2024

Prior Authorization Criteria

For

Non-Grandfathered Commercial Plans

Drugs
Tymlos

Covered Uses
Patient is diagnosed with osteoporosis with a BMD less than -2.5. Patient fails treatment with IV bisphosphonate and denosumab. For Patients with Calculated GFR or CRcl ; 60ml/min Referral must include recent iPTH. Vitamin D (25 OH, 1,25 OH) labs. Must be within normal limits.

Exclusion Criteria
Children, adolescents, Pagets patients with Pagets disease or hypercalcemia, or patients with a history of primary or metastatic bone cancer.

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
Tymlos is indicated to treat osteoporosis. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. Limitations of treatment - 2 years of treatment.

Drugs
Abiraterone Acetate Oral Tablet 250 MG

Covered Uses
FDA approved indications

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction

Coverage Duration
Up to 12 months or until disease progression or toxicity

Other Criteria
Abieraterone is indicated to treat metastatic prostate cancer. It is taken orally along with prednisone daily. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Hadlima, **Hadlima PushTouch**

Covered Uses
All FDA-approved indications not otherwise excluded from Part D. Adalimumab is indicated for the treatment of confirmed rheumatoid arthritis (RA), plaque psoriasis (PP), Psoriatic Arthritis (PSA) Crohn's disease (CD), ulcerative colitis (UC), Hydradenitis suppurativa, uveitis. This is non-preferred for commercial, ACA, and Exchange. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.Must be written by Rheumatology, Dermatology or Specialist trained in management of prescribed condition. Dosing for indication is the FDA approved dose, off label dosing for an indication is not covered. For RA Patient must fail adequate trial of MTX in combination with a DMARD If MTX contraindicated, must try combination of 2-nonbiologic DMARDS (3 month trial in past 6 months). For Ankylosing Spondylitis PT must fail MTX or sulfasalazine and 2 NSAIDS within past 6 months. For Plaque Psoriasis patient must fail MTX or Soriatane and topical therapy. For Psoriatic Arthritis Patient must fail adequate trial of MTX or LEF in past 6 months. Renflexis, Azathioprine, and 6 Mercaptopurine. For hidradenitis suppurativa must have moderate to severe disease and have failed recent trial 8 to 12 week trial in past month of oral clindamycin and rifampin or doxycycline/Minocycline, Infliximab, AND oral retinoid (acitretin or isotretinoin) unless contraindicated in the past 6 months. For Uveitis patient must fail 8-12 week trial of methotrexate

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Must be written by Rheumatology, Dermatology or Specialist trained in management of prescribed condition.

Coverage Duration
12 months

Other Criteria

Drugs
Gilotrif

Covered Uses
Patient must have NSCLC mutations consistent with FDA label. Test for T790M mutation if previously on a TKI inhibitor

Exclusion Criteria

Required Medical Information
Medical notes, previous treatment history and associated studies, including test for T790M mutation if previously on a TKI inhibitor

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Prescribing restricted to oncology.

Coverage Duration
Up to 12 months or until disease progression or toxicity

Other Criteria
Gilotrif is an oral tyrosine kinase inhibitor indicated to treat NCSLC with the genetic tumor markers of exon 19 deletion and exon 21 substitution. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Alecensa

Covered Uses
FDA approved indications, off label use will be covered when there is an NCCN supported indication with a recommendation of class 2A or greater

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Prescriber must be an oncologist

Coverage Duration
Up to 12 months or until disease progression or toxicity

Other Criteria
Alecensa is indicated to treat patients with ALK+ metastatic Non-Small cell lung cancer. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician

Drugs
Panretin

Covered Uses
FDA approved indications. Failure of vinblastine.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
Panretin is a retinoid indicated for Karposi sarcoma. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Ambrisentan

Covered Uses
FDA approved indications. Pulmonary hypertension must be diagnosed by heart catheterization. Patient must have failed or have contraindication to sildenafil. Evaluation, EKG, diffusion studies, catheterization results and an objective test of exercise ability (6 minute walk) must be submitted with referral. Approved referrals will initially provide coverage for 12 weeks. Continuation of coverage will be determined by an improvement of an objective test of exercise (6 minute walk) from baseline. Follow-up documentation must be submitted for continuation of coverage. Patients who have had an initial positive response based the 12 week follow-up will be approved for an additional 6 months, and re-evaluation with documentation will be required every 6 months for continuation of coverage.

Exclusion Criteria
This medication is contraindicated in pregnancy, those of childbearing ability who are not using contraception.

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction

Coverage Duration
Initial approval for 12 weeks. See "Covered Use" for continuation of coverage details.

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

Drugs
Kineret Subcutaneous Solution Prefilled Syringe

Covered Uses
FDA approved indications. Patient must fail two anti-TNF biologics and Xeljanz.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction

Coverage Duration
Up to 12 months

Other Criteria
Kineret is a biologic agent indicated for treatment of rheumatoid arthritis. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Aprepitant Oral Capsule, **Emend Oral Suspension Reconstituted**

Covered Uses
FDA approved indications. Patient must have failed Zofran. A pre-packaged three-day course of this medication will be approved per each co-pay incidental to a chemotherapy treatment cycle.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Medication will be approved through referrals when written by Oncology

Coverage Duration
12 months

Other Criteria
Emend is used as part of a three day regimen for chemotherapy induced nausea and vomiting (CINV) of moderate to highly emetogenic Chemotherapy treatments, and Post-Operative Nausea and Vomiting. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Abilify Maintena Intramuscular Prefilled Syringe

Covered Uses
FDA approved indications. Failure of oral aripiprazole and lurasidone.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Approved when written/ordered by a Psychiatrist or Neurologist through referrals for new starts.

Coverage Duration
12 months

Other Criteria
Aripiprazole is a psychotropic medication. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy.

Drugs
Strensiq

Covered Uses
All FDA-approved indications not otherwise excluded from Part D. Criteria for coverage as follows: Must meet ALL of the following criteria:1. Member is diagnosed with any of the following:a. Perinatal/infantile-onset hypophosphatasia (HPP)b. Juvenile-onset hypophosphatasia (HPP) AND 2. Member's diagnosis of HPP is confirmed by or in consultation with an endocrinologist or a boneand mineral specialist. AND3. Member has skeletal abnormalities indicative of HPP - documentation from the medical recordmust be provided.a. Note: Examples of skeletal abnormalities include chest wall deformities, hypomineralized.skeleton, rickets, nonhealing fractures.AND4. Member has an alkaline phosphatase (ALP) level below age-adjusted lower limit of normal, while off medications which can lower ALP such as anti- resorptives. AND5. Member has a pyridoxal-5'-phosphate (PLP) level greater than two times laboratory's upper limit, while off vitamin supplementation (2 week washout) AND6. Member has an ALPL genetic mutation - laboratory documentation must be provided. AND7. Member has an onset of clinical signs and symptoms of HPP prior to 12 years of age -documentation from the medical record must be provided.STRENSIQ continued.. AND8. Strensiq is prescribed by or in consultation with an endocrinologist or a bone and mineralspecialist. AND9. Dose does not exceed 6 mg/kg/week.Initial approval 6 monthsContinuation of Strensiq meets definition of Medical Necessity for members when the following criteria are met:1. Member has demonstrated an objective clinical improvement in symptoms following initiation of asfotase alfa - documentation from the medical record must be provided. This could include improvement in fracture healing, improved 6 minute walk time, improved bone density, reduction in baseline disability. AND2. Strensiq is prescribed by or in consultation with an endocrinologist or a bone and mineral specialist 3. Dose does not exceed: a. Perinatal/infantile-onset HPP: 9 mg/kg/week b. Juvenile-onset HPP: 6 mg/kg/week

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
Strensiq is an enzyme replacement therapy indicated for infantile or pediatric onset hypophosphatasia.Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Inlyta

Covered Uses
Inlyta is an oral tyrosine kinase inhibitor indicated for advanced renal cell carcinoma.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Prescribing restricted to oncology.

Coverage Duration
12 months

Other Criteria
Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Benefix Intravenous Kit

Covered Uses
Approval will be based on Diagnosis of Hemophilia B and history of Bleeding or joint effusions OR perioperative prophylaxis

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria

Drugs
Bosentan

Covered Uses
FDA approved indications. Pulmonary hypertension must be diagnosed by heart catheterization. Patient must have failed or have contraindication to sildenafil, ambrisentan, and tadalafil. Evaluation, EKG, diffusion studies, catheterization results and an objective test of exercise ability (6 minute walk) must be submitted with referral. Approved referrals will initially provide coverage for 12 weeks. Continuation of coverage will be determined by an improvement of an objective test of exercise (6 minute walk) from baseline. Follow-up documentation must be submitted for continuation of coverage. Patients who have had an initial positive response based the 12 week follow-up will be approved for an additional 6 months, and re-evaluation with documentation will be required every 6 months for continuation of coverage.

Exclusion Criteria
This medication is contraindicated in pregnancy, those of childbearing ability who are not using contraception, those on glyburide or cyclosporine and in those with active liver disease.

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction

Coverage Duration
Initial approval for 12 weeks. See "Covered Use" for continuation of coverage details.

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

Drugs
Bosulif Oral Tablet

Covered Uses
FDA approved indications, off label use will be covered when there is an NCCN supported indication with a recommendation of class 2A or greater. AND Failure of imatinib.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Restricted to hematology/oncology

Coverage Duration
Up to 12 months or until disease progression or toxicity

Other Criteria
Bosolif is indicated for treatment of Ph+ CML after failure of a first line tyrosine kinase inhibitor. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy.

Drugs
Berinert

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

Exclusion Criteria
Must not be taking medications that can exacerbate the frequency and/or severity of hereditary angioedema(HAE) attacks including estrogens and ACE inhibitors.

Required Medical Information
Must have C1INH deficiency demonstrated by labs (C1INH and C4 labs)

Age Restriction

Prescriber Restriction
Must be prescribed by an immunologist, allergist or hematologist

Coverage Duration
12 months

Other Criteria
BERINERT is a plasma-derived C1 Esterase Inhibitor (Human) indicated for the treatmentof acute abdominal, facial, or laryngeal hereditary angioedema (HAE) attacks in adultand pediatric patients. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Cometriq (100 MG Daily Dose) Oral Kit 80 & 20 MG, **Cometriq (140 MG Daily Dose) Oral Kit 3 x 20 MG & 80 MG**, **Cometriq (60 MG Daily Dose)**

Covered Uses
FDA approved indications.

Exclusion Criteria
Combination use with other tyrosine kinase inhibitors is excluded.

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Prescriber must be a Hematologist/Oncologist.

Coverage Duration
Up to 12 months or until disease progression or toxicity

Other Criteria
Cometriq is indicated for treatment of metastatic medullary thyroid cancer Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Zykadia Oral Tablet

Covered Uses
FDA approved indications. Must have progressed on Xalkori.

Exclusion Criteria
Not covered in combination with other tyrosine kinase inhibitors or EGRf inhibitors.

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Must be written by oncologist.

Coverage Duration
Up to 12 months or until disease progression or toxicity

Other Criteria
Zykadia is a TKI inhibitor indicated for metastatic NSCLC which is ALK (anaplastic lymphoma kinase) positive, it is indicated for patients who have failed/progressed on crizotinib (Xalkori) Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Cinacalcet HCl

Covered Uses
FDA approved indications. Patient is identified as having hypercalcemia associated with parathyroid carcinoma OR Patient is identified as having hyperparathyroidism secondary ESRD in patient with elevated PTH. Patient must have failed phosphate binders and active Vitamin-D therapy, iPTH must be >300 in dialysis patients. This information is sent to the Referrals Department.

Exclusion Criteria
Not for use in children, pregnancy, seizure disorder.

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
This medication must be prescribed by Nephrology or Endocrinology or Oncology

Coverage Duration
12 months

Other Criteria
Sensipar is indicated to treat hyperparathyroidism that is secondary to renal insufficiency or hypercalcemia secondary to parathyroid carcinoma. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Clobazam

Covered Uses
FDA approved indications. Failure of levetiracetam, topiramate ,and clonazepam.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Approved when written/ordered by a Neurologist through referrals for new starts.

Coverage Duration
12 Months

Other Criteria
Onfi is a benzodiazepine indicated to treat seizures. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Cotellic

Covered Uses
FDA approved indications, off label use will be covered when there is an NCCN supported indication with a recommendation of class 2A or greater. Must be prescribed by Oncologist. Must be used in combination with Zelboraf.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Must be prescribed by Oncologist.

Coverage Duration
Up to 12 months or until disease progression or toxicity

Other Criteria
Cotellic is indicated for treatment of BRAF+ metastatic or unresectable melanoma. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Xalkori Oral Capsule

Covered Uses
FDA approved indications.

Exclusion Criteria
Not covered in combination with other tyrosine kinase inhibitors or EGRF inhibitors.

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Must be written by oncologist.

Coverage Duration
Up to 12 months or until disease progression or toxicity

Other Criteria
Xalkori is a TKI inhibitor for metastatic NSCLC which is ALK (anaplastic lymphoma kinase) positive, or ROS positive. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Tafinlar Oral Capsule

Covered Uses
FDA approved indications, off label use will be covered when there is an NCCN supported indication with a recommendation of class 2A or greater. Patient must have BRAF V600E/K mutation

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Must be written by an oncologist.

Coverage Duration
Up to 12 months or until disease progression or toxicity

Other Criteria
Tafinlar is a BRAF inhibitor indicated to treat BRAF+ V600e/k mutation Stage IIIc-IV metastatic Melanoma and NSCLC. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

dalfampridine (Ampyra)

Drugs
Dalfampridine ER

Covered Uses
Diagnosis of multiple sclerosis AND patient is ambulatory.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction

Coverage Duration
Initial - 3 months. Renewal - 12 months.

Other Criteria
Ampyra is indicated to treat patients with multiple sclerosis who have walking disability. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Dasatinib

Covered Uses
FDA approved indications AND failure of imatinib.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction

Coverage Duration
Up to 12 months or until disease progression or toxicity

Other Criteria
Sprycel is an oral antineoplastic agent used to treat Philadelphia Chromosome + CML and PH+ ALL. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Deferasirox Oral Tablet Soluble

Covered Uses
FDA approved indications Patient has failed or is intolerant to Deferoxamine.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
Exjade is an oral medication used to treat iron overload typically in patients receiving chronic RBC transfusions. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Firmagon

Covered Uses
FDA approved indications. Limited to two per month.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Written by oncology or urology

Coverage Duration
12 months

Other Criteria
Firmagon is indicated to treat advanced prostate cancer. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Prolia Subcutaneous Solution Prefilled Syringe

Covered Uses
FDA approved indications Intolerance or contraindication to injectable bisphosphonate required for coverage of Prolia.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
Prolia is a RANK-L ligand antagonist indicated for treatment of osteoporosis and prevention of osteoporosis for patients taking aromatase inhibitors. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Nuedexta

Covered Uses
FDA approved indications.

Exclusion Criteria
Not covered for off-label use

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Prescriber must be a neurologist.

Coverage Duration
Up to 12 months

Other Criteria
Nuedexta is indicated to treat pseudobulbar affect. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Dimethyl Fumarate Oral, Dimethyl Fumarate Starter Pack Oral

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Neurology

Coverage Duration
12 months

Other Criteria
Dimethyl fumerate is an oral CMT (disease modifying treatment) indicated to treat relapsing remitting multiple sclerosis. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Pulmozyme Inhalation Solution 2.5 MG/2.5ML

Covered Uses
FDA approved indications. Patient must have an FVC ? 40% of predicted value and recurrent pulmonary infections.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Must be written by a pulmonologist.

Coverage Duration
Up to 12 months

Other Criteria
Pulmozyme is indicated to reduce pulmonary exacerbation in patients with cystic fibrosis. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Multaq

Covered Uses
FDA approved indications. Must have previously failed or have contraindication to both sotalol and amiodarone.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
Multaq is indicated for treatment of atrial fibrillation. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Orilissa

Covered Uses
All FDA-approved indications not otherwise excluded from Part D. Orilissa is indicated for moderate to severe pain due to endometriosis. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.Criteria for coverage as follows:FDA approved indications. Failure of an NSAID and oral contraceptive/progestin for endometriosis.

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
OB/GYN

Coverage Duration
6 months

Other Criteria

Drugs
Oriahnn

Covered Uses
All FDA-approved indications not otherwise excluded from Part D. Oraihnn is indicated for treatment of heavy menstrual bleeding due to uterine fibroids. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.Criteria for coverage as follows: FDA approved indications. Failure of an NSAID and oral contraceptive/progestin for endometriosis.

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
OB/GYN

Coverage Duration
24 months

Other Criteria

Drugs
Promacta Oral Packet 12.5 MG, **Promacta Oral Tablet**

Covered Uses
FDA approved indications. Patient must have chronic ITP and bleed risk, with platelet count less than 30,000, and refractory to IVIG, corticosteroids or splenectomy.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction

Coverage Duration
Up to 12 months

Other Criteria
Promacta is indicated to treat ITP and thrombocytopenia secondary to HCV treatment. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Idhifa

Covered Uses
FDA approved indications, off label use will be covered when there is an NCCN supported indication with a recommendation of class 2A or greater.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Prescriber must be a Hematologist/Oncologist

Coverage Duration
Up to 12 months or until disease progression or toxicity

Other Criteria
Idhifa is indicated for treatment of relapsed or refractory AML in patients with an IDH2 mutation as detected by an approved test Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Rozlytrek Oral Capsule

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
Rozyltrek is a kinase inhibitor indicated for solid tumors with NTRK-Fusions and ROS-1 mutated Non-Small Cell lung cancer. Medical history, studies, and appropriate confirmatory tests are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Xtandi

Covered Uses
FDA approved indications. Coverage will be based on failure of Abiraterone for overlapping indications (Metastatic Prostate Cancer and Castrate sensitive high risk non-metastatic cancer).

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Must be prescribed by oncologist or urologist.

Coverage Duration
Covered for 6 months and continuation based on lack of disease progression.

Other Criteria
Xtandi is an androgen receptor blocker used for Castrate Resistant Prostate Cancer pre- and post-chemotherapy. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Retacrit Injection Solution 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML

Covered Uses
All FDA-approved indications not otherwise excluded from Part D. Pharmacy coverage criteria as follows:FDA approved indications. Patient must have adequate iron stores (ferritin greater than or equal to 100 ng/ml, transferrin saturation greater than 20%). Hemoglobin for initiation and maintenance must be compliant with current FDA labeling.

Exclusion Criteria
ESAs are not indicated for patients receiving myelosuppressive therapy when the anticipated outcome is cure.

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
6 months

Other Criteria
ESAs are used to treat anemia related to Chronic Kidney Disease, Chemotherapy, Myelodysplastic Syndrome, Antiviral therapy. Prior authorization is required for pharmacy coverage of medication. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy.

Drugs
Aimovig

Covered Uses
Aimovig is a anti-CGRP antibody indicated for prophylaxis of Episodic and Chronic MigrainesEpisodic MigrainesAimovig will be approved based upon all of the following criteria:(1) Diagnosis of episodic migraines with both of the following:(a) Less than 15 headache days per month(b) Patient has 4 to 14 migraine days per month-AND-(2) Recent trial and failure (trial of at least three months) of two generic medications FDA indicated for migraine prophylaxis (topiramate/divalproex). If either or both are contraindicated or not tolerated the medications below could be used:(a) Amitriptyline (b) atenolol, metoprolol, nadolol, propranolol, or timolol(e) Venlafaxine (Effexor/Effexor XR)AND (3) Medication will not be used in combination with an oral CGRP antagonist or inhibitorAuthorization will be issued for 6 months.2. Reauthorizationa. Aimovig will be approved based on all of the following criteria:(1) Patient has experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity-AND-(2) Medication will not be used in combination with an oral CGRP Antagonist.Authorization will be issued for 12 months.B. Chronic Migraines1. Initial TherapyAimovig will be approved based upon all of the following criteria:(1) Diagnosis of chronic migraines with both of the following:(a) Greater than or equal to 15 headache days per month continued.(b) Greater than or equal to 8 migraine days per month-AND-Recent trial and failure (trial of at least three months) of two generic medications FDA indicated for migraine prophylaxis (topiramate/divalproex). If either or both are contraindicated or not tolerated the medications below could be used:(a) Amitriptyline (b) atenolol, metoprolol, nadolol, propranolol, or timolol(e) Venlafaxine (Effexor/Effexor XR)-AND-(3) Medication will not be used in combination with an oral CGRP antagonist Authorization will be issued for 6 months.2. Reauthorizationa. Aimovig will be approved based on all of thefollowing criteria:(1) Patient has experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity-AND-(2) Medication will not be used in combination with an oral CGRP Antagonist.Authorization will be issued for 12 months.

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
6 to 12 months

Other Criteria

Drugs
Erlotinib HCl

Covered Uses
FDA approved indications, off label use will be covered when there is an NCCN supported indication with a recommendation of class 2A or greater.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
Tarceva is indicated to treat patients with metastatic non-small cell lung cancer who possess an EGFR mutation. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Aptiom

Covered Uses
FDA approved indications. Failure of Oxcarbazepine and carbamazepine.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Must be written by neurology for adjunctive treatment of seizures.

Coverage Duration
12 months

Other Criteria
Aptiom is an anti-convulsant indicated for adjunctive treatment of partial seizures. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy.

Drugs
Menest Oral Tablet 0.3 MG, 0.625 MG, 1.25 MG

Covered Uses
Used for palliative treatment of breast cancer.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Must be written by an oncologist.

Coverage Duration
Up to 12 months

Other Criteria
Menest is only covered for palliative treatment of breast cancer. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

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

Covered Uses
Indicated for RA, JRA, PSA, and Plaque Psoriasis. See "Guidelines for Enbrel" form.

Exclusion Criteria
FDA labeled contraindications

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

Age Restriction
Ages approved in FDA labeling/compendia

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

Coverage Duration
Up to 12 months

Other Criteria
For RA, patient must fail adequate trial of MTX in combination with a DMARD. If MTX is contraindicated, must try combination of 2-nonbiologic DMARDS (3month trial in past 6 months). For Ankylosing Spondylitis, patient must fail MTX (3 month trial in past 6 months)or sulfasalazine and 2 NSAIDS within past 6 months. For Plaque Psoriasis, patient must fail MTX or Soriatane (3 month trial in past 6 months) and topical therapy. For Psoriatic Arthritis, patient must fail adequate trial of MTX or LEF (3month trial in past 6 months).

Drugs
Everolimus Oral Tablet 2.5 MG, 5 MG, 7.5 MG

Covered Uses
Afinitor is an oral tyrosine kinase inhibitor indicated to treat several malignancies.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Prescribing restricted to oncology.

Coverage Duration
12 months

Other Criteria
Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Everolimus Oral Tablet 0.25 MG, 0.5 MG, 0.75 MG, 1 MG

Covered Uses
FDA approved indications. Patient must have failure or intolerance to a calcineurin inhibitor.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Prescriber must be a transplant specialist.

Coverage Duration
12 months

Other Criteria
Zortress is an immunosuppressive anti-rejection agent for solid organ transplant. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

fentanyl citrate lozenge (Actiq)

Drugs
fentaNYL Citrate Buccal Lozenge On A Handle

Covered Uses
All FDA-approved indications not otherwise excluded from Part D. Fentanyl citrate lozenges approved after failure of hydromophone IR and morphine IR and oxycodone IR

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Approved when written/ordered by an Oncologist or Pain Management through referrals.

Coverage Duration
12 months

Other Criteria
Fentanyl Citrate Lozenge is a short acting opioid indicated for cancer breakthrough pain. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

fentanyl transdermal product (Duragesic)

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

Covered Uses
FDA approved indications.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Approved when written/ordered by an Oncologist or Pain Management through referrals.

Coverage Duration
12 months

Other Criteria
Fentanyl patch is a long acting opioid analgesic indicated for moderate to severe chronic pain. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Fingolimod HCl

Covered Uses
Covered for patients who have failed a trial of glatiramer and Dimethyl Fumerate

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Must be written by a neurologist

Coverage Duration
12 months

Other Criteria
Gilenya is an oral medication indicated for treatment of relapsing remitting multiple sclerosis Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Emgality, **Emgality (300 MG Dose)**

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
consultation with NEUROLOGY

Coverage Duration
See covered uses

Other Criteria

Drugs
Gefitinib

Covered Uses
FDA approved indications, off label use will be covered when there is an NCCN supported indication with a recommendation of class 2A or greater. T790 mutation testing when indicated i.e. previously treated with a TKI inhibitor

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Must be prescribed by Oncologist

Coverage Duration
12 Months

Other Criteria
Iressa is indicated to treat non-small cell lung cancer with EGFR mutation exon 19 deletion or Exon 21 substitution mutations. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Baqsimi One Pack

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Ordered by an endocrinologist.

Coverage Duration
12 months

Other Criteria
Baqsimi is indicated for severe hypoglycemia where patient is unable to eat, drink or follow commands. Baqsimi is intranasal but does not need to be inhaled, patient does not need to be conscious for Baqsimi to be administered. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy. Limit of 1 device per dispensing, two per year.

Drugs
Mavyret Oral Tablet, Zepatier

Covered Uses
FDA approved indications. Mavyret is the preferred DAA for all genotypes, other DAAs will be covered on a case by case basis if Mavyret use is not supported by current FDA indication or HCV guidelines based on patient specific characteristics.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Gastroenterologist or Infectious Disease

Coverage Duration
12 months

Other Criteria
Mavyret is the exclusive and preferred DAA for treatment of HCV in chronically infected non-cirrhotic and compensated cirrhotic patients for genotypes 1-6. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

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

Covered Uses
Initiation restricted to endocrinology. Insulin requirements of >200 units/day.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Initiation restricted to endocrinology.

Coverage Duration
12 months

Other Criteria
Humulin U 500 is used to treat insulin resistant diabetes mellitus. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

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

Covered Uses
FDA approved indications. NCCN supported use with evidence rating 2a or greater.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Must be prescribed by Hematologist/oncologist.

Coverage Duration
Up to 12 months or until disease progression or toxicity

Other Criteria
Imbruvica is a BTK inhibitor used to treat B cell lymphomas. It is indicated for relapsed waldenstroms macroglobinemia, refractory chronic lymphocytic leukemia and Mantle Cell Lymphoma, and first line CLL. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Imbruvica Oral Suspension

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Hematology/ Oncology/ Transplant Specialist

Coverage Duration
12 months

Other Criteria
Unable to swallow or use a tablet or capsule

Drugs
Zydelig

Covered Uses
FDA approved indications.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Must be written by oncologist.

Coverage Duration
Up to 12 months or until disease progression or toxicity

Other Criteria
Zydelig is a PI3K kinase inhibitor for treatment of relapsed Chronic lymphocytic leukemia, relapsed follicular lymphoma, and small lymphocytic lymphoma. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Fanapt, **Fanapt Titration Pack**

Covered Uses
FDA approved indications. Failure of aripiprazole, lurasidone.

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
Fanapt is indicated to treat schizophrenia. Prior authorization only applies to existing members who are new starts on the drug. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Xeomin

Covered Uses
FHCP covers this medication only for medically necessary purposes, like cervical dystonia, not responsive to physical therapy, blepharospasm that interferes significantly with vision, and headache not responsive to preventive and acute therapy by Neurology for at least 16 weeks.

Exclusion Criteria
FDA labeled contraindications OR cosmetic conditions

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

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction

Coverage Duration
12 months

Other Criteria

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

Covered Uses
Failure of glatiramer and Dimethyl Fumerate for new starts.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
Avonex is an interferon indicated to treat multiple sclerosis. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

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

Covered Uses
Failure of glatiramer and Dimethyl Fumerate for new starts.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
Rebif is an interferon indicated to treat multiple sclerosis. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Betaseron Subcutaneous Kit

Covered Uses
Failure of Dimethyl Fumarate and glatiramer or fingolimod for new starts

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
Betaseron is an interferon indicated to treat multiple sclerosis. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Actimmune

Covered Uses
FDA approved indications. Coverage will be based on medical history/status, antibiotic failure for chronic granulomatous disease.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Limited to specialist trained in management of prescribed condition.

Coverage Duration
Up to 12 months

Other Criteria
Actimmune is indicated to prevent infection in Chronic Granulomatous disease, and also delay the time to progression with severe malignant osteopetrosis. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Kalydeco Oral Packet 25 MG, 50 MG, 75 MG, Kalydeco Oral Tablet

Covered Uses
FDA approved indications. Patient must have an FDA approved mutation.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Must be prescribed by a Pulmonologist.

Coverage Duration
12 months

Other Criteria
Kalydeco is an oral medication indicated to treat Cystic fibrosis patients with specific genetic mutations in the CFTR gene. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Ninlaro

Covered Uses
FDA approved indications, off label use will be covered when there is an NCCN supported indication with a recommendation of class 2A or greater. Must have failed bortezomib.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Must be prescribed by Oncology.

Coverage Duration
Up to 12 months or until disease progression or toxicity

Other Criteria
Ninlaro is an oral proteasome inhibitor indicated to treat relapsed or refractory multiple myeloma. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

lacosamide (Vimpat)

Drugs
Lacosamide Oral Solution 10 MG/ML

Covered Uses
FDA approved indications. Failure of Levetiracetam, topiramate, and lamotrigine.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Approved when written/ordered by a Neurologist.

Coverage Duration
12 months

Other Criteria
Vimpat is indicated as an adjunct agent used to treat partial onset seizures. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Somatuline Depot

Covered Uses
FDA approved indications. Failure of octreotide.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Prescriber must be an endocrinologist.

Coverage Duration
12 months

Other Criteria
This medication is used to treat Acromegaly. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

lanthanum carbonate (Fosrenol)

Drugs
Lanthanum Carbonate

Covered Uses
Patient has ESRD. Patient has elevated calcium on phosphate binders, or not a candidate for calcium based phosphate binders based on KDOQI guidelines. Failure of Sevelamer.

Exclusion Criteria
Not covered in combination with other non-calcium based phosphate binders.

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Prescribed by a nephrologist.

Coverage Duration
12 months

Other Criteria
Fosrenol is a non-calcium based, chewable, phosphate binder indicated to manage hyperphosphatemia in ESRD. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Lapatinib Ditosylate

Covered Uses
FDA approved indications. Patient has HER2/neu + breast cancer that has failed treatment/progressed with a regimen including an anthracycline, a taxane and Herceptin. Used to treat Metastatic HR+ HER2/neu+ breast cancer in combination with an aromatase inhibitor.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Prescriber is an oncologist.

Coverage Duration
Up to 12 months or until disease progression or toxicity

Other Criteria
Tykerb is indicated to treat Advanced HER2+ breast cancer in combination with Xeloda. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

lenalidomide (Revlimid)

Drugs
Lenalidomide

Covered Uses
FDA approved indications. Patient must have failed Aranesp & Procrit for MDS anemia. Mantle cell Lymphoma requires failure of two prior treatment regimens one of which being bortezomib.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Prescriber is a hematologist/oncologist.

Coverage Duration
Up to 12 months or until disease progression or toxicity

Other Criteria
Revlimid is indicated for treatment of Multiple Myeloma , Myelodysplastic syndrome, anemia that is transfusion dependent and has 5q deletion karyotype, mantle cell lymphoma Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

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

Covered Uses
FDA approved indications.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Must be written by an oncologist/hematologist.

Coverage Duration
Up to 12 months or until disease progression or toxicity

Other Criteria
Lenvima is a tyrosine kinase inhibitor indicated for several cancers. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Liraglutide

Covered Uses
Covered after failure of metformin and Bydureon. Covered for use in established cardiovascular disease for patients on a Statin who have failed metformin.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
Victoza is a medication indicated for treatment of type 2 diabetes mellitus.

Drugs
Increlex

Covered Uses
FDA approved indications. Coverage will be based on medical history/status, response to previous treatments, and the consideration of other therapeutic options.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Must be prescribed by a Pediatric Endocrinologist.

Coverage Duration
12 months

Other Criteria
Increlex is indicated to treat short stature in patient with primary Insulin like Growth Factor deficiency, and patients with neutralizing antibodies to HGH. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Nucala

Covered Uses
The following criteria must be met for coverage for severe eosinophilic asthma: Prescriber must be a pulmonologist or allergist. Two or more severe exacerbations in the past 12 months. Patient must fail 3 months of therapy on maximal indicated doses of Trelegy and Montelukast.

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
Nucala is an interleukin 5 antagonist indicated for eosinophillic asthma and eosophilic granulomatosis with polyangiitis and nasal polyps. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. Nasal Polyp indication is covered only by exception and will be based on all available treatment options including nebulized sinus treatments and devices.

Drugs
Rydapt

Covered Uses
FDA approved indications, off label use will be covered when used in alignment with NCCN recommendations of class 2A or greater.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Must be prescribed by an oncologist/hematologist.

Coverage Duration
Up to 12 months or until disease progression or toxicity

Other Criteria
Rydapt is a kinase inhibitor indicated to treat AML, MCL, and systemic mastocytosis. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Kynamro Subcutaneous Solution Prefilled Syringe

Covered Uses
FDA approved indications. Genetic confirmation that patient is HoFH. Failure of Statin, Ezetimibe, and PCSK-9 therapy. Continuation of Kynamro after 3 month trial based on LDL reduction of at least 25% while on therapy.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction

Coverage Duration
3 months initially, up to 12 months after response

Other Criteria
Kynamro is indicated to treat Homozygous Familial hypercholesterolemia Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Mirabegron ER

Covered Uses
FDA approved indications. Failure of solifenacin, trospium, and Toviaz.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
This medication is used to treat over active bladder. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Synarel

Covered Uses
FDA approved indications.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Approved when written by an endocrinologist or gynecologist.

Coverage Duration
Up to 12 months

Other Criteria
Synarel is a GNRH analog (intranasal formulation) indicated to treat precocious puberty in children or endometriosis in adults. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Movantik

Covered Uses
FDA approved indications. Requires failure of lactulose and Miralax.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
Movantik is a Peripherally Acting Mu Opioid Antagonist (PAMORA) indicated for opioid induced constipation
Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Nerlynx

Covered Uses
FDA approved indications, off label use will be covered when there is an NCCN supported indication with a recommendation of class 2A or greater.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Prescriber must be a Hematologist/Oncologist

Coverage Duration
12 Months

Other Criteria
Nerlynx is indicated for extended adjuvant treatment of early stage HER2 breast cancer Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Nicotrol

Covered Uses
Must have previously failed or have contraindication to Bupropion. Coverage is approved for 24 weeks of treatment. Copayment will be applied per package.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction

Coverage Duration
24 weeks

Other Criteria
Indicated for smoking cessation therapy. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Tasigna

Covered Uses
FDA approved indications. Covered for treatment failure with imatinib.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction

Coverage Duration
Up to 12 months or until disease progression or toxicity

Other Criteria
Tasigna is an oral antineoplastic agent used to treat Philadelphia Chromosome + CML Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Zejula Oral Capsule

Covered Uses
FDA approved indications, off label use will be covered when used in alignment with NCCN recommendations of class 2A or greater.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Must be prescribed by an oncologist/hematologist.

Coverage Duration
Up to 12 months or until disease progression or toxicity

Other Criteria
Zejula is a poly (ADP-ribose) polymerase (PARP) inhibitor indicated for the maintenance treatment of adult patients with recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in a complete or partial response to platinum-based chemotherapy. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Ocrevus

Covered Uses
FDA approved indications. For Relapsing Remitting Multiple Sclerosis must have failed Dimethyl Fumarate or Glatiramer

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Must be prescribed by a neurologist.

Coverage Duration
12 months

Other Criteria
Ocrevus is a CD20-directed cytolytic antibody indicated for the treatment of relapsing remitting or primary progressive forms of multiple sclerosis. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Zyprexa Relprevv

Covered Uses
FDA approved indications. Failure of oral aripiprazole and olanzapine.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Approved when written/ordered by a Psychiatrist or Neurologist through referrals for new starts.

Coverage Duration
12 months

Other Criteria
Zyprexa Relprevv is a psychotropic medication. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy.

Drugs
Lynparza Oral Tablet

Covered Uses
Lynparza is used to treat BRCA+ ovarian or breast cancers.

Exclusion Criteria
Progression on a PARP inhibitor

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Restricted to Hematology/Oncology.

Coverage Duration
Up to 12 months or until disease progression or toxicity

Other Criteria
Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Xolair Subcutaneous Solution Prefilled Syringe 150 MG/ML, 75 MG/0.5ML, Xolair Subcutaneous Solution Reconstituted

Covered Uses
•Xolair is an anti-IgE monoclonal antibody indicated for patients 12 years and older with moderate to severe persistent asthma who have a positive skin test or in-vitro reactivity to an aeroallergen and chronic idiopathic urticaria. Xolair was not studied in patients who smoke. •Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.•Nasal Polyp indication is covered only by exception and will be based on all available treatment options including nebulized sinus treatments and devices The following criteria must be met for coverage for severe asthma:•Prescriber must be a pulmonologist or allergist.•Patient must have baseline IGE levels within indicated range for Xolair labeling.•Patient must test positive to an aeroallergen (either skin test or blood test).•Patient must fail 3 months of therapy on maximal indicated doses of Trelegy.•Patient must have failed leukotriene receptor antagonist The following criteria must be met for coverage for chronic idiopathic urticaria:•Prescribed by an allergist, immunologist, or dermatologist•Patient must have a diagnosis of chronic idiopathic urticaria (at least a 6 week history)•Patient must have tried, for a minimum of 2 weeks and failed 2 of the following antihistamines at maximal doses used to treat CIU: cetirizine(40mg/day), levocetirizine (20mg/day), desloratadine(20mg/day), fexofenadine (540mg/day), loratadine (40mg/day) with MONTELUKAST AND trial Dicyclomine or Hydroxyzine

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction

Coverage Duration
12 months

Other Criteria

Omnipod/ Omnipod Dash

Drugs
Omnipod 5 DexG7G6 Intro Gen 5, **Omnipod 5 DexG7G6 Pods Gen 5**, **Omnipod 5 G7 Intro (Gen 5)**, **Omnipod 5 G7 Pods (Gen 5)**, **Omnipod Classic Pods (Gen 3)**, **Omnipod DASH Pods (Gen 4)**

Covered Uses
Omnipod and Omnipod Dash are covered for Type 1 diabetics who meet MCG (Milliman Coverage Guideline) criteria

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician

Drugs
Botox

Covered Uses
Non-Cosmetic FDA approved indications

Exclusion Criteria
FDA labeled contraindications, and excluded for cosmetic conditions

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

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
FHCP covers this medication only for medically necessary purposes, like cervical dystonia, not responsive to physical therapy, blepharospasm that interferes significantly with vision, and headache not responsive to preventive and acute therapy by Neurology for at least 16 weeks

Drugs
Tagrisso

Covered Uses
FDA approved indications, off label use will be covered when there is an NCCN supported indication with a recommendation of class 2A or greater. Must possess the t790m mutation if being used after progression on an EGFR tyrosine kinase inhibitor.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction

Coverage Duration
Up to 12 months or until disease progression or toxicity

Other Criteria
Tagrisso is indicated to treat patients with metastatic non-small cell lung cancer who possess an EGFR mutation. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Oxandrolone Oral

Covered Uses
FDA approved indications.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Approved when written by Oncology, through referrals.

Coverage Duration
up to 12 months

Other Criteria
Oxandrin is an anabolic steroid indicated for weight gain in cachexia. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Anadrol-50

Covered Uses
FDA approved indications. Medical history and information reviewed by referrals. Coverage will be response to previous treatments, and the consideration of other therapeutic options (ESAs, B12/folate, iron).

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction

Coverage Duration
Up to 12 months

Other Criteria
Anadrol is an anabolic steroid indicated to treat various types of anemia. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Ibrance

Covered Uses
FDA approved indications. Diagnosis Metastatic ER+ HER- Breast cancer.

Exclusion Criteria
Progression on a CDK 4/6 inhibitor

Required Medical Information
Medical notes, previous treatment history and associated studies, including diagnosis of metastatic ER+ HER- breast cancer.

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Must be prescribed by Hematologist/oncologist.

Coverage Duration
Up to 12 months or until disease progression or toxicity

Other Criteria
Ibrance is a CDK 4/6 inhibitor indicated for first-line/second line treatment of metastatic ER+/HER- breast cancer used in combination with an aromatase inhibitor Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Invega Sustenna Intramuscular Suspension Prefilled Syringe

Covered Uses
FDA approved indications. Failure of oral aripiprazole, paliperidone and risperidone.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Approved when written/ordered by a Psychiatrist or Neurologist through referrals.

Coverage Duration
12 months

Other Criteria
Invega Sustenna is a psychotropic medication. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy.

Drugs
Farydak

Covered Uses
FDA approved indications.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Must be written by an oncologist.

Coverage Duration
Up to 12 months or until disease progression or toxicity

Other Criteria
Farydak is indicated to treat multiple myeloma in patients who have received at least two therapies including Velcade and an immunomodulatory agent. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
PAZOPanib HCl

Covered Uses
Votrient is an oral tyrosine kinase inhibitor indicated to treat Renal cell carcinoma, and soft tissue sarcoma.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Prescribing restricted to oncology.

Coverage Duration
12 months

Other Criteria
Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Fulphila, **Udenyca**, **Udenyca Onbody**

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

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

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

Covered Uses
FDA approved indications. Must be used as adjuvant treatment within 84 days of surgical resection in patients with metastatic melanoma with nodal involvement.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Prescriber must be an oncologist.

Coverage Duration
Up to 12 months

Other Criteria
Sylatron is an adjuvant treatment for metastatic melanoma. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

penicillamine (Cuprimine)

Drugs
Penicillamine Oral Capsule

Covered Uses
FDA approved indications. Coverage for Rheumatoid Arthritis requires failure of a TNF Agent, and a JAK inhibitor or Abatacept.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Written by a Rheumatologist, or Neurologist, or Urologist or Hepatologist.

Coverage Duration
12 Months

Other Criteria
Cuprimine is indicated for treatment of Rheumatoid arthritis, Wilsons Disease and cystinuria. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

pentamidine isothionate (Nebupent) nebulized

Drugs
Pentamidine Isethionate Inhalation

Covered Uses
Failure of topical ketoconazole, econazole, clotrimazole betamethasone, nystatin triamcinolone.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
Nebupent is a inhaled solution used to treat PCP pneumonia. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Fycompa Oral Tablet

Covered Uses
Written by a neurologist for treatment of seizures. Failure of Levetiracetam, topiramate, and lamotrigine.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Written by a neurologist.

Coverage Duration
12 months

Other Criteria
Fycompa is an anti-convulsant indicated for adjunctive treatment of partial seizures. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Pirfenidone

Covered Uses
Pirfenidone is indicated for idiopathic pulmonary fibrosis. Medical history and studies are reviewed in Referrals and if approved will notify the physician.Criteria for coverage as follows: Confirmed diagnosis of IPF by high resolution CT or surgical biopsy. Prescribed by a pulmonologist

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
pulmonologist

Coverage Duration
12 months

Other Criteria

Drugs
Pomalyst

Covered Uses
FDA approved indications, Off label use must be supported by NCCN with evidence rating of 2a or greater. Coverage requires failure of Revlimid and Velcade.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Restricted to Hematology/Oncology.

Coverage Duration
Up to 12 months or until disease progression or toxicity

Other Criteria
Pomalyst is thalidomide analog used to treat refractory Multiple Myeloma Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Iclusig

Covered Uses
FDA approved indications.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Must be prescribed by Hematologist/oncologist.

Coverage Duration
Up to 12 months or until disease progression or toxicity

Other Criteria
Iclusig is a tyrosine Kinase inhibitor indicated to treat Chronic Myelogenous Leukemia. Coverage will be based on failure of first or second line TKI for CML or presence of T350I mutation. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Noxafil Oral Suspension, Posaconazole Oral Tablet Delayed Release

Covered Uses
FDA approved indications. Organism must be resistant to itraconazole, voriconazole, and fluconazole.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction

Coverage Duration
3 months

Other Criteria
Noxafil is an anti-fungal indicated for aspergillus and Candida in immunocompromised patients. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

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

Covered Uses
FDA approved indications. Patient is uncontrolled despite optimal insulin utilization with Ha1c between 7%-9%. Not for use in patients with gastroparesis.

Exclusion Criteria

Required Medical Information
Medical notes, previous treatment history, and labs, including HA1c

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Prescriber is an endocrinologist.

Coverage Duration
12 months

Other Criteria
Symlin is indicated to treat Type 1 and 2 Diabetes. Symlin is indicated for adjunctive treatment of DM with insulin. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Pyrimethamine Oral

Covered Uses
Toxoplasmosis. Patient must have failed recent trial of combination of inhaled corticosteroids AND long acting beta Agonist AND inhaled anti-cholinergic.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction

Coverage Duration
12 Months

Other Criteria
Daraprim is used to treat toxoplasmosis. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Stivarga

Covered Uses
Stivarga is an oral tyrosine kinase inhibitor indicated to treat Colorectal cancer and , Hepatocellular carcinoma.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Prescribing restricted to oncology.

Coverage Duration
12 Months

Other Criteria
Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Arcalyst

Covered Uses
Diagnosis of CAPS and Documentation of disability due to the condition, failure of anakinra, and nsaids.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Prescribing limited to immunologist.

Coverage Duration
Up to 12 months

Other Criteria
Arcalyst is indicated to treat Cryopyrin Associated Periodic Syndromes (CAPS). Medical history and studies are reviewed in Referrals and if approved will notify pharmacy.

Drugs
risperiDONE Microspheres ER

Covered Uses
FDA approved indications. Failure of oral aripiprazole and risperidone.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Approved when written/ordered by a Psychiatrist or Neurologist through referrals.

Coverage Duration
12 months

Other Criteria
Risperdal Consta is a psychotropic medication. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy.

Drugs
Neupro

Covered Uses
FDA approved indications. Failure of Ropinorole and Pramipexole.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
Neupro is a transdermal dopamine agonist indicated for treatment of Parkinsons disease. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Rufinamide

Covered Uses
FDA approved indications

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Approved when written/ordered by a Neurologist for seizures through referrals.

Coverage Duration
12 months

Other Criteria
Banzel is indicated for treatment of Lennox Gastaut syndrome. Prior authorization only applies to existing members who are new starts on the drug. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy.

Drugs
Jakafi

Covered Uses
FDA approved indications. Not used in combination with lenalidomide/thalidomide, other JAK or TKI inhibitors. Continuation in therapy will require 50% reduction in baseline spleen size, or 35% reduction in spleen volume, or a 50% reduction in baseline Myelofibrosis symptom score.

Exclusion Criteria

Required Medical Information

Age Restriction
Ages approved in FDA labeling/compendia

Prescriber Restriction
Prescriber is a hematologist/oncologist.

Coverage Duration
Up to 12 months or until disease progression or toxicity

Other Criteria
Jakafi is an oral JAK inhibitor indicated for treatment of intermediate to high risk myelofibrosis including primary myelofibrosis, polycythemia vera, myelofibrosis, and essential thrombocythemia myelofibrosis Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Entresto Oral Tablet

Covered Uses
All FDA-approved indications not otherwise excluded from Part D. For Heart Failure with reduced ejection fraction (less than or equal to 40%)For initiation: eGFR greater than or equal to 30ml/min and K+ less than 5.0 meq/l for initiationPatient has NYHA Class II-IV symptomsApprove for 3 months initiallyFor continuation:Member is at target dose approve for 12 monthsMember is below Entresto target dose THENApprove for 3 months if member is tolerating dose but has not had a titration attempt and SBP greater than 100 ORApprove for 12 months if member has failed titration attempt or SBP less than 100 For Heart Failure with preserved ejection fractionFor initiation:Patient has an ejection fraction less than or equal to 55%NYHA Class II-IV symptomsCurrently taking an SGLT-2 inhibitoreGFR greater than30 ml/minApprove for 3 months initiallyFor continuation:Member is at target dose approve for 12 monthsMember is below Entresto target dose THENApprove for 3 months if member is tolerating dose but has not had a titration attempt and SBP greater than 100ORApprove for 12 months if member has failed titration attempt or SBP less than 100

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
Entresto is a medication used for treatment of Heart Failure. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy.

Drugs
Kevzara

Covered Uses
Kevzara is an injectible Il-6 antagonist indicated for rheumatoid arthritis. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.Criteria for coverage as follows:Coverage is limited to Rheumatoid arthritis. Must fail a preferred specialty agent (Enbrel, Xeljanz,Hadlima) Most have clear documentation of moderate to severe rheumatoid arthritis

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria

Drugs
Sildenafil Citrate Oral Tablet 20 MG

Covered Uses
FDA approved indications. Pulmonary hypertension must be diagnosed by heart catheterization. Evaluation, EKG, catheterization results and an objective test of exercise ability (6 minute walk) must be submitted with referral.

Exclusion Criteria
This medication is contraindicated in patients using organic nitrates either regularly or intermittently

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

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

Drugs
Januvia

Covered Uses
FDA approved indications. Patient must be on maximal doses of Metformin and Sulfonylurea or other combination therapy if metformin contraindicated for at least 6 months, or have intolerance/ contraindication. Failure of Onglyza.

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
Januvia is an oral anti-diabetic agent used to treat Type 2 Diabetes (DPP-IV inhibitor). Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Sodium Oxybate

Covered Uses
Only covered for Narcolepsy with cataplexy. Coverage will be based on recent failure of Modafinil AND Armodafinil AND Amphetamine/Dextroamphetamine And soriamfetol. Tricyclic Antidepressant shown to be effective in cataplexy (Clomipramine/Protriptyline) and Venlafaxine (for cataplexy) Three month discontinuation trials for moderate to highly sedating medications such as benzodiazepines, opioids, anticholinergics, muscle relaxers, atypical antipsychotics, dopamine agonists.

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Must be prescribed by physician board certified in sleep medicine.

Coverage Duration
Up to 12 months

Other Criteria
This medication is used for treatment of narcolepsy with cataplexy or excessive daytime sleepiness due to narcolepsy. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Lokelma

Covered Uses
Hyperkalemia after discontinuation trial of potassium sparring medications, trial of a loop diuretic if clinically indicated.

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
Lokelma is indicated for the treatment of hyperkalemia. Medical history and studies are reviewed in referrals and if approved will notify pharmacy and the physician.

Drugs
Omnitrope Subcutaneous Solution Cartridge, **Omnitrope Subcutaneous Solution Reconstituted**

Covered Uses
FDA approved indications. This information with the lab attached is sent to the Referrals Department.

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
Growth Hormone is a pituitary hormone used for endogenous HGH deficiencies Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Odomzo

Covered Uses
FDA approved indications.

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Must be prescribed by Oncology.

Coverage Duration
Up to 12 months or until disease progression or toxicity

Other Criteria
Odomzo is an oral oncology agent indicated to treat locally advanced basal cell carcinoma which has recurred following radiation or surgery. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
SORAfenib Tosylate

Covered Uses
Nexavar is an oral tyrosine kinase inhibitor indicated to treat Renal cell carcinoma, Hepatocellular carcinoma, and thyroid carcinoma.

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Prescribing restricted to oncology.

Coverage Duration
12 months

Other Criteria
Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
SUNItinib Malate

Covered Uses
Sutent is an oral tyrosine kinase inhibitor indicated to treat Renal cell carcinoma, Gastrointestinal Stromal Tumors, and pancreatic neuroendocrine tumors.

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Prescribing restricted to oncology.

Coverage Duration
12 Months

Other Criteria
Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Sunosi Oral Tablet 150 MG, 75 MG

Covered Uses
Sunosi is a dopamine and norepinephrine inhibitor indicated for treatment of excessive daytime sleepiness due to narcolepsy or obstructive sleep apnea. Coverage is limited to indication of Narcolepsy Criteria for coverage as follows:Failure of Modafinil and Armodafinil

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Board Certified Sleep Medicine

Coverage Duration
12 months

Other Criteria

Drugs
Tadalafil (PAH)

Covered Uses
FDA approved indications. Pulmonary hypertension must be diagnosed by right heart catheterization. Evaluation, EKG, catheterization results and an objective test of exercise ability (6 minute walk) must be submitted with referral.

Exclusion Criteria
This medication is contraindicated in patients using organic nitrates either regularly or intermittently.

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
Adcirca is indicated for treatment of pulmonary arterial hypertension (WHO group 1). Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Tazarotene External Cream 0.1 %, Tazarotene External Gel, **Tazorac External Cream 0.05 %**

Covered Uses
FDA approved indications. For Psoriasis patient must have failed medium to high potency topical corticosteroid. For acne patient must have failed adapalene or tretinoin or oral tetracycline class antibiotic.

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Must be written by dermatology.

Coverage Duration
12 months

Other Criteria
Tazorac is a topical retinoid indicated to treat Acne or Psoriasis. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Teriflunomide

Drugs
Teriflunomide

Covered Uses
Teriflunimide is indicated to treat Multiple Sclerosis. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.Criteria for coverage as follows:FDA approved indications. Prescriber must be a neurologist.

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria

Drugs
Tetrabenazine

Covered Uses
FDA approved indications. Patient must have moderate to severe chorea that is refractory to amantadine, neuroleptics or anticonvulsants.

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Prescriber must be a neurologist.

Coverage Duration
12 months

Other Criteria
Xenazine is indicated to treat chorea associated with Huntingtons disease. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Dronabinol

Covered Uses
For cachexia, patient must fail megestrol acetate. For nausea and vomiting patient must fail Ondansetron and Emend.

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
Dronabinol is indicated to treat HIV/Cancer related Cachexia and chemotherapy induced nausea and vomiting. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Thalomid

Covered Uses
FDA approved indications.

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Approved when written by Oncology, Infectious Disease or in HIV through referrals.

Coverage Duration
12 months

Other Criteria
Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Lonsurf

Covered Uses
FDA approved indications, off label use will be covered when there is an NCCN supported indication with a recommendation of class 2A or greater.

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Must be prescribed by an Oncologist

Coverage Duration
Up to 12 months or until disease progression or toxicity

Other Criteria
Lonsurf is indicated to treat patients with metastatic colorectal cancer who have progressed on two to three lines of treatment Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Xeljanz Oral Solution, **Xeljanz Oral Tablet**, **Xeljanz XR**

Covered Uses
FDA approved indications. For rheumatoid arthritis must be written by Rheumatology, Patient must fail adequate trial of MTX in combination with a DMARD If MTX contraindicated, must try combination of 2-nonbiologic DMARDS (3 month trial in past 6 months) and a preferred TNF. For Psoriatic Arthritis Patient must fail adequate trial of MTX or LEF in past 6 months. For with ulcerative colitis must be written by a gastroenterologist and had recent failure of an immunosuppressant (Azathioprine, 6-mp or Methotrexate) and an anti-inflammatory (5-asa, sulfasalazine, balsalazide, mesalamine)

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
For rheumatoid arthritis must be written by Rheumatology. For with ulcerative colitis must be written by a gastroenterologist.

Coverage Duration
Up to 12 months

Other Criteria
Xeljanz is indicated for treatment of Moderate to severe Rheumatoid arthritis in adults, Psoriatic Arthritis, Ulcerative colitis, JIA. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Mekinist Oral Tablet

Covered Uses
FDA approved indications, off label use will be covered when there is an NCCN supported indication with a recommendation of class 2A or greater. Patient must have BRAF V600E/K mutation.

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Must be written by an oncologist.

Coverage Duration
Up to 12 months or until disease progression or toxicity

Other Criteria
Mekinist is a MEK inhibitor indicated to treat BRAF+ V600e/k mutation Stage IIIc-IV metastatic Melanoma and NSCLC. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Tretinoin Oral

Covered Uses
FDA approved indications.

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Approved when written by Oncology through referrals.

Coverage Duration
12 months

Other Criteria
Vesanoid is indicated to treat promyelocytic leukemia. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

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

Covered Uses
Tretinoin is indicated to treat moderate to severe acne and diseases of keratinization such as ichthyosis and keratosis follicularis. Prior authorization only required for patients greater than 30 years of age. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.Criteria for coverage as follows: FDA approved indications. This medication is not covered for wrinkles or photo aging.

Exclusion Criteria
This medication is not covered for wrinkles or photo aging.

Required Medical Information

Age Restriction
Prior authorization only required for patients greater than 30 years of age.

Prescriber Restriction

Coverage Duration
12 months

Other Criteria

Drugs
Stelara Subcutaneous Solution 45 MG/0.5ML, **Stelara Subcutaneous Solution Prefilled Syringe**

Covered Uses
Stelara is indicated for treatment of moderate to severe plaque psoriasis and psoriatic arthritis and Crohn's disease. Medical history and studies are reviewed in Referrals and if approved will notify the physician.Criteria for coverage as follows:•FDA approved indications only at FDA approved doses•Prescribed by a dermatologist or Rheumatologist.•Only covered as a medical benefit.•Notes supporting moderate to severe Plaque psoriasis or Psoriatic arthritis•For Plaque Psoriasis, recent failure (in past 6 months) of Renflexis, and Enbrel in combination with topical treatment following conventional therapy.•For Psoriatric Arthritis failure of adalimumab, Renflexis, Enbrel, Xeljanz,. •For Crohns Disease must fail conventional agents AND adalimumab, Renflexis, Entyvio, , AND TNF in combination with a conventional immunosuppressant (when clinically appropriate) with 5-ASA anti-inflammatory.•For Ulcerative Colitis must fail conventional agents AND adalimumab, Renflexis, Entyvio, Xeljanz, AND TNF in combination with a conventional immunosuppressant (when clinically appropriate) with 5-ASA anti-inflammatory.

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Up to 12 months

Other Criteria

Drugs
Caprelsa

Covered Uses
FDA approved indications, off label use will be covered when there is an NCCN supported indication with a recommendation of class 2A or greater.

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Prescriber must be a Hematologist/Oncologist.

Coverage Duration
Up to 12 months or until disease progression or toxicity

Other Criteria
Caprelsa medication indicated for treatment of metastatic medullary thyroid cancer Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Zelboraf

Covered Uses
FDA approved indications, off label use will be covered when there is an NCCN supported indication with a recommendation of class 2A or greater. Patient must have BRAF V600E/K mutation.

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Must be written by an oncologist.

Coverage Duration
Up to 12 months or until disease progression or toxicity

Other Criteria
Zelboraf is a BRAF inhibitor indicated to treat BRAF+ V600e/k mutation Stage IIIc-IV metastatic Melanoma, NSCLC, and Metastatic colorectal cancer. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Venclexta, **Venclexta Starting Pack**

Covered Uses
FDA approved indications.

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Restricted to Hematology/Oncology.

Coverage Duration
Up to 12 months or until disease progression or toxicity

Other Criteria
Venclexta is a BCL-2 inhibitor indicated for treatmentBCell Lymphomas. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Erivedge

Covered Uses
FDA approved indications.Patient has Metastatic basal cell cancer, or recurrent basal cell cancer, or who are not candidates for surgery and not candidates for radiation.

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Prescriber is a hematologist/oncologist.

Coverage Duration
Up to 12 months or until disease progression or toxicity

Other Criteria
Erivedge is indicated for treatment of metastatic or locally advanced basal cell carcinoma that has recurred following surgery or who are not candidates for surgery and are not candidates for radiation. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Voriconazole Oral

Covered Uses
FDA approved indications. Two of the following medications have been tried, unless resistance or contraindication precludes use, Itraconazole, fluconazole, ketoconazole. Exclusions to pre-requisite medications are Invasive pulmonary aspergillosis, Scedosporium apiospermum, and fusarium.

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
Voriconazole is an antifungal medication used to treat aspergillosis and other invasive fungal infections. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Zolinza

Covered Uses
FDA approved indications. Failed minimum of two systemic treatments, one of which must be Targretin, unless contraindicated.

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Up to 12 months or until disease progression or toxicity

Other Criteria
Zolinza is indicated for cutaneous manifestations of cutaneous T-cell Lymphoma Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Trintellix

Covered Uses
FDA approved indications. Failure or intolerance to two generically available anti-depressants in past 6 months.

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
Trintellix is an antidepressant used to treat major depressive disorder. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

Drugs
Zileuton ER

Covered Uses
FDA approved indications. Uncontrolled Asthma while on maximal doses of long acting bronchodilators and inhaled corticosteroids AND montelukast. 6 months of medication compliance with maintenance treatments.

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Must be written by a pulmonologist.

Coverage Duration
12 months

Other Criteria
Zyflo is indicates for treatment of asthma. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.