MTX contraindicated, must try combination of 2-nonbiologic DMARDS. For Ankylosing Spondylitis PT must fail 2 NSAIDS within past 6 months. For Psoriatic Arthritis Patient must fail adequate trial of MTX or LEF in past 6 months. For ulcerative colitis patient must fail Azathioprine/6MP in combination with a 5-ASA compound.

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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**

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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**

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## **SUBOXONE FILM**

---

### **Drugs**

SUBOXONE SUBLINGUAL FILM

### **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**

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.



## Sylvant

---

### Drugs

SYLVANT

### 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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## SYMLIN

---

### **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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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.

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## Tagrisso

---

### Drugs

TAGRISSE

### 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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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.

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## TAZORAC

---

### **Drugs**

TAZAROTENE EXTERNAL, TAZORAC EXTERNAL CREAM 0.05 %, TAZORAC EXTERNAL GEL

### **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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.



## 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**

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## TOBI PODHALER

---

### Drugs

TOBI PODHALER

### Covered Uses

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

### Exclusion Criteria

#### Required Medical Information

Medical notes describing indication for the management of cystic fibrosis patients with *Pseudomonas aeruginosa* and with forced expiratory volume in 1 second (FEV1) greater than 25% or less than 80%.

#### Age Restriction

6 years and older

#### Prescriber Restriction

#### Coverage Duration

Through benefit year

#### Other Criteria

Safety and efficacy have not been demonstrated in patients with forced expiratory volume in 1 second (FEV1) less than 25% or greater than 80%, or patients colonized with *Burkholderia cepacia*

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## Transderm-Scop

---

### **Drugs**

*scopolamine*, 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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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**

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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**

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## Trintellix

---

### **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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.



## 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.

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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**

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## Verzenio FHCP

---

### Drugs

VERZENIO

### 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 clinical progression

### Other Criteria

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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**

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## Voriconazole

---

### Drugs

*voriconazole 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

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*

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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.

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.



## Welchol

---

### Drugs

*colesevelam hcl oral tablet*, WELCHOL

### 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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## **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/Gastroenterology

### **Coverage Duration**

12 months

### **Other Criteria**

For Rheumatoid arthritis- 3 month trial of Combination DMARD therapy in past 6 months, For Psoriatic Arthritis Patient must fail adequate trial of MTX or LEF in past 6 months. For ulcerative colitis patient must fail Azathioprine/6MP in combination with a 5-ASA compound.

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## **XEOMIN**

---

### **Drugs**

XEOMIN INTRAMUSCULAR SOLUTION RECONSTITUTED 50 UNIT

### **Covered Uses**

All FDA-approved indications not otherwise excluded from Part D. Additional off-label coverage is provided for spasticity (i.e. stroke).

### **Exclusion Criteria**

Coverage is not provided for cosmetic uses

### **Required Medical Information**

### **Age Restriction**

### **Prescriber Restriction**

### **Coverage Duration**

Authorization will be for 12 months.

### **Other Criteria**

Blepharospasm, approve if the patient has tried onabotulinumtoxinA (Botox).

## XGEVA

---

### **Drugs**

XGEVA

### **Covered Uses**

All FDA-approved indications not otherwise excluded from 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.

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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.

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## XTANDI

---

### **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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.



## 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.

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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.

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## ZAVESCA

---

### **Drugs**

*miglustat*, 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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## **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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## ZELBORAF

---

### **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.

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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 PO<sub>4</sub>, 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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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**

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## 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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.



## 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**

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## ZYKADIA

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### **Drugs**

ZYKADIA

### **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**

Restricted to use in ALK+ Non Small Cell Lung Cancer

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## ZYPREXA IM INJ

---

### **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**

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

## ZYTIGA

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### **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

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

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## Part B vs. Part B PA Only

<b>Product</b>	<b>V26</b>
Abilify Maintena Prefilled Syringe 400 MG Intramuscular	
Abilify Maintena Suspension Reconstituted ER 300 MG Intramuscular	
Abilify Maintena Suspension Reconstituted ER 400 MG Intramuscular	
Abraxane SUSPENSION RECONSTITUTED 100 MG Intravenous	
AcetaZOLAMIDE Sodium Solution Reconstituted 500 MG Injection	
Acetylcysteine SOLUTION 10 % INHALATION	
Acetylcysteine SOLUTION 20 % INHALATION	
Acyclovir Sodium SOLUTION 50 MG/ML Intravenous	
Adagen SOLUTION 250 UNIT/ML Intramuscular	
Albuterol Sulfate Nebulization Solution (2.5 MG/3ML) 0.083% Inhalation	
Aldurazyme SOLUTION 2.9 MG/5ML Intravenous	
Alimta SOLUTION RECONSTITUTED 100 MG Intravenous	
Alimta SOLUTION RECONSTITUTED 500 MG Intravenous	
Aliqopa SOLUTION RECONSTITUTED 60 MG Intravenous	
Aloxi Solution 0.25 MG/5ML Intravenous	
Aminophylline Solution 25 MG/ML Intravenous	
Amiodarone HCl Solution 150 MG/3ML Intravenous	
Amphotericin B SOLUTION RECONSTITUTED 50 MG INJECTION	
Ampicillin Sodium Solution Reconstituted 1 GM Injection	
Ampicillin Sodium SOLUTION RECONSTITUTED 125 MG INJECTION	
Ampicillin-Sulbactam Sodium Solution Reconstituted 1.5 (1-0.5) GM Injection	
Ampicillin-Sulbactam Sodium Solution Reconstituted 3 (2-1) GM Injection	
Aristada Prefilled Syringe 1064 MG/3.9ML Intramuscular	
Aristada Prefilled Syringe 441 MG/1.6ML Intramuscular	
Aristada Prefilled Syringe 662 MG/2.4ML Intramuscular	
Aristada Prefilled Syringe 882 MG/3.2ML Intramuscular	
Arranon SOLUTION 5 MG/ML Intravenous	
Atgam INJECTABLE 50 MG/ML Intravenous	
AzaCITIDine Suspension Reconstituted 100 MG Injection	
AzaTHIOprine TABLET 50 MG Oral	
Azithromycin SOLUTION RECONSTITUTED 500 MG Intravenous	
Bavencio SOLUTION 200 MG/10ML Intravenous	
BCG Vaccine INJECTABLE INJECTION	
Beleodaq SOLUTION RECONSTITUTED 500 MG Intravenous	
Benztropine Mesylate Solution 1 MG/ML Injection	
Bicillin C-R 900/300 SUSPENSION 900000-300000 UNIT/2ML Intramuscular	
Bicillin C-R SUSPENSION 1200000 UNIT/2ML Intramuscular	
Bicillin L-A SUSPENSION 1200000 UNIT/2ML Intramuscular	
Bicillin L-A SUSPENSION 2400000 UNIT/4ML Intramuscular	
Bicillin L-A SUSPENSION 600000 UNIT/ML Intramuscular	
BiCNU Solution Reconstituted 100 MG Intravenous	
Briviact SOLUTION 50 MG/5ML Intravenous	
Budesonide Suspension 0.25 MG/2ML Inhalation	

## Part B vs. Part B PA Only

Product	V26
Budesonide Suspension 0.5 MG/2ML Inhalation	
Budesonide SUSPENSION 1 MG/2ML Inhalation	
Bumetanide Solution 0.25 MG/ML Injection	
Buprenorphine HCl SOLUTION 0.3 MG/ML Injection	
Calcitriol SOLUTION 1 MCG/ML Intravenous	
Cancidas SOLUTION RECONSTITUTED 50 MG Intravenous	
Cancidas SOLUTION RECONSTITUTED 70 MG Intravenous	
Capastat Sulfate SOLUTION RECONSTITUTED 1 GM INJECTION	
CARBOplatin Solution 150 MG/15ML Intravenous	
CeFAZolin Sodium Solution Reconstituted 1 GM Injection	
CeFAZolin Sodium SOLUTION RECONSTITUTED 10 GM Injection	
CeFAZolin Sodium Solution Reconstituted 500 MG Injection	
Cefuroxime Sodium Solution Reconstituted 1.5 GM Intravenous	
Cefuroxime Sodium Solution Reconstituted 7.5 GM Injection	
Cefuroxime Sodium Solution Reconstituted 750 MG Injection	
Chlorothiazide Sodium SOLUTION RECONSTITUTED 500 MG Intravenous	
ChlorproMAZINE HCl SOLUTION 50 MG/2ML INJECTION	
Chorionic Gonadotropin SOLUTION RECONSTITUTED 10000 UNIT Intramuscular	
Cidofovir SOLUTION 75 MG/ML Intravenous	
Ciprofloxacin in D5W Solution 200 MG/100ML Intravenous	
CISplatin Solution 50 MG/50ML Intravenous	
Cladribine Solution 10 MG/10ML Intravenous	
Clindamycin Phosphate SOLUTION 600 MG/4ML Injection	
Clofarabine SOLUTION 1 MG/ML Intravenous	
Cosmegen SOLUTION RECONSTITUTED 0.5 MG Intravenous	
Cresemba SOLUTION RECONSTITUTED 372 MG Intravenous	
Cromolyn Sodium Nebulization Solution 20 MG/2ML Inhalation	
Cyclophosphamide Capsule 25 MG Oral	
Cyclophosphamide Capsule 50 MG Oral	
CycloSPORINE CAPSULE 100 MG Oral	
CycloSPORINE CAPSULE 25 MG ORAL	
CycloSPORINE Modified Capsule 100 MG Oral	
CycloSPORINE Modified CAPSULE 25 MG Oral	
CycloSPORINE Modified Capsule 50 MG Oral	
CycloSPORINE Modified Solution 100 MG/ML Oral	
CycloSPORINE Solution 50 MG/ML Intravenous	
Cyramza SOLUTION 100 MG/10ML Intravenous	
Cyramza SOLUTION 500 MG/50ML Intravenous	
Cytarabine Solution 20 MG/ML Injection	
Dacarbazine SOLUTION RECONSTITUTED 200 MG Intravenous	
DACTINomycin SOLUTION RECONSTITUTED 0.5 MG Intravenous	
Darzalex SOLUTION 100 MG/5ML Intravenous	
DAUNOrubicin HCl INJECTABLE 5 MG/ML Intravenous	

## Part B vs. Part B PA Only

Product	V26
Decitabine Solution Reconstituted 50 MG Intravenous	
Delestrogen Oil 10 MG/ML Intramuscular	
Depo-Estradiol Oil 5 MG/ML Intramuscular	
Desmopressin Acetate SOLUTION 4 MCG/ML Injection	
Dexamethasone Sodium Phosphate SOLUTION 10 MG/ML INJECTION	
Dexamethasone Sodium Phosphate SOLUTION 120 MG/30ML INJECTION	
Dicyclomine HCl SOLUTION 10 MG/ML Intramuscular	
Digoxin SOLUTION 0.25 MG/ML Injection	
Dihydroergotamine Mesylate SOLUTION 1 MG/ML Injection	
DiphenhydrAMINE HCl Solution 50 MG/ML Injection	
Diphtheria-Tetanus Toxoids DT SUSPENSION 25-5 LFU/0.5ML Intramuscular	
DOCetaxel Concentrate 80 MG/4ML Intravenous	
Doxercalciferol Solution 4 MCG/2ML Intravenous	
DOXOrubicin HCl Liposomal Injectable 2 MG/ML Intravenous	
DOXOrubicin HCl SOLUTION 2 MG/ML Intravenous	
Doxy 100 SOLUTION RECONSTITUTED 100 MG Intravenous	
Duramorph SOLUTION 0.5 MG/ML Injection	
Duramorph SOLUTION 1 MG/ML Injection	
Eligard KIT 22.5 MG Subcutaneous	
Eligard KIT 7.5 MG Subcutaneous	
Empliciti SOLUTION RECONSTITUTED 300 MG Intravenous	
Empliciti SOLUTION RECONSTITUTED 400 MG Intravenous	
Engerix-B SUSPENSION 10 MCG/0.5ML Injection	
Engerix-B SUSPENSION 20 MCG/ML INJECTION	
Epirubicin HCl Solution 200 MG/100ML Intravenous	
Eraxis SOLUTION RECONSTITUTED 100 MG Intravenous	
Eraxis SOLUTION RECONSTITUTED 50 MG Intravenous	
Erbix SOLUTION 100 MG/50ML Intravenous	
Erwinaze SOLUTION RECONSTITUTED 10000 UNIT INJECTION	
Erythrocin Lactobionate SOLUTION RECONSTITUTED 500 MG Intravenous	
Estradiol Valerate Oil 20 MG/ML Intramuscular	
Estradiol Valerate Oil 40 MG/ML Intramuscular	
Etoposide SOLUTION 100 MG/5ML Intravenous	
Faslodex SOLUTION 250 MG/5ML Intramuscular	
Fluconazole in Sodium Chloride Solution 200-0.9 MG/100ML-% Intravenous	
Fluconazole in Sodium Chloride Solution 400-0.9 MG/200ML-% Intravenous	
Fludarabine Phosphate SOLUTION RECONSTITUTED 50 MG Intravenous	
Fluorouracil SOLUTION 5 GM/100ML Intravenous	
FluPHENAZine Decanoate Solution 25 MG/ML Injection	
FluPHENAZine HCl SOLUTION 2.5 MG/ML INJECTION	
Fomepizole Solution 1.5 GM/1.5ML Intravenous	
Fosphenytoin Sodium Solution 100 MG PE/2ML Injection	
Furosemide Solution 10 MG/ML Injection	

## Part B vs. Part B PA Only

Product	V26
Ganciclovir Sodium SOLUTION RECONSTITUTED 500 MG Intravenous	
Gentamicin Sulfate SOLUTION 40 MG/ML Injection	
Geodon SOLUTION RECONSTITUTED 20 MG Intramuscular	
Glycopyrrolate Solution 4 MG/20ML Injection	
Granix Solution Prefilled Syringe 300 MCG/0.5ML Subcutaneous	
Granix Solution Prefilled Syringe 480 MCG/0.8ML Subcutaneous	
Halaven SOLUTION 1 MG/2ML Intravenous	
Haloperidol Decanoate SOLUTION 100 MG/ML Intramuscular	
Haloperidol Decanoate Solution 50 MG/ML Intramuscular	
Haloperidol Lactate Solution 5 MG/ML Injection	
Heparin Sodium (Porcine) Solution 1000 UNIT/ML Injection	
Heparin Sodium (Porcine) Solution 10000 UNIT/ML Injection	
Heparin Sodium (Porcine) Solution 20000 UNIT/ML Injection	
Heparin Sodium (Porcine) Solution 5000 UNIT/ML Injection	
Herceptin SOLUTION RECONSTITUTED 150 MG Intravenous	
Herceptin SOLUTION RECONSTITUTED 440 MG Intravenous	
HydrALAZINE HCl Solution 20 MG/ML Injection	
IDArubicin HCl Solution 10 MG/10ML Intravenous	
Ifosfamide SOLUTION RECONSTITUTED 1 GM Intravenous	
Imfinzi SOLUTION 120 MG/2.4ML Intravenous	
Imfinzi SOLUTION 500 MG/10ML Intravenous	
Intralipid EMULSION 30 % Intravenous	
Intron A SOLUTION 10000000 UNIT/ML INJECTION	
Intron A SOLUTION 6000000 UNIT/ML INJECTION	
Intron A SOLUTION RECONSTITUTED 10000000 UNIT Injection	
Intron A SOLUTION RECONSTITUTED 18000000 UNIT Injection	
Intron A SOLUTION RECONSTITUTED 50000000 UNIT Injection	
Invega Sustenna SUSPENSION 156 MG/ML Intramuscular	
Ipratropium Bromide Solution 0.02 % Inhalation	
Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML Inhalation	
Irinotecan HCl Solution 100 MG/5ML Intravenous	
Jevtana SOLUTION 60 MG/1.5ML Intravenous	
Keytruda SOLUTION 100 MG/4ML Intravenous	
Kyprolis SOLUTION RECONSTITUTED 30 MG Intravenous	
Kyprolis SOLUTION RECONSTITUTED 60 MG Intravenous	
Lactated Ringers Solution Intravenous	
Lartruvo SOLUTION 190 MG/19ML Intravenous	
Lartruvo SOLUTION 500 MG/50ML Intravenous	
Leucovorin Calcium SOLUTION RECONSTITUTED 100 MG Injection	
Leucovorin Calcium SOLUTION RECONSTITUTED 350 MG INJECTION	
Leukine SOLUTION RECONSTITUTED 250 MCG Intravenous	
Leuprolide Acetate KIT 1 MG/0.2ML Injection	
Levofloxacin in D5W Solution 500 MG/100ML Intravenous	

## Part B vs. Part B PA Only

Product	V26
Levofloxacin Solution 25 MG/ML Intravenous	
Lupron Depot (1-Month) KIT 3.75 MG Intramuscular	
Lupron Depot (1-Month) KIT 7.5 MG Intramuscular	
Lupron Depot (3-Month) KIT 11.25 MG Intramuscular	
Lupron Depot (3-Month) KIT 22.5 MG Intramuscular	
Lupron Depot-Ped (1-Month) KIT 11.25 MG Intramuscular	
Lupron Depot-Ped (1-Month) KIT 15 MG Intramuscular	
Magnesium Sulfate Solution 50 % Injection	
Meperidine HCl SOLUTION 100 MG/ML INJECTION	
Meperidine HCl SOLUTION 25 MG/ML INJECTION	
Meperidine HCl SOLUTION 50 MG/ML INJECTION	
Mesna Solution 100 MG/ML Intravenous	
MethylPREDNISolone Acetate Suspension 40 MG/ML Injection	
MethylPREDNISolone Acetate Suspension 80 MG/ML Injection	
MethylPREDNISolone Sodium Succ SOLUTION RECONSTITUTED 1000 MG Injection	
MethylPREDNISolone Sodium Succ SOLUTION RECONSTITUTED 125 MG Injection	
MethylPREDNISolone Sodium Succ SOLUTION RECONSTITUTED 40 MG Injection	
Metoclopramide HCl SOLUTION 5 MG/ML INJECTION	
Metoprolol Tartrate Solution 5 MG/5ML Intravenous	
MetroNIDAZOLE in NaCl SOLUTION 500-0.79 MG/100ML-% Intravenous	
Miacalcin SOLUTION 200 UNIT/ML INJECTION	
Mircera Solution Prefilled Syringe 100 MCG/0.3ML Injection	
Mircera Solution Prefilled Syringe 50 MCG/0.3ML Injection	
Mircera Solution Prefilled Syringe 75 MCG/0.3ML Injection	
Mitomycin SOLUTION RECONSTITUTED 20 MG Intravenous	
MitoMYcin Solution Reconstituted 40 MG Intravenous	
MitoMYcin SOLUTION RECONSTITUTED 5 MG Intravenous	
Mitoxantrone HCl CONCENTRATE 25 MG/12.5ML Intravenous	
Mozobil SOLUTION 24 MG/1.2ML Subcutaneous	
Mustargen SOLUTION RECONSTITUTED 10 MG Injection	
Mycophenolate Mofetil CAPSULE 250 MG Oral	
Mycophenolate Mofetil SUSPENSION RECONSTITUTED 200 MG/ML ORAL	
Mycophenolate Mofetil Tablet 500 MG Oral	
Mycophenolate Sodium Tablet Delayed Release 180 MG Oral	
Mycophenolate Sodium Tablet Delayed Release 360 MG Oral	
Mylotarg SOLUTION RECONSTITUTED 4.5 MG Intravenous	
Nebupent SOLUTION RECONSTITUTED 300 MG INHALATION	
Neulasta Solution Prefilled Syringe 6 MG/0.6ML Subcutaneous	
Neupogen SOLUTION 300 MCG/ML INJECTION	
Neupogen SOLUTION 480 MCG/1.6ML INJECTION	
Nulojix SOLUTION RECONSTITUTED 250 MG Intravenous	
Octreotide Acetate SOLUTION 100 MCG/ML Injection	
Octreotide Acetate SOLUTION 1000 MCG/ML Injection	

## Part B vs. Part B PA Only

Product	V26
Octreotide Acetate SOLUTION 200 MCG/ML Injection	
Octreotide Acetate SOLUTION 50 MCG/ML Injection	
Octreotide Acetate SOLUTION 500 MCG/ML Injection	
Ondansetron HCl Solution 4 MG/2ML Injection	
Ondansetron HCl SOLUTION 4 MG/5ML Oral	
Ondansetron HCl Tablet 4 MG Oral	
Ondansetron HCl Tablet 8 MG Oral	
Ondansetron Tablet Dispersible 4 MG Oral	
Ondansetron Tablet Dispersible 8 MG Oral	
Oxacillin Sodium Solution Reconstituted 10 GM Injection	
Oxacillin Sodium Solution Reconstituted 2 GM Injection	
Oxaliplatin Solution 100 MG/20ML Intravenous	
Oxaliplatin Solution Reconstituted 100 MG Intravenous	
PAClitaxel Concentrate 100 MG/16.7ML Intravenous	
Pamidronate Disodium SOLUTION 6 MG/ML Intravenous	
Pantoprazole Sodium SOLUTION RECONSTITUTED 40 MG Intravenous	
Penicillin G Potassium Solution Reconstituted 2000000 UNIT Injection	
Penicillin G Procaine SUSPENSION 600000 UNIT/ML Intramuscular	
Pentam SOLUTION RECONSTITUTED 300 MG INJECTION	
Perjeta SOLUTION 420 MG/14ML Intravenous	
Phenytoin Sodium SOLUTION 50 MG/ML Injection	
Piperacillin Sod-Tazobactam So Solution Reconstituted 3.375 (3-0.375) GM Intravenous	
Piperacillin Sod-Tazobactam So Solution Reconstituted 4.5 (4-0.5) GM Intravenous	
Piperacillin Sod-Tazobactam So Solution Reconstituted 40.5 (36-4.5) GM Intravenous	
Potassium Chloride Solution 2 MEQ/ML Intravenous	
Procainamide HCl SOLUTION 100 MG/ML Injection	
Procainamide HCl SOLUTION 500 MG/ML Injection	
Prochlorperazine Edisylate SOLUTION 5 MG/ML Injection	
Procrit SOLUTION 2000 UNIT/ML INJECTION	
Procrit SOLUTION 3000 UNIT/ML INJECTION	
Procrit SOLUTION 4000 UNIT/ML INJECTION	
Proleukin SOLUTION RECONSTITUTED 22000000 UNIT Intravenous	
Promethazine HCl Solution 25 MG/ML Injection	
Promethazine HCl SOLUTION 50 MG/ML Injection	
Propranolol HCl SOLUTION 1 MG/ML Intravenous	
RaNITidine HCl Solution 50 MG/2ML Injection	
Rapamune SOLUTION 1 MG/ML ORAL	
Recombivax HB SUSPENSION 10 MCG/ML Injection	
Recombivax HB SUSPENSION 10 MCG/ML INJECTION (1ML SYRINGE)	
Recombivax HB SUSPENSION 40 MCG/ML Injection	
Recombivax HB SUSPENSION 5 MCG/0.5ML Injection	
Rifampin Solution Reconstituted 600 MG Intravenous	
RisperDAL Consta SUSPENSION RECONSTITUTED 12.5 MG Intramuscular	

## Part B vs. Part B PA Only

Product	V26
RisperDAL Consta SUSPENSION RECONSTITUTED 25 MG Intramuscular	
RisperDAL Consta SUSPENSION RECONSTITUTED 37.5 MG Intramuscular	
RisperDAL Consta SUSPENSION RECONSTITUTED 50 MG Intramuscular	
SandoSTATIN LAR Depot KIT 10 MG Intramuscular	
SandoSTATIN LAR Depot KIT 20 MG Intramuscular	
SandoSTATIN LAR Depot KIT 30 MG Intramuscular	
Sirolimus TABLET 0.5 MG ORAL	
Sirolimus Tablet 1 MG Oral	
Sirolimus TABLET 2 MG ORAL	
Solu-CORTEF SOLUTION RECONSTITUTED 100 MG INJECTION	
Solu-CORTEF SOLUTION RECONSTITUTED 250 MG INJECTION	
Sulfamethoxazole-Trimethoprim SOLUTION 400-80 MG/5ML Intravenous	
Synagis SOLUTION 100 MG/ML Intramuscular	
Synagis SOLUTION 50 MG/0.5ML Intramuscular	
Tacrolimus CAPSULE 0.5 MG Oral	
Tacrolimus Capsule 1 MG Oral	
Tacrolimus CAPSULE 5 MG Oral	
Tecentriq SOLUTION 1200 MG/20ML Intravenous	
Teflaro SOLUTION RECONSTITUTED 400 MG Intravenous	
Teflaro SOLUTION RECONSTITUTED 600 MG Intravenous	
Tenivac INJECTABLE 5-2 LFU Intramuscular	
Tetanus-Diphtheria Toxoids Td SUSPENSION 2-2 LF/0.5ML Intramuscular	
Thiotepa Solution Reconstituted 15 MG Injection	
Tigecycline SOLUTION RECONSTITUTED 50 MG Intravenous	
Tobramycin Nebulization Solution 300 MG/5ML Inhalation	
Topotecan HCl Solution Reconstituted 4 MG Intravenous	
Tranexamic Acid Solution 1000 MG/10ML Intravenous	
Travasol Solution 10 % Intravenous	
Treanda Solution Reconstituted 100 MG Intravenous	
Treanda Solution Reconstituted 25 MG Intravenous	
Trisenox SOLUTION 12 MG/6ML Intravenous	
Valproate Sodium SOLUTION 100 MG/ML Intravenous	
Vancomycin HCl SOLUTION RECONSTITUTED 10 GM Intravenous	
Vancomycin HCl Solution Reconstituted 1000 MG Intravenous	
Vancomycin HCl Solution Reconstituted 500 MG Intravenous	
Vectibix SOLUTION 100 MG/5ML Intravenous	
Velcade SOLUTION RECONSTITUTED 3.5 MG INJECTION	
Verapamil HCl Solution 2.5 MG/ML Intravenous	
Vimpat SOLUTION 200 MG/20ML Intravenous	
VinBLASTine Sulfate SOLUTION 1 MG/ML Intravenous	
VinCRISTine Sulfate SOLUTION 1 MG/ML Intravenous	
Voriconazole SOLUTION RECONSTITUTED 200 MG Intravenous	
Vpriv SOLUTION RECONSTITUTED 400 UNIT Intravenous	

Part B vs. Part B PA Only

Product	V26
Vyxeos Suspension Reconstituted 44-100 MG Intravenous	
Yondelis SOLUTION RECONSTITUTED 1 MG Intravenous	
Zarxio Solution Prefilled Syringe 300 MCG/0.5ML Injection	
Zarxio Solution Prefilled Syringe 480 MCG/0.8ML Injection	
Zoledronic Acid Concentrate 4 MG/5ML Intravenous	
Zoledronic Acid Solution 5 MG/100ML Intravenous	
Zortress TABLET 0.25 MG ORAL	
Zortress TABLET 0.5 MG ORAL	
Zortress TABLET 0.75 MG ORAL	
ZyPREXA Relprevv Suspension Reconstituted 210 MG Intramuscular	



## Discrimination is Against the Law

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

Florida Health Care Plans:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified Interpreters
  - Information written in other languages

If you need these services, contact:

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

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

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

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

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

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

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

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

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

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

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

Se você, ou alguém que estiver a ajudar, tiver dúvidas sobre Florida Health Care Plans, tem o direito de obter ajuda e informações na sua língua, sem nenhuma 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)

إذا كان لديك أو الشخص الذي تساعد 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 Plans에 관한 질문이 있을 경우, 귀하에게는 무료로 본인이 구사하는 언어로 도움과 정보를 받을 권리가 있습니다. 통역으로 전화 연결하려면 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 કોઈ 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 หรือคนที่กำลังช่วยเหลืออยู่มีคำถามเกี่ยวกับ Florida Health Care Plans คุณจะได้รับการช่วยเหลือและได้รับข้อมูลในภาษาของคุณโดยที่ไม่มีค่าใช้จ่ายใดๆ หากต้องการพูดคุยกับล่ามแปลภาษา โทร. 1-877-615-4022. (TTY: TRS Relay 711)