AdventHealth
Advantage Plans

6450 U.S. Highway 1
Rockledge, FL 32955
myAHplan.com

Commercial Plans

2020 Prior Authorization Criteria

36194_MPINFO7669AH(10/19)

Drugs
acitretin

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria
Severely impaired liver or kidney function. Chronic abnormally elevated blood lipid values. Concomitant use of methotrexate or tetracyclines. Pregnancy. Females of child-bearing potential who intend to become pregnant during therapy or at any time for at least 3 years after discontinuing therapy. Females of child-bearing potential who will not use reliable contraception while undergoing treatment and for at least 3 years following discontinuation. Females of child-bearing potential who drink alcohol during treatment or for two months after cessation of therapy.

Required Medical Information
Documented diagnosis of severe psoriasis

Age Restriction
18 years of age or older

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria
Will not be approved for the treatment of acne.

Drugs
ACTIMMUNE

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria
Hypersensitivity to interferon gamma, E. coli derived proteins, or any component of the formulation.

Required Medical Information
Documentation of diagnosis of chronic granulomatous disease or severe malignant osteoporosis.

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
tadalafil (pulm. hypertension), *tadalafil oral tablet 20 mg*

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria
Receiving nitrate therapy (includes intermittent use).

Required Medical Information

Age Restriction
18 years or older

Prescriber Restriction
Cardiologist or Pulmonologist

Coverage Duration
Plan year

Other Criteria
Sildenafil citrate (generic Revatio indicated for Pulmonary Hypertension) must be tried first.

Drugs
adefovir

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction
12 years and older.

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria
Optimal treatment duration is unknown.

Drugs
ADEMPAS

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria
Pregnancy. Concomitant administration with nitrates or nitric oxide donors (such as amyl nitrate) in any form. Concomitant administration with phosphodiesterase inhibitors, including specific PDE-5 inhibitors (such as sildenafil, tadalafil, or vardenafil) or non-specific PDE inhibitors (such as dipyridamole or theophylline).

Required Medical Information

Age Restriction
18 years of age or older

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria
For renewal, medication was effective (i.e. improved 6 minute walk distance, oxygen saturation, etc.)

Drugs
AFINITOR ORAL TABLET 10 MG, 2.5 MG, 5 MG, 7.5 MG, *everolimus (antineoplastic)*

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Diagnosis of one of the following: A) Advanced metastatic renal cell carcinoma and patient has failed therapy (disease progressed) with Sutent or Nexavar (Afinitor only), or B) Progressive pancreatic, nonfunctional GI or lung neuroendocrine tumors (NET) that are unresectable, locally advanced or metastatic (Afinitor only), or C) Renal angiomyolipoma with tuberous sclerosis complex (TSC) and patient does not require immediate surgery (Afinitor only), or D) Advanced hormone receptor-positive, HER2-negative breast cancer and patient is a postmenopausal woman and patient has failed treatment with Femara or Arimidex and the medication will be used in combination with Aromasin (Afinitor only), or E) Subependymal giant cell astrocytoma (SEGA) associated with TSC that requires therapeutic intervention but is not a candidate for curative surgical resection (Afinitor or Afinitor Disperz only).

Age Restriction
18 years of age or older for RCC, pNET, and renal angiomyolipoma with TSC. 1 year of age or older for SEGA.

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
ALINIA

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation indicating treatment needed for diarrhea caused by Giardia lamblia or Cryptosporidium parvum.

Age Restriction
Age 1 year or older (Suspension) Age 12 years or older (Tablets)

Prescriber Restriction

Coverage Duration
30 days

Other Criteria

Drugs
ALIQOPA

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

Exclusion Criteria

Required Medical Information
Documented diagnosis of relapsed follicular lymphoma (FL) who have received at least two prior systemic therapies.

Age Restriction

Prescriber Restriction
Oncologist or Hematologist

Coverage Duration
Through end of benefit year

Other Criteria

Drugs
alosetron

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria
Initial therapy for Irritable Bowel Syndrome (IBS) in the male gender.

Required Medical Information
Initial Therapy for Irritable Bowel Syndrome (IBS): 1. Confirmed diagnosis of IBS with diarrhea predominant symptoms for at least 6 months Reauthorization for Irritable Bowel Syndrome (IBS): 1. Recurrence of diarrhea predominant IBS, AND 2. documentation of positive clinical response while on Lotronex.

Age Restriction
Patient must be at least 18 years of age or older

Prescriber Restriction
Prescriber must be specially trained gastrointestinal physician

Coverage Duration
IBS Initial Therapy: 12 weeks Reauthorization: 6 months

Other Criteria
Initial Therapy for Irritable Bowel Syndrome (IBS): 1. Failure to both: a. An antispasmodic (e.g. dicyclomine) AND b. An anti-diarrhea agent (e.g. loperamide, diphenoxylate-atropine)

Drugs
dalfampridine

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria
History of seizure. Moderate or severe renal impairment (creatinine clearance less than or equal to 50 mL/minute). Patient currently using any other forms of 4-aminopyridine.

Required Medical Information
Diagnosis of multiple sclerosis AND patient is ambulatory AND patient has walking impairment.

Age Restriction

Prescriber Restriction
Neurologist

Coverage Duration
Initial: 3 months. Renewal: Plan year

Other Criteria
For renewal, documentation that walking speed has improved from baseline must be provided.

Drugs
APTIOM

Covered Uses
All FDA-approved indications not otherwise excluded from Health Plan.

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
APTIVUS, **APTIVUS (WITH VITAMIN E)**

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction
2 years of age and older

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria
Do not use Aptivus in treatment-naïve patients.

Drugs
ARCALYST

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria
Use in combination with other IL-1 inhibitors (e.g. Ilaris, Kineret) or tumor necrosis factor (TNF) inhibitors (e.g. Enbrel, Humira, Remicade, etc). Individual is receiving live vaccines. Exhibiting evidence of active or chronic infection(s), including tuberculosis, or a history of recurrent infections. Individual has not had a tuberculin skin test (TST) or Centers for Disease Control (CDC)-recommended equivalent to evaluate for latent tuberculosis prior to initiating treatmentwith rilonacept.

Required Medical Information
Documented diagnosis of cryopyrin-associated period syndromes (CAPS), including Familial Cold Auto-inflammatory Syndrome (FCAS) and/or Muckle-Wells Syndrome (MWS). Member's diagnosis of CAPS must be confirmed by either NRLP=3 gene mutation OR overproduction of interleukin-1.

Age Restriction
12 years of age and older

Prescriber Restriction
Prescribed by or in consultation with or recommendation of, an immunologist, allergist, dermatologist, rheumatologist, neurologist, or other medical specialist.

Coverage Duration
Plan year

Other Criteria
Approve doses based on FDA labeling.

Drugs
armodafinil

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Documentation of diagnosis and treatment history.

Age Restriction
Patient must be at least 17 years or older

Prescriber Restriction
Idiopathic hypersomnia-- approve if the diagnosis is confirmed by a sleep specialist physician or at an institution that specializes in sleep disorders (i.e., sleep center)

Coverage Duration
Plan year

Other Criteria

Drugs
ATRIPLA

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction
12 years and older

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
AUBAGIO

Covered Uses
All FDA-approved indications not otherwise excluded from Health Plan

Exclusion Criteria
Concurrent use of Aubagio with other disease-modifying agents used for multiple sclerosis (MS) [eg, Avonex, Rebif, Betaseron, Extavia, Copaxone, Tysabri, Tecfidera, or Gilenya].

Required Medical Information
Documented diagnosis of relapsing form of MS (RRMS, SPMS with relapses, or PRMS) and previous MS therapies tried.

Age Restriction

Prescriber Restriction
Prescribed by or in consultation with a neurologist or MS specialist.

Coverage Duration
Plan year

Other Criteria
For use in a relapsing form of MS, approve if: 1) Patient is currently taking teriflunomide (Aubagio), OR 2) Patient has tried dimethyl fumarate (Tecfidera), interferon beta-1a intramuscular (Avonex) and glatiramer acetate (Copaxone).

Drugs
AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
3 Months

Other Criteria

Drugs
AVONEX INTRAMUSCULAR PEN INJECTOR KIT, **AVONEX INTRAMUSCULAR SYRINGE KIT**

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria
Treatment of primary progressive MS is not covered. Combination therapy with a beta interferon product, Gilenya, Aubagio, Tecfidera, Tysabri or Copaxone is not covered.

Required Medical Information
Diagnosis of relapsing form of multiple sclerosis OR diagnosis of first clinical episode and MRI features consistent with multiple sclerosis

Age Restriction

Prescriber Restriction
Prescribed by or in consultation with a neurologist or MS specialist.

Coverage Duration
Plan year

Other Criteria

Drugs
AYVAKIT

Covered Uses

Exclusion Criteria

Required Medical Information
documentation of unresectable or metastatic GIST harboring a platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation.

Age Restriction

Prescriber Restriction
Oncology

Coverage Duration
3 months

Other Criteria

Drugs
BALVERSA

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

Exclusion Criteria

Required Medical Information
Documented diagnosis of locally advanced or metastatic urothelial carcinoma AND member has susceptible FGFR3 or FGFR2 genetic alteration as detected by an FDA-approved companion diagnostic AND disease has progressed during or following at least one line of prior platinum-containing chemotherapy including within 12 months of neoadjuvant or adjuvant platinum-containing chemotherapy.

Age Restriction
8 years or older

Prescriber Restriction

Coverage Duration
3 Months

Other Criteria

Drugs
BANZEL ORAL SUSPENSION, **BANZEL ORAL TABLET 200 MG, 400 MG**

Covered Uses
All FDA-approved indications not otherwise excluded from Health Plan.

Exclusion Criteria
Banzel is not covered for members with the diagnosis of Familial Short QT syndrome

Required Medical Information
Documentation of diagnosis. Documentation of previous therapies and that the current medication regimen is inadequate to control disease.

Age Restriction
Must be 1 years of age or older

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria
Patient must be refractory to at least 2 of the following: Felbamate (Felbatol), Lamotrigine (Lamictal),Topiramate (Topamax), Valproic acid (Depakene),Divalproex sodium (Depakote)

Drugs
BARACLUDE ORAL SOLUTION, *entecavir*

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Documentation of diagnosis

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
BAVENCIO

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Oncologist

Coverage Duration
3 Months

Other Criteria

Drugs
BELSOMRA

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

Exclusion Criteria

Required Medical Information
Documented trial and failure of two formulary alternatives AND documented medication review to rule out medication induced insomnia.

Age Restriction

Prescriber Restriction

Coverage Duration
Through end of benefit year

Other Criteria

Drugs
BENLYSTA SUBCUTANEOUS AUTO-INJECTOR

Covered Uses
All FDA-approved indications not otherwise exluded for part D

Exclusion Criteria

Required Medical Information
Documentation from the medical record of diagnosis

Age Restriction

Prescriber Restriction

Coverage Duration
3 months

Other Criteria

Drugs
benznidazole

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

Exclusion Criteria
Patients who have used disulfiram within two weeks of initiation of benznidazole

Required Medical Information
Documentation of a consultation with an infectious disease specialist. Reviewer will verify patient claim history to confirm that patient has not used disulfiram within two weeks prior to benznidazole initiation

Age Restriction

Prescriber Restriction

Coverage Duration
60 days

Other Criteria

Drugs
DIAZEPAM INTENSOL, *diazepam oral concentrate*

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Documentation of diagnosis

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
BETASERON SUBCUTANEOUS KIT

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria
Treatment of primary progressive MS is not covered. Combination therapy with a beta interferon product, Gilenya, Aubagio, Tecfidera, Tysabri or Copaxone is not covered.

Required Medical Information
Diagnosis of relapsing form of multiple sclerosis OR diagnosis of first clinical episode and MRI features consistent with multiple sclerosis.

Age Restriction

Prescriber Restriction
Prescribed by or in consultation with a neurologist or MS specialist.

Coverage Duration
Plan year

Other Criteria
Approve if: 1) Patient is currently taking Betaseron, OR 2) Patient has tried dimethyl fumarate (Tecfidera), interferon beta-1a intramuscular (Avonex) and glatiramer acetate (Copaxone)

Drugs
BRAFTOVI ORAL CAPSULE 50 MG, 75 MG

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

Exclusion Criteria

Required Medical Information
Documentation of unresectable or metastatic melanoma with a BRAF V600E or V600K mutation, as detected by an FDA-approved test and the medication will be used in combination with binimetinib.

Age Restriction

Prescriber Restriction
Oncology

Coverage Duration
3 months

Other Criteria

Drugs
CAPLYTA

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

Exclusion Criteria

Required Medical Information
Documented trial of any of the two following drugs: aripiprazole, clozapine, olanzapine, risperidone, quetiapine, ziprasidone

Age Restriction

Prescriber Restriction

Coverage Duration
Through end of benefit year

Other Criteria

Breast Cancer Prevention Medications - $0 Cost-share Eligibility Criteria

Drugs
raloxifene, *tamoxifen*

Covered Uses
This criteria is a copay review process. The medications tamoxifen or raloxifene may be eligible for $0 cost-share for women 35 years of age or older who: 1) do not have a history of breast cancer, and 2) are being prescribed tamoxifen or raloxifene for the purpose of primary prevention of invasive breast cancer because the member is deemed high risk, and 3) are post-menopausal, if prescribed raloxifene (this requirement does not apply to tamoxifen)

Exclusion Criteria
Women under 35 years of age, history of breast cancer

Required Medical Information
A 5-year predicted risk of breast cancer greater than or equal to 1.66%, as calculated by the Gail model.

Age Restriction
35 years and older

Prescriber Restriction

Coverage Duration
5 years

Other Criteria

Drugs
BROVANA

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Documentation of diagnosis

Age Restriction
18 years and older.

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria
Must have documented failure, intolerance or contraindication to a long-acting beta agonist formulary product OR be unable to use a hand-actuated device.

Drugs
BRUKINSA

Covered Uses

Exclusion Criteria

Required Medical Information
Documentation of mantle cell lymphoma (MCL) in patients who have received at least one prior therapy.

Age Restriction

Prescriber Restriction
Oncology

Coverage Duration
3 Months

Other Criteria

Drugs
BUPHENYL ORAL TABLET, *sodium phenylbutyrate oral tablet*

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Documentation of diagnosis confirmed by enzymatic, biochemical or genetic testing. Buphenyl will be used for chronic management of urea cycle disorders (UCD).

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
buprenorphine HCl sublingual, *buprenorphine-naloxone sublingual film 12-3 mg, 2-0.5 mg, 4-1 mg, 8-2 mg*

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

Exclusion Criteria
Being used for the treatment of pain OR patient is using short or long acting narcotics concurrently with Suboxone/Subutex.

Required Medical Information
The indicated diagnosis and medication usage must be supported by documentation from the patient's medical records.

Age Restriction
Must be 16 years of age or older.

Prescriber Restriction
Prescribing provider must have a DEA number starting with the letter X, AND physician must be listed on the Buprenorphine Physician Locator maintained by the Substance Abuse and Mental Health Services Administration (SAMSHA).

Coverage Duration
12 months

Other Criteria

Drugs
BUSULFEX

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Documentation of diagnosis

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
BYNFEZIA

Covered Uses

Exclusion Criteria

Required Medical Information
To be used to treat of the following •Treatment of severe diarrhea/flushing episodes associated with metastatic carcinoid tumors in adult patients•Treatment of profuse watery diarrhea associated with vasoactive intestinal peptide tumors (VIPomas) in adult patients•To reduce the amount of growth hormone and insulin like growth factor 1 in adult patients with acromegaly who have had inadequate response to or cannot be treated with surgical resection, pituitary irradiation, and bromocriptine mesylate at maximally tolerated doses

Age Restriction

Prescriber Restriction

Coverage Duration
Through end of benefit year

Other Criteria

Drugs
AIMOVIG AUTOINJECTOR, **AJOVY AUTOINJECTOR**, **AJOVY SYRINGE**

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

Exclusion Criteria

Required Medical Information
Clinical documentation of migraines and member has tried and failed two formulary alternatives for migraine prophylaxis with two different mechanism of action.

Age Restriction

Prescriber Restriction

Coverage Duration
Through end of benefit year

Other Criteria

Drugs
CALQUENCE

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

Exclusion Criteria

Required Medical Information
Documented diagnosis of mantle cell lymphoma (MCL) who have received at least one prior therapy.

Age Restriction

Prescriber Restriction
Oncologist or hematologist

Coverage Duration
3 Months

Other Criteria

Drugs
capecitabine

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction
18 years and older.

Prescriber Restriction
Oncologist

Coverage Duration
Plan year

Other Criteria

Drugs
CAPRELSA ORAL TABLET 100 MG, 300 MG

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria
Congenital long QT syndrome

Required Medical Information
Diagnosis of symptomatic or progressive medullary thyroid cancer with unresectable locally advanced or metastatic disease.

Age Restriction
18 years or older

Prescriber Restriction
Oncologist or endocrinologist

Coverage Duration
3 Months

Other Criteria

CASPOFUNGIN

Drugs
caspofungin

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

Exclusion Criteria

Required Medical Information
Diagnosis of one of the following: A)Empirical therapy for presumed fungal infections in febrile, neutropenic patients, or B)Treatment of candidemia and other Candida infections (intraabdominal abscesses, peritonitis and pleural space infections), or C)Treatment of esophageal candidiasis, or D)Treatment of invasive aspergillosis in patients who are refractory to or intolerant of other therapies (amphotericin B, itraconazole).Age Restrictions: 3 months of age or older

Age Restriction

Prescriber Restriction

Coverage Duration
3 months

Other Criteria

Drugs
CAYSTON

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

Exclusion Criteria

Required Medical Information
Diagnosis of cystic fibrosis AND patient has evidence of P. aeruginosa in the lungs

Age Restriction
7 years of age and older

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria
For renewal, Patient is benefiting from treatment (i.e. improvement in lung function [FEV1], decreased number of pulmonary exacerbations)

Drugs
CESAMET

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Documentation that nabilone is being used for the treatment of the nausea and vomiting associated with cancer chemotherapy in patients who have a failed to respond adequately to conventional antiemetic treatments (e.g. Zofran and Emend).

Age Restriction
Older than 10 months

Prescriber Restriction
Oncologist

Coverage Duration
Through the duration of chemotherapy

Other Criteria
A substantial proportion of any group of patients treated with nabilone can be expected to experience disturbing psychotomimetic reactions not observed with other antiemetic agents. Because of its potential to alter the mental state, nabilone is intended for use under circumstances that permit close supervision of the patient by a responsible individual, particularly during the initial use of nabilone and during dose adjustments. Nabilone is not intended for use on an as-needed basis or as the first antiemetic product prescribed for a patient.

Drugs
cinacalcet

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

Exclusion Criteria

Required Medical Information
Documentation of secondary hyperparathyroidism due to chronic kidney disease on dialysis, Or Hypercalcemia due to parathyroid carcinoma, Or severe hypercalcemia in patients with primary hyperparathyroidism who are unable to undergo parathyroidectomy.

Age Restriction

Prescriber Restriction

Coverage Duration
3 months

Other Criteria

Drugs
CLOVIQUE

Covered Uses

Exclusion Criteria
Not recommended in cystinuria or rheumatoid arthritis. Not indicated for biliary cirrhosis.

Required Medical Information
For use in patients with diagnosis of Wilson disease who are intolerant to penicillamine.

Age Restriction
Geriatric patients: Use with caution. Initiate at lower end of the dosing range.Pediatric dosage: Children and adolescents: Oral: Initial: 20 mg/kg/day (round dose to the nearest 250 mg) in 2 to 3 divided doses. Maximum initial daily dose: 1,000 mg/day. titrate dose based on clinical response and free serum copper (non-ceruloplasmin bound copper) concentrations and/or 24-hour urinary copper excretion. usual maintenance dose: 900 to 1,500 mg/day in 2 to 3 divided doses

Prescriber Restriction

Coverage Duration
Through end of benefit year.

Other Criteria

Drugs
clozapine oral tablet,disintegrating

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria
If the patient has any of the following contraindications: agranulocytosis, bone marrow suppression, coma, ileus, leukopenia, myocarditis or neutropenia, OR if the patient has CNS depression, dementia-related psychosis or uncontrolled epilepsy.

Required Medical Information
A statement showing the patient is unwilling or unable to take tablets or capsules orally or at high risk for non-compliance AND is not receiving other tablets or capsules indicating that the patient can take non-dissolvable tablets.

Age Restriction

Prescriber Restriction
Part of a clozapine registry.

Coverage Duration
Plan Year

Other Criteria

Drugs
COPAXONE SUBCUTANEOUS SYRINGE 20 MG/ML, 40 MG/ML

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria
Treatment of primary progressive MS is not covered. Combination therapy with a beta interferon product, Gilenya, Aubagio, Tecfidera, Tysabri or Copaxone is not covered.

Required Medical Information
Diagnosis of relapsing-remitting multiple sclerosis OR diagnosis of first clinical episode with MRI features consistent with multiple sclerosis.

Age Restriction

Prescriber Restriction
By or in consultation with a Neurologist or a Certified MS Specialist

Coverage Duration
Plan year

Other Criteria

Drugs
COPIKTRA

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

Exclusion Criteria

Required Medical Information
Documentation of the following: A) relapsed or refractory CLL or SLL after at least two prior therapies OR B)relapsed or refractory FL after at least two prior systemic therapies.

Age Restriction

Prescriber Restriction
Oncology

Coverage Duration
3 months

Other Criteria

Drugs
CORLANOR ORAL SOLUTION

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

Exclusion Criteria

Required Medical Information
Must be clinically diagnosed with A) stable, symptomatic chronic heart failure in adults with left ventricular ejection fraction less than or equal to 35% supported by documentation from the patient's medical records, AND have sinus rhythm with resting heart rate greater than or equal to 70 beats per minute, AND be on maximally tolerated doses of beta blockers unless contraindicated, AND be on optimal therapy with standard treatment of ACEI or ARB unless intolerant or contraindicated, AND be on optimal therapy with standard treatment of an aldosterone antagonist unless intolerant or contraindicated, AND documentation of trial and failure of Entresto OR B)stable symptomatic heart failure due to dilated cardiomyopathy (DCM) in pediatric patients aged 6 months and older AND have sinus rhythm with an elevated heart rate.

Age Restriction

Prescriber Restriction
Cardiologist

Coverage Duration
Through end of benefit year

Other Criteria

Drugs
COSENTYX, **COSENTYX (2 SYRINGES)**, **COSENTYX PEN**, **COSENTYX PEN (2 PENS)**

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

Exclusion Criteria

Required Medical Information
Documented trial and failure of preferred TNF inhibitors (Enbrel and Humira)AND negative Tuberculin test prior to therapy AND patient is free of any clinically important active infections.

Age Restriction

Prescriber Restriction

Coverage Duration
Initial Authorization will be for 3 months. Reauthorization will be for 1 year.

Other Criteria

Drugs
CRIXIVAN ORAL CAPSULE 200 MG

Covered Uses
All FDA-approved indications not otherwise excluded from Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction
18 years and older (off-label dosing for pediatrics)

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
CYCLOSET

Covered Uses
All FDA-approved indications not otherwise excluded from Health Plan

Exclusion Criteria

Required Medical Information
Documented diagnosis of type 2 diabetes mellitus

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
CYSTAGON

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria
Cysteamine is contraindicated in patients who have demonstrated hypersensitivity to cysteamine or penicillamine hypersensitivity.

Required Medical Information
Documentation of diagnosis

Age Restriction

Prescriber Restriction

Coverage Duration
3 Months

Other Criteria
Do not administer intact cysteamine capsules to children less than 6 years old because of aspiration risk. Capsules may be administered by sprinkling contents over food.

Drugs
DAURISMO ORAL TABLET 100 MG, 25 MG

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

Exclusion Criteria

Required Medical Information
Documentation that the medication will be used in combination with low-dose cytarabine for the treatment of newly-diagnosed acute myeloid leukemia (AML), and the patient is A) 75 years of age or older old OR B)has comorbidities that preclude use of intensive induction chemotherapy.

Age Restriction

Prescriber Restriction
oncology

Coverage Duration
3 months

Other Criteria

Drugs
DESCOVY

Covered Uses
All FDA-approved indications not otherwise excluded from Health Plan

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
DIACOMIT ORAL CAPSULE

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

Exclusion Criteria

Required Medical Information
Documentation that the medication is prescribed for the treatment of seizures associated with confirmed diagnosis of Dravet syndrome AND member has been inadequately controlled on clobazam and valproate (unless contraindicated) despite optimized therapy AND the member will be receiving concurrent clobazam therapy.

Age Restriction
Member is 2 years of age or older

Prescriber Restriction
Medication is prescribed by a neurologist

Coverage Duration
3 months

Other Criteria
Reauthorization requires documentation of significant decrease in the frequency of seizures

Drugs
diazoxide

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

Exclusion Criteria

Required Medical Information
Documentation that the medication will be used for the management of hypoglycemia due to hyperinsulinism associated with one of the following conditions:A) Adults: Inoperable islet cell adenoma or carcinoma, or extrapancreatic malignanc OR B) Infants and Children: Leucine sensitivity, islet cell hyperplasia, nesidioblastosis, extrapancreatic malignancy, islet cell adenoma, or adenomatosis.

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria

Drugs
diclofenac sodium topical gel 3 %

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Documentation of diagnosis and treatment history

Age Restriction
DO NOT use Solaraze in children.

Prescriber Restriction

Coverage Duration
3 months

Other Criteria
Must have failed topical 5-FU cream

Drugs
didanosine oral capsule,delayed release(DR/EC) 250 mg, 400 mg

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction
2 weeks and older.

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
DIFICID

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Diagnosis of Clostridium difficile associated diarrhea (CDAD) with one of the following: A) Patient has mild to moderate CDAD and failure, contraindication or intolerance to oral Flagyl (metronidazole) and oral Vancocin (vancomycin), or B) Patient has severe CDAD.

Age Restriction
18 years or older

Prescriber Restriction

Coverage Duration
10 Days

Other Criteria

Drugs
doxercalciferol oral

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction
18 years and older.

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
dronabinol oral capsule 10 mg, 2.5 mg, 5 mg

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria
Any pertinent clinical situation as defined by the product label that could affect patient safety and/or therapeutic efficacy (i.e. contraindications, warnings, precautions, adverse effects, renal or hepatic function, drug interactions, lab values, required prior or concomitant therapy, inappropriate dosing and/or duration, etc).

Required Medical Information
For treatment of chemotherapy-induced nausea or vomiting refractory to conventional antiemetic agents: 1. Patient is receiving cancer chemotherapy, AND 2. Failure to preferred 5HT-3 receptor antagonist. preferred agents include ondansetron or granisetron, AND 3. Failure to one of the following agents: a. Antihistamine b. Corticosteroid c. Prokinetic agent d. Antipsychotic. For treatment of anorexia associated with weight loss in patients with HIV: documentation of trial and failure, contraindication, or intolerance to megestrol.

Age Restriction
18 years old and greater for the treatment of anorexia associated with weight loss in patients with HIV

Prescriber Restriction

Coverage Duration
3 Months

Other Criteria

Drugs
DUPIXENT PEN, **DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 200 MG/1.14 ML, 300 MG/2 ML**

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

Exclusion Criteria

Required Medical Information
Patient must have the following: A) Moderate-to-severe atopic dermatitis (eczema)AND submission of medical records (e.g. chart notes, laboratory values) documenting the following: Inadequate response, intolerance or contraindication to ONE medication in EACH of the following categories:a. Topical calcineurin inhibitor b. High potency topical corticosteroid. OR B) Moderate-to-severe asthma AND submission of medical records documenting the following: 1. Patient has ONE of the following: a. Asthma with eosinophilic phenotype with eosinophil count greater than or equal to 300 cells/mcL in the past 12 months, or b. Oral corticosteroid dependent asthma with at least 1 month of daily oral corticosteroid use within the last 3 months AND 2. Inadequate control of asthma symptoms after a minimum of 3 months of compliant use of one of the following: a. Inhaled corticosteroids & long acting beta2 agonist, or b. Inhaled corticosteroids & long acting muscarinic antagonist. OR C)Chronic rhinosinusitis with nasal polyposis (CRSwNP)AND submission of medical records (e.g. chart notes, laboratory values) documenting the following: Inadequate response, intolerance or contraindication to ONE medication in EACH of the following categories: 1. Inadequate response, intolerance or contraindication to ONE medication in EACH of the following categories: a. Nasal corticosteroid spray and b. Oral corticosteroid.

Age Restriction
18 or older

Prescriber Restriction
Dermatologist or allergist/immunologist

Coverage Duration
Initial Authorization will be for 3 months. Reauthorization will be for 1 year.

Other Criteria
Renewals require submission of medical records (e.g. chart notes, laboratory values) documenting improvement of the condition.

Drugs
EDECRIN

Covered Uses
All FDA-approved indications not otherwise excluded from Health Plan

Exclusion Criteria
Use for pediatrics 12 months and younger

Required Medical Information
Documentation of diagnosis.

Age Restriction
13 months and older.

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria
Must have documented failure, intolerance or contraindication to at least 2 other loop diuretics.

Drugs
EDURANT

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction
12 years and older.

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
ELIGARD, **ELIGARD (3 MONTH)**, **ELIGARD (4 MONTH)**, **ELIGARD (6 MONTH)**

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

Exclusion Criteria

Required Medical Information
Clinical documentation of advanced prostate cancer diagnosis

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria

Drugs
ELZONRIS

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

Exclusion Criteria

Required Medical Information
Patient must have a definitive diagnosis of Blastic Plasmacytoid Dendritic Cell Neoplasm (BPDCN) AND Patient has CD123 positive expressing disease AND Patient has a baseline serum albumin level of at least 3.2 g per dL

Age Restriction
Patient is 2 years of age or older

Prescriber Restriction

Coverage Duration
6 months

Other Criteria

Drugs
EMCYT

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Documented diagnosis of metastatic and/or progressive prostate cancer.

Age Restriction
18 years or older

Prescriber Restriction
Oncologist prescriber

Coverage Duration
6 months

Other Criteria

Drugs
EMEND ORAL CAPSULE 40 MG, 80 MG, **EMEND ORAL CAPSULE,DOSE PACK**

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction
18 years and older.

Prescriber Restriction

Coverage Duration
3 Months

Other Criteria

Drugs
EMSAM

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria
Pheochromocytoma. Patient is taking or will take any of the following: SSRIs, SNRIs, tricyclic antidepressants (TCAs), bupropion, buspirone, meperidine, tramadol, methadone, pentazocine, dextromethorphan, St. John's wort, mirtazapine, cyclobenzaprine, oral selegiline, other MAOIs, oxcarbazepine, carbamazepine, and/or sympathomimetic amines.

Required Medical Information
Diagnosis of major depressive disorder, AND 1) Failure of at least two generic oral antidepressants from different classes(at least one should be from the following list: selective serotonin reuptake inhibitors, serotonin and norepinephrine reuptake inhibitors, mirtazapine, or bupropion unless contraindicated), AND 2) Patient had an adequate washout period (for patients previously on agents requiring a washout period)

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
EMTRIVA

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
ENBREL SUBCUTANEOUS SOLUTION

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

Exclusion Criteria
Active serious infection (including tuberculosis).

Required Medical Information
Diagnosis of one of the following: A) Moderate to severe rheumatoid arthritis and patient had an inadequate response to, intolerance to, or contraindication to at least one non-biologic disease modifying anti-rheumatic drugs (DMARD) and one NSAID for at least 3 months, or B) Moderate to severe polyarticular juvenile idiopathic arthritis and patient had an inadequate response, intolerance or contraindication to at least one DMARD and one NSAID for at least 3 months, OR C) Psoriatic arthritis and patient had an inadequate response, intolerance, or contraindication to methotrexate, or D) Ankylosing spondylitis and patient had an inadequate response, intolerance or contraindication to at least two NSAIDs, or E) Moderate to severe chronic plaque psoriasis (affecting more than 5% of body surface area or affecting crucial body areas such as the hands, feet, face, or genitals) and patient had an inadequate response, intolerance or contraindication to conventional therapy with to at least two of the following: phototherapy (including but not limited to Ultraviolet A with a psoralen [PUVA] and/or retinoids [RePUVA] for at least one continuous month or one or more oral systemic treatments (i.e. methotrexate, cyclosporine, acitretin, sulfasalazine) for at least 3 months.

Age Restriction
2 years of age or older for JIA. 4 years of age or older for plaque psoriasis. 18 years of age or older for all other indications.

Prescriber Restriction

Coverage Duration
Through end of benefit year

Other Criteria
Preferred NSAIDs include: ibuprofen, naproxen, ketoprofen, meloxicam. Preferred DMARDs include: methotrexate, sulfasalazine, hydroxychloroquine, cuprimine, azathioprine, leflunomide. Dosing as per FDA approved labeling.

Drugs
ENBREL SUBCUTANEOUS RECON SOLN, **ENBREL SUBCUTANEOUS SYRINGE 25 MG/0.5 ML (0.5), 50 MG/ML (1 ML)**, **ENBREL SURECLICK**

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria
Tuberculosis (TB), or invasive fungal infections or other active seriousinfections, or history if recurrent infections. Individuals who have not had a tuberculin skin test or Center for Disease Control recommended equivalent to evaluate for latent tuberculosis prior to initiating therapy. Using in combination with other TNF antagonists,IL-1R antagonists, janus kinase inhibitor, anti-cd20 monoclonalantibodies or selective co-stimulation modulators.

Required Medical Information
Documentation of diagnosis, treatment history and TB evaluation. FDA-approved indications include: Ankylosing Spondylitis (AS), Polyarticular Juvenile Idiopathic Arthritis (PJIA), Plaque Psoriasis, Psoriatic Arthritis (PsA), Rheumatoid Arthritis (RA).

Age Restriction
2 years of age or older for JIA. 18 years of age or older for all other indications.

Prescriber Restriction
Rheumatologist (RA, PJIA, PsA, AS), Dermatologist for Plaque Psoriasis

Coverage Duration
Plan year

Other Criteria
APPROVE for AS if patient has had an inadequate response, intolerance or contraindication to one or more NSAIDs (e.g. ibuprofen, naproxen, meloxicam, celecoxib). APPROVE for PJIA if patient has has an inadequate response, intolerance or contraindication to one or more non-biologic disease modifying anti-rheumatic drugs (DMARDs) (e.g., hydroxychloroquine [HCQ], sulfasalazine, methotrexate [MTX], leflunomide, azathioprine, cyclosporine) for at least 3 consecutive months. APPROVE for Plaque Psoriasis (affecting more than 5% of body surface area or affecting crucial body areas such as the hands, feet, face, or genitals) if patient has had an inadequate response, intolerance or contraindication to conventional therapy with to at least two of the following: phototherapy (including but not limited to Ultraviolet A with a psoralen [PUVA] and/or retinoids [RePUVA] for at least one continuous month or one or more oral systemic treatments (e.g. MTX, cyclosporine, acitretin, sulfasalazine) for at least 3 consecutive months. APPROVE for PsA if patient has had an inadequate response, intolerance, or contraindication to MTX. APPROVE for RA if patient has had inadequate response to, intolerance to, or contraindication to at least one non-biologic disease modifying anti-rheumatic drugs (DMARD) Patient has been tested for TB and latent TB has been ruled out or is being treated. Dosing as per FDA approved labeling.(e.g., HCQ, sulfasalazine, MTX, leflunomide, azathioprine, cyclosporine) for at least 3 consecutive months.

Drugs
ENDARI

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

Exclusion Criteria

Required Medical Information
Documented diagnosis of sickle cell disease.

Age Restriction
5 years and older

Prescriber Restriction

Coverage Duration
Through end of benefit year

Other Criteria

Drugs
ENTRESTO

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria
Use of Entresto with an Angiotensin Converting Enzyme (ACE) Inhibitor or an ACE Inhibitor-Containing Product. Use of Entresto with an Angiotensin II Receptor Blocker (ARB) or an ARB-Containing Product. Use of Entresto with Tekturna® (aliskiren tablets) or a Tekturna-Containing Product in patients with diabetes.

Required Medical Information
Clinical documentation of FDA-approved indication for treatment AND the patient has a left ventricular ejection fraction (LVEF) less than or equal to 40% prior to initiation of Entresto.

Age Restriction
18 years and older.

Prescriber Restriction
Cardiologist

Coverage Duration
Through end of benefit year

Other Criteria

Drugs
EPCLUSA ORAL TABLET 400-100 MG

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

Exclusion Criteria
Current alcohol, drug use or reinfection after 3 months of successful treatment. Alcohol urine metabolite and drug screen required.

Required Medical Information
Provider must submit medical records documenting the diagnosis of chronic hepatitis C with genotype and subtype, if applicable (i.e., genotypes 1, 2, 3, 4, 5, or 6) AND submit medical records documenting viral load taken within 6 months of beginning therapy, AND submit medical records documenting F2-F4 fibrosis with a fibrosis score of 0.48 and up or be a documented health Care worker in direct patient care setting.

Age Restriction
18 years of age and older

Prescriber Restriction
Prescribed by, or in consultation with, a gastroenterologist, hepatologist, or infectious disease physician.

Coverage Duration
12 weeks or as defined by current AASLD/IDSA guidance.

Other Criteria
Mavyret, generic Ledipasvir/Sofosbuvir, or generic Sofosbuvir/Velpatasvir must be tried first in patients with chronic hepatitis C. Criteria and coverage durations will be applied consistent with current AASLD/IDSA guidance. Must have contraindication to or be unable to tolerate Mavyret, generic Ledipasvir/Sofosbuvir, and generic Sofosbuvir/Velpatasvir.

Drugs
EPIDIOLEX

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

Exclusion Criteria

Required Medical Information
Documentation of the following A) diagnosis of seizures associated with Lennox-Gastaut syndrome (LGS)or seizures associated with Dravet syndrome (DS): AND B) normal serum transaminases (ALT and AST) and total bilirubin levels: AND C) inadequate treatment response, intolerance, or contraindication to TWO generic antiepileptic medications (i.e. clobazam, Valproic acid, Lamotrigine, Levetiracetam, Topiramate, etc.)

Age Restriction
2 years of age or older

Prescriber Restriction

Coverage Duration
Through end of benefit year

Other Criteria
Dosing is within the FDA labeled dose of up to 20mg/kg/day.

Drugs
EPIVIR HBV ORAL SOLUTION

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction
3 months of age or older

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
abacavir-lamivudine, **EPZICOM**

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria
Documented negative HLA-B*5701 screening.

Drugs
ERLEADA

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

Exclusion Criteria

Required Medical Information
Documented diagnosis of non-metastatic, castration-resistant prostate cancer (NM-CRPC).

Age Restriction

Prescriber Restriction

Coverage Duration
3 Months

Other Criteria

Drugs
ERTACZO

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction
12 years and older.

Prescriber Restriction

Coverage Duration
4 weeks

Other Criteria
Failure to generic topical antifungal medications.

Drugs
ESBRIET

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

Exclusion Criteria

Required Medical Information
The patient has a diagnosis of idiopathic pulmonary fibrosis confirmed by a high resolution CT scan or biopsy AND the patient does not have evidence or suspicion of an alternative interstitial lung disease diagnosis AND liver function tests have been performed prior to start of therapy and base line PFTs provided.

Age Restriction

Prescriber Restriction
Prescribed by or in consultation with a pulmonologist

Coverage Duration
Through benefit year

Other Criteria
For renewal, patient experienced stabilization from baseline or a less than 10 percent decline in force vital capacity AND the patient has not experienced AST or ALT elevations greater than 5 times the upper limit of normal or greater than 3 times the upper limit of normal with signs or symptoms of severe liver damage.

Drugs
EVENITY

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

Exclusion Criteria

Required Medical Information
Diagnosis of Osteoporosis in a postmenopausal female AND one or more of the following: 1) History of osteoporotic fracture, or 2) Documented trial and failure of bisphosphonate or 3) Documented contraindication or intolerance to bisphosphonate therapy. Patient has not received more than 1 year of therapy with Evenity.

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria

Drugs
AKYNZEO (FOSNETUPITANT) INTRAVENOUS RECON SOLN, **AKYNZEO (NETUPITANT)**, **ALECENSA**, **ALUNBRIG ORAL TABLET 180 MG, 30 MG, 90 MG**, **ALUNBRIG ORAL TABLETS,DOSE PACK**, **BOSULIF ORAL TABLET 100 MG, 400 MG, 500 MG**, **CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG**, **COMETRIQ ORAL CAPSULE 100 MG/DAY(80 MG X1-20 MG X1), 140 MG/DAY(80 MG X1-20 MG X3), 60 MG/DAY (20 MG X 3/DAY)**, **COTELLIC**, **ERIVEDGE**, **FARYDAK**, **GILOTRIF**, **GLEOSTINE ORAL CAPSULE 10 MG, 100 MG, 40 MG**, **HYCAMTIN**, **ICLUSIG ORAL TABLET 15 MG, 45 MG**, **IDAMYCIN PFS**, **INLYTA**, **IRESSA**, **LONSURF**, **MEKINIST ORAL TABLET 0.5 MG, 2 MG**, **NINLARO**, **ODOMZO**, **ROZLYTREK ORAL CAPSULE 100 MG, 200 MG**, **RUBRACA**, **RYDAPT**, **SANCUSO**, **STIVARGA**, **TAGRISSO ORAL TABLET 40 MG, 80 MG**, **TOPOSAR**, **VALCHLOR**, **VARUBI**, **VENCLEXTA**, **VENCLEXTA STARTING PACK**, **XERMELO**, **ZEJULA**, **ZELBORAF**, **ZYKADIA ORAL TABLET**

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

Exclusion Criteria

Required Medical Information
Documentation that the medication would be used for an FDA approved indication.

Age Restriction

Prescriber Restriction
Oncologist

Coverage Duration
12 months

Other Criteria
For authorization, please submit to EviCore at evicore.com or call at 877-825-7722.

Drugs
EVOTAZ

Covered Uses
All FDA-approved indications not otherwise excluded from Health Plan

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
EXJADE

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria
Creatinine clearance less than 40 mL/minute. Platelet count less than 50 x 109/L. Poor performance status. Severe (Child-Pugh class C) hepatic impairment. High-risk myelodysplastic syndromes. Advanced malignancies. Gastrointestinal ulceration or hemorrhage.

Required Medical Information
Medical documentation of FDA approved diagnosis, serum ferritin levels and serum creatinine.

Age Restriction
2 years of age or older for chronic iron overload due to transfusions. 10 years of age or older for chronic iron overload due to NTDT.

Prescriber Restriction

Coverage Duration
3 months

Other Criteria

Drugs
FANAPT ORAL TABLET, **FANAPT ORAL TABLETS,DOSE PACK**

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Documentation of diagnosis and treatment history.

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria
Approve if member has tried two following drugs: aripiprazole, clozapine, olanzapine, risperidone, quetiapine, ziprasidone

Drugs
FASENRA PEN

Covered Uses

Exclusion Criteria

Required Medical Information
Documentation that the patient has asthma with an eosinophilic phenotype defined as blood eosinophils greater than or equal to 300 cells/μL within previous 12 months or greater than or equal to 150 cells/μL within 6 weeks of dosing AND medication will be used in combination with a corticosteroid inhaler and long acting beta2-agonist AND Patient must have experienced two or more exacerbations in the previous year OR require daily oral corticosteroids

Age Restriction

Prescriber Restriction

Coverage Duration
6 months

Other Criteria

Drugs
fentanyl citrate buccal lozenge on a handle

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria
Coverage not provided in the management of acute or postoperative pain (including headache/migraines), opiod non-tolerant patients, patients with known intolerance or hypersensitivity to the drug or fentanyl.

Required Medical Information
Diagnosis of cancer AND 1. Use is for breakthrough cancer pain, AND 2. Patient is opioid tolerant and taking at least 60 mg morphine/day, at least 25 mcg transdermal fentanyl/hour, at least 30 mg of oxycodone daily, at least 8 mg oral hydromorphone daily or an equianalgesic dose of another opioid for a week or longer, AND 3. Other formulary short-acting strong narcotic analgesic alternatives (other than fentanyl) have been ineffective, not tolerated, or contraindicated, AND 4. Prescriber is registered in the Transmucosal Immediate Release Fentanyl (TIRF) Risk Evaluation and Mitigation Strategy Access program.

Age Restriction
16 years or older

Prescriber Restriction
Prescribed by an oncologist or pain specialist.

Coverage Duration
3 months

Other Criteria
Patient must have tried and failed or not responded to the following formulary short-acting narcotics, Oxycodone and morphine. Available only to those enrolled in the Transmucosal Immediate Release Fentanyl (TIRF) EMS Program.

Drugs
FERRIPROX ORAL TABLET 500 MG

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria
Any pertinent clinical situation as defined by the product label that could affect patient safety and/or therapeutic efficacy (i.e. contraindications, warnings, precautions, adverse effects, renal or hepatic function, drug interactions, lab values, required prior or concomitant therapy, inappropriate dosing and/or duration, etc).

Required Medical Information
Diagnosis of transfusional iron overload due to thalassemia syndromes AND patient has failed prior chelation therapy with Desferal or Exjade (failure is defined as a serum ferritin level greater than 2,500 mcg/L) or patient has a contraindication or intolerance to Desferal or Exjade AND Patient has an absolute neutrophil count greater than 1.5 x 109/L.

Age Restriction

Prescriber Restriction
Prescribed by a hematologist/oncologist or hepatologist

Coverage Duration
Per treatment

Other Criteria
For renewal, patient has experienced at least a 20% reduction in serum ferritin levels and has an absolute neutrophil count greater than 0.5 x 109/L

Drugs
FINTEPLA

Covered Uses

Exclusion Criteria

Required Medical Information
Patients had a clinical diagnosis of Dravet syndrome and seizures that were inadequately controlled on at least 1 antiepileptic drug (AED) OR treatment including vagal nerve stimulation OR ketogenic diet.

Age Restriction
Children 2 and older

Prescriber Restriction

Coverage Duration
Through end of benefit year

Other Criteria

Drugs
ICATIBANT

Covered Uses
All FDA-approved indications not otherwise exluded for part D

Exclusion Criteria

Required Medical Information
Documentation of clinical diagnosis of hereditary angioedema or C1 inhibitor deficiency and having angioedema attacks.

Age Restriction

Prescriber Restriction
Must be prescribed by an allergist, immunologist, hematologist, or a physician that specializes in the treatment of HAE or related disorders.

Coverage Duration
3 months

Other Criteria

Drugs
FIRDAPSE, **RUZURGI**

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

Exclusion Criteria
Member has a history of seizures

Required Medical Information
The diagnosis has been confirmed by one of the following: A) Presence of anti-P/Q-type voltage-gated calcium channel (VGCC) antibodies OR B) Characteristic electromyography (EMG).

Age Restriction

Prescriber Restriction
Neurologist

Coverage Duration
Through the benefit year

Other Criteria

Drugs
fondaparinux subcutaneous syringe 10 mg/0.8 mL, 2.5 mg/0.5 mL, 5 mg/0.4 mL, 7.5 mg/0.6 mL

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria
CrCl (EGFR) less than 30mL/min. Patient's weight less than 50kg.

Required Medical Information
Clinical documentation of FDA approved indication for treatment. Patient's weight and creatinine clearance (CrCl).

Age Restriction
18 years and older.

Prescriber Restriction

Coverage Duration
Per treatment. Post-op DVT prophylaxis 1. hip/knee replacement max of 35 days. 2. abdominal surgery

Other Criteria

Drugs
FORTEO

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria
Because of an increased incidence of osteosarcoma, Forteo should not be prescribed for patients who are at increased baseline risk for osteosarcoma (including those with Paget's disease of bone or unexplained elevations of alkaline phosphatase, open epiphyses, or prior radiation therapy involving the skeleton).

Required Medical Information
Approve the following: 1. Treatment of postmenopausal women with osteoporosis at high risk for fracture OR 2. Increase of bone mass in men with primary or hypogonadal osteoporosis at high risk for fracture, AND member meets the following criteria: a. fracture OR b. BMD screening results of -2.5 or below OR c. previously failure / contraindication / intolerance of an oral bisphosphonate AND Prolia 3. Treatment of men and women with osteoporosis associated with sustained systemic glucocorticoid therapy at high risk for fracture, AND member meets the following criteria: a. previous fracture, OR b. multiple risk factors for fracture, OR c. previous failure/contraindication/intolerance of the following: oral bisphosphonate AND Prolia. Patient has not received more than 2 years of therapy with Forteo.

Age Restriction

Prescriber Restriction

Coverage Duration
For initial therapy up to 1 year. Continuation up to 1 year not to exceed 2 years of total therapy.

Other Criteria
Treatment failure is defined as documented continued bone loss after at leaast three months despite treatment with a bisphosphonate or Prolia. Note: Since the effects of long-term treatment with teriparatide are not known at this time, therapy for more than 2 years duration is considered experimental and investigational.

Drugs
FUZEON SUBCUTANEOUS RECON SOLN

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria
For treatment-experienced patients.

Drugs
FYCOMPA ORAL SUSPENSION, **FYCOMPA ORAL TABLET 10 MG, 12 MG, 2 MG, 4 MG, 6 MG, 8 MG**

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
GENVOYA

Covered Uses
All FDA-approved indications not otherwise excluded from Health Plan

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
GILENYA ORAL CAPSULE 0.5 MG

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria
Recent (within the last 6 months) occurrence of: myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, or Class III/IV heart failure. History or presence of Mobitz Type II 2nd degree or 3rd degree AV block or sick sinus syndrome, unless patient has a pacemaker. Baseline QTc interval greater than or equal to 500 ms. Receiving concurrent treatment with Class Ia or Class III anti-arrhythmic drugs (quinidine, procainamide, amiodarone, sotalol). Treatment of primary progressive MS is not covered. Combination therapy with a beta interferon product, Gilenya, Aubagio, Tecfidera, Tysabri or Copaxone is not covered.

Required Medical Information
Diagnosis of a relapsing form of multiple sclerosis or diagnosis of first clinical episode with MRI features consistent with MS AND Patient will be observed for signs and symptoms of bradycardia in a controlled setting for at least 6 hours after the first dose.

Age Restriction

Prescriber Restriction
Prescribed by or in consultation with a neurologist or MS specialist.

Coverage Duration
Plan year

Other Criteria
In patients with relapsing forms of MS, Avonex, Copaxone, and Tecfidera must be tried before any other formulary agent will be approved.

Drugs
OMNITROPE

Covered Uses
All FDA approved indications not otherwise excluded by Health Plan. Additional off-label coverage is provided for (note - some growth hormone drugs may be labeled for 1 or more of these indications): adult growth hormone deficiency, growth failure in children small for gestational age or with intrauterine growth retardation, idiopathic short stature, GH deficiency associated with Turner Syndrome, growth failure secondary to chronic renal failure/insufficiency in children who have not received a renal transplant, short stature associated with Noonan Syndrome, short bowel syndrome, and for the treatment of Prader-Willi Syndrome.

Exclusion Criteria
Coverage is not provided for constitutional delayed growth

Required Medical Information
Pediatric GHD: epiphyses must be confirmed open in patients 10 years of age and older, AND 1. diagnosis confirmed by any 2 provocative tests or by both low IGF-1 and IGFBP-3 levels in patients who meet the height related conditions of coverage, 2. diagnosis confirmed by 2 provocative tests and both low IGF-1 and IGF-BP3 in patients not meeting height related coverage conditions, or 3. 3 pituitary hormone deficiencies in pt with irreversible hypothalamic-pituitary structural lesions or panhypopituitarism. Growth failure from CRF: PGHD criteria must be met without the provocative tests or IGF-1 and IGF-BP3 related conditions. Idiopathic Short Stature: epiphyses must be confirmed as open in patients greater than or equal 10 years of age, height must be less than or equal - 2.25 sds from the mean. Small for Gestational Age: failure to manifest catch up growth by age 2 defined as birth weight, birth length, or both that are more than 2 sds mean normal values following adjustment for age and gender. Turner's syndrome and Noonan Syndrome: epiphyses must be confirmed as open and when on therapy. Adult GHD: requires either 1. a negative GH provocative test when the AGHD is due to childhood onset GHD, pituitary or hypothalamic disease, surgery or radiation therapy, or trauma, OR 2. 3 pituitary hormone deficiencies and baseline serum IGF-I levels below the age- and sex-appropriate reference range when the AGHD is due to irreversible hypothalamic-pituitary structural lesions or panhypopituitarism not acquired as a child, OR 3. 3 pituitary hormone deficiencies if adult panhypopit or irreversible hypothalamic-pituitary structural lesions are from childhood. Short bowel syndrome: when receiving specialized nutritional support.

Age Restriction
7 years of age or older for Idiopathic short stature

Prescriber Restriction
Pediatric endocrinologist for ISS

Coverage Duration
1 month for short bowel syndrome, 12 months for other indications

Other Criteria
Height related conditions of coverage: 1. height below the third percentile for their age and gender related height, 2. growth velocity subnormal greater than or equal 2 standard deviations (sds) from the age related mean, 3. delayed skeletal maturation greater than or equal 2 sds below the age/gender related mean. Renewals for PGHD, CFR, SGA, Turner's and Noonan Syndromes require growth response of greater than or equal 4.5 cm/yr (pre-pubertal) or greater than or equal 2.5 cm/yr (post-pubertal) AND open epiphyses. For pediatric patients with irreversible hypothalamic-pituitary structural lesions or panhypopituitarism coverage is renewable if the patient has had 3 pituitary hormone deficiencies. Renewals for short bowel syndrome is provided in the presence of clinical benefit (such as, decreasing the patient?s intravenous nutritional requirements). Renewals for Prader-Willi syndrome is provided if pt has increase in lean body mass or decrease in fat mass. Renewals for ISS is provided in the presence of a growth response of greater than or equal 1.5 cm/yr AND open epiphyses. Renewals for AGHD is provided in the presence of clinical benefit (e.g., increase in total lean body mass, increase in IGF-1 and IGFBP-3 levels, or increase in exercise capacity).

Drugs
HARVONI ORAL TABLET 90-400 MG

Covered Uses
All FDA-approved indications not otherwise excluded from Health Plan.

Exclusion Criteria
1. Active IV drug users, 2. Active alcohol users, 3. Reinfection after 6 months cure

Required Medical Information
For initial authorization (12 weeks maximum), provider must submit completed HCV Tx form, medical records documenting the diagnosis of chronic hepatitis C with genotype and subtype, if applicable, medical records documenting viral load taken within 6 months of beginning therapy AND submit medical records documenting advanced fibrosis as corresponding to a FibroSure or a Liver Biopsy proven. Other fibrosis scores, physical findings, or clinical evidence consistent with cirrhosis as attested by the prescribing physician may be also considered. For any retreatment or extension of PA, 100% compliance will be required (Claim hx). Urine alcohol metabolite and drug screen required.

Age Restriction
Patient must be 18 years of age or older

Prescriber Restriction
Prescribed by, a gastroenterologist, hepatologist, or infectious disease physician.

Coverage Duration
Based on the AASLD treatment guidelines

Other Criteria
Criteria and coverage durations will be applied consistent with current AASLD/IDSA guidance. Documentation of F2-F4 fibrosis (fibrosis score of 0.48 and greater) or patient is Health Care worker in direct patient care setting. Must have contraindication to or be unable to tolerate Mavyret, generic Ledipasvir/Sofosbuvir, and generic Sofosbuvir/Velpatasvir.

Drugs
HERCEPTIN HYLECTA

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

Exclusion Criteria

Required Medical Information
Documentation of 1) HER2 overexpressing node positive or node negative breast cancer as part of a treatment regimen consisting of a) doxorubicin, cyclophosphamide, and either paclitaxel or docetaxel or b)docetaxel and carboplatin or c) as a single agent following multi-modality anthracycline based therapy OR 2)HER2-overexpressing metastatic breast cancer either a) in combination with paclitaxel for first-line treatment or b) as a single agent for patients who have received one or more chemotherapy regimens for metastatic disease.

Age Restriction

Prescriber Restriction
Oncology

Coverage Duration
3 months

Other Criteria

Drugs
HORIZANT

Covered Uses
All FDA-approved indications not otherwise excluded from Health Plan

Exclusion Criteria

Required Medical Information
Documented diagnosis of postherpetic neuralgia (PHN) and trial of gabapentin, or diagnosis of moderate to severe primary restless legs syndrome (RLS) in adults and trial of ropinirole and pramipexole.

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
HUMIRA PEN, **HUMIRA PEN CROHNS-UC-HS START**, **HUMIRA PEN PSOR-UVEITS-ADOL HS**, **HUMIRA SUBCUTANEOUS SYRINGE KIT 10 MG/0.2 ML, 20 MG/0.4 ML, 40 MG/0.8 ML**, **HUMIRA(CF) PEDI CROHNS STARTER**, **HUMIRA(CF) PEN CROHNS-UC-HS**, **HUMIRA(CF) PEN PSOR-UV-ADOL HS**, **HUMIRA(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML, 80 MG/0.8 ML**, **HUMIRA(CF) SUBCUTANEOUS SYRINGE KIT 10 MG/0.1 ML, 20 MG/0.2 ML, 40 MG/0.4 ML**

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria
Tuberculosis (TB), or invasive fungal infections or other active seriousinfections, or history if recurrent infections. Individuals who have not had a tuberculin skin test or Center for Disease Control recommended equivalent to evaluate for latent tuberculosis prior to initiating treatmetn. Using in combination with other TNF antagonists,IL-1R antagonists, janus kinase inhibitor, anti-cd20 monoclonalantibodies or selective co-stimulation modulators.

Required Medical Information
Documentation of diagnosis, treatment history and TB evaluation. FDA-approved indications include Ankylosing Spondylitis (AS), Moderate to Severe Crohn's Disease (CD), Hidradenitis Suppurativa (HS), Polyarticular Juvenile Idiopathic Arthritis (PJIA), Plaque Psoriasis, Psoriatic Arthritis (PsA), Rheumatoid Arthritis (RA), Moderate to Severe Ulcerative Colitis (UC), Uveitis

Age Restriction
2 years of age or older for JIA. 6 years of age and older for pediatric Crohn's disease. 18 years of age or older for all other indications.

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria
APPROVE for AS if patient has had an inadequate response, intolerance or contraindication to one or more NSAIDs (e.g. ibuprofen, naproxen, meloxicam, celecoxib). APPROVE for HS if patient has had an inadequate response, intolerance or contraindication to one or more of the following: intralesional or oral corticosteroids, systemic antibiotics, isotretinoin. APPROVE for PJIA if patient has had an inadequate response, intolerance or contraindication to one or more non-biologic DMARDs (e.g., hydroxychloroquine [HCQ], sulfasalazine, MTX, leflunomide, azathioprine, cyclosporine) for at least 3 consecutive months. APPROVE for Plaque Psoriasis (affecting more than 5% of body surface area or affecting crucial body areas such as the hands, feet, face, or genitals) if patient has had an inadequate response, intolerance or contraindication to conventional therapy with to at least two of the following: phototherapy (including but not limited to Ultraviolet A with a psoralen [PUVA] and/or retinoids [RePUVA] for at least one continuous month or one or more oral systemic treatments (i.e. MTX, cyclosporine, acitretin, sulfasalazine) for at least 3 consecutive months. APPROVE for PsA if patient has had an inadequate response, intolerance, or contraindication to MTX. APPROVE for RA if patient has had inadequate response to, intolerance to, or contraindication to at least one non-biologic DMARD (e.g., HCQ, sulfasalazine, MTX, leflunomide, azathioprine, cyclosporine) for at least 3 consecutive months. APPROVE for Uveitis if patient has tried one of the following therapies: periocular, intraocular, or systemic corticosteroids, immunosuppressants (azathioprine, MTX, mycophenolate mofetil, cyclophosphamide, cyclosporine). Patient has been tested for TB and latent TB has been ruled out or is being treated. Dosing as per FDA approved labeling.

Drugs
IBRANCE

Covered Uses
All FDA-approved indications not otherwise excluded from Health Plan.

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
IDHIFA

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

Exclusion Criteria

Required Medical Information
1. Diagnosis of relapsed or refractory acute myeloid leukemia (AML) with an isocitrate dehydrogenase-2 (IDH2) mutation AND 2. Prescriber agrees to monitor for signs and symptoms of differentiation syndrome.

Age Restriction

Prescriber Restriction
Oncologist or Hematologist

Coverage Duration
Through the end of benefit year

Other Criteria

Drugs
imatinib oral tablet 100 mg, 400 mg

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Diagnosis of one of the following: A) Philadelphia chromosome-positive chronic myelogenous leukemia (Ph+ CML), or B) Ph+ acute lymphoblastic leukemia (ALL), or C) Gastrointestinal tumor (GIST) where patient has documented c-KIT (CD117) positive unresectable or metastatic malignant GIST or patient had resection of c-KIT positive GIST and imatinib will be used as an adjuvant therapy, or D) Dermatofibrosarcoma protuberans that is unresectable, recurrent, or metastatic, or E) Hypereosinophilic syndrome or chronic eosinophilic leukemia, or F) Myelodysplastic syndrome or myeloproliferative disease associated with platelet-derived growth factor receptor gene re-arrangements, or G) Aggressive systemic mastocytosis without the D816V c-KIT mutation or with c-KIT mutation or with c-KIT mutational status unknown.

Age Restriction
1 year of age or older - newly diagnosed CML in the chronic phase or newly diagnosed Ph+ ALL. 18 years of age or older for other indications.

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

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

Covered Uses
All FDA-approved indications not otherwise excluded from Health Plan.

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
3 Months

Other Criteria

Drugs
INBRIJA

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

Exclusion Criteria
patient is not currently taking or has recently (within 2 weeks) taken a nonselective monoamine oxidase (MAO) inhibitor (e.g., phenelzine and tranylcypromine)

Required Medical Information
Patient is currently treated with carbidopa/levodopa AND is experiencing intermittent OFF episodes secondary to Parkinson's disease

Age Restriction

Prescriber Restriction

Coverage Duration
3 months

Other Criteria
Reauthorization requires physician attestation of medications efficacy

Drugs
INCRELEX

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria
Insulin-like growth factor therapy is considered NOT medically necessary when any of the following criteria are met: Final adult height has been reached as determined by the 5th percentile of adult height OR the bone epiphyses are closed OR the patient is older than 18 years of age. Contraindicated in neonates, patients with closed epiphyses, and suspected neoplasia.

Required Medical Information
1. All of the following: a. Diagnosis of severe primary IGF-1 deficiency. b. Height standard deviation score of -3.0 or less. c. Basal IGF-1 standard deviation score of -3.0 or less. d. Normal or elevated growth hormone. e. Open finger epiphyses on last boneradiograph GH gene deletion: a. Diagnosis of growth hormone gene deletion who have developed neutralizing antibodies to GH, AND b. Have open finger epiphyses on last bone radiograph.

Age Restriction
The patient is between 2 years -18 years old for Increlex therapy

Prescriber Restriction
Must be endocrinologist to prescribe

Coverage Duration
6 months to 1 year

Other Criteria
Not a substitute for GH treatment. For renewal, Patient had a minimum growth rate of at least 2 cm/year.

Drugs
INREBIC

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

Exclusion Criteria
Patients on treatment with ruxolitinib before initiation must taper and discontinue according to ruxolitinib prescribing information

Required Medical Information
Must provide labs showing patient is not thiamine deficient before starting drug

Age Restriction
18 years of age and older

Prescriber Restriction
Oncologist or Hematologist

Coverage Duration
3 months

Other Criteria

Drugs
INTELENCE ORAL TABLET 100 MG, 200 MG, 25 MG

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria
For treatment-experienced patients.

Drugs
INTRON A INJECTION

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Type B viral Hepatitis (HBeAg positive): Serum HBsAg positive for at least six months, AND elevated serum ALT 2 times ULN or moderate to severe hepatitis or fibrosis on biopsy. Type B Viral Hepatitis (HBeAg negative) HBsAG positive for at least 6 months AND BHV DNA level of 2000 IU/ml or more than 11,200 copies/ml AND One of the following, persistent ALT 2 times UNL or moderate to severe hepatitis or fibrosis on biopsy. Documentation must be provided showing trial and failure to our preferred agent Peg-Intron. Chronic Hepatitis C: Positive HCV antibody and HCV RNA. Documentation must be provided showing trial and failure to our preferred agent Peg-Intron. Condyloma Acuminatum or Perianal Warts: Must have documentation of trial and failure to preferred alternative or intolerance/contraindication to preferred alternatives. For external perianal warts, condylox gel, for external genital warts, podofilox, or imiquimod. Hairy Cell Leukemia: Medical documentation indicating diagnosis. Malignant Melanoma: Indicated as adjuvant to surgical treatment with malignant melanoma who are free of disease but at high risk for systemic recurrence, within 56 days of surgery. Follicular Lymphoma: Indicated for the initial treatment of clinically aggressive follicular Non-Hodgkins Lymphoma in conjunction with anthracycline-containing combination chemotherapy. Efficacy in patients with low-grade, low-tumor burden follicular Non-Hodgkins Lymphoma has not been demonstrated. AIDS-Related Kaposis Sarcoma: Indicated for the treatment of selected patients. The likelihood of response to therapy is greater in patients who are without systemic symptoms, who have limited lymphadenopathy and who have a relatively intact immune system as indicated by total CD4 count.

Age Restriction
For Hepatitis B- age 1 or older, For Hepatitis C - age 3 or older, All other diagnoses- 18 years or older.

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
INVEGA SUSTENNA, *paliperidone oral tablet extended release 24hr 1.5 mg, 3 mg, 6 mg, 9 mg*

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Diagnosis of Schizophrenia AND documented treatment failure or intolerable side effects from treatment with two formulary antipsychotic medications such as risperidone, ziprasidone,

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
INVIRASE ORAL TABLET

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria
Pretreatment EKG should be done and therapy is NOT to be initiated if QT interval exceeds 450 msec. Must be used in combination with ritonavir.

Drugs
ISENTRESS HD, **ISENTRESS ORAL POWDER IN PACKET**, **ISENTRESS ORAL TABLET**, **ISENTRESS ORAL TABLET,CHEWABLE**

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
ISTURISA ORAL TABLET 1 MG, 10 MG, 5 MG

Covered Uses

Exclusion Criteria

Required Medical Information
Diagnosis of Cushing disease: Treatment of Cushing disease in adults for whom pituitary surgery is not an option or has not been curative.

Age Restriction

Prescriber Restriction

Coverage Duration
Through end of benefit year

Other Criteria

Drugs
itraconazole oral capsule

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
3 months

Other Criteria
For onychomycosis - must have documented failure, intolerance or contraindication to terbinafine.

Drugs
GAMMAGARD LIQUID

Covered Uses
All medically accepted indications not otherwise excluded by Health Plan, chronic inflammatory demyelinating polyneuropathy, multifocal motor neuropathy, dermatomyositis, polymyositis, Guillain-Barre syndrome (GBS), relapsing-remitting multiple sclerosis (RRMS), myasthenia gravis, Lambert-Eaton myasthenic syndrome, Kawasaki syndrome, idiopathic thrombocytopenic purpura, pure red cell aplasia (PRCA), fetal/neonatal alloimmune thrombocytopenia, and prophylaxis of bacterial infections in B-cell chronic lymphocytic leukemia (CLL), bone marrow/hematopoietic stem cell transplant (BMT/HSCT) recipients, and pediatric HIV infection.

Exclusion Criteria
IgA deficiency with antibodies to IgA and a history of hypersensitivity. History of anaphylaxis or severe systemic reaction to human immune globulin or product components.

Required Medical Information
Documentation of diagnosis and previous treatment. For dermatomyositis and polymyositis: standard 1st line treatments (corticosteroids or immunosuppressants) have been tried but were unsuccessful or not tolerated OR patient is unable to receive standard therapy because of a contraindication or other clinical reason. For GBS: physical mobility must be severely affected such that the patient requires an aid to walk AND IVIG therapy must be initiated within 2 weeks of symptom onset. For RRMS: standard 1st line treatments (e.g. interferon, glatiramer, dimethyl fumarate) have been tried but were unsuccessful or not tolerated OR patient is unable to receive standard therapy because of a contraindication or other clinical reason. For CLL: serum IgG less than 500 mg/dL OR a history of recurrent bacterial infections. For BMT/HSCT: serum IgG less than 400 mg/dL. For pediatric HIV infection: serum IgG less than 400 mg/dL OR a history of recurrent bacterial infections. PRCA is secondary to parvovirus B19 infection. For all indications: patients with any of the following risk factors for renal dysfunction must receive the minimum dose or concentration available of IVIG and the minimum infusion rate practicable: pre-existing renal insufficiency, diabetes mellitus, age over 65 years, volume depletion, sepsis, paraproteinemia, or receiving concomitant nephrotoxic drugs. For all indications: patients with any of the following risk factors for thrombosis must receive the minimum dose or concentration available of IVIG and the minimum infusion rate practicable: age 45 years or older, prolonged immobilization, hypercoagulable conditions, history of venous or arterial thrombosis, use of estrogens, indwelling central vascular catheters, hyperviscosity, or cardiovascular risk factors.

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Statement of diagnosis for treatment of patients with intermediate or highrisk myelofibrosis, including primary myelofibrosis, post-polycythemia vera myelofibrosis and post-essential thrombocythemia myelofibrosis and lab work indicating a complete blood count and platelet count before initiating therapy and recent lab work indicating complete blood count and platelet count for a dosage adjustment. Lab work must indicate platelets are more than 50 x 109/L and dose must be less than 50 mg per day. No dose increases will be approved within 4 weeks of therapy and not more frequently than every 2 weeks. If no spleen reduction or symptom improvement after 6 months then discontinue the drug.

Age Restriction
18 years or older

Prescriber Restriction
Myelofibrosis: Prescribed by a Hematologist/Oncologist

Coverage Duration
3 months

Other Criteria

Drugs
JYNARQUE ORAL TABLETS, SEQUENTIAL 45 MG (AM)/ 15 MG (PM), 60 MG (AM)/ 30 MG (PM), 90 MG (AM)/ 30 MG (PM)

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

Exclusion Criteria

Required Medical Information
Medication requested is being used to slow kidney function decline AND Liver function laboratory values (ALT, AST and bilirubin) have been reviewed and are appropriate before initiation.

Age Restriction
Patient is 18 years of age or older

Prescriber Restriction

Coverage Duration
Initial Authorization will be for 3 months. Reauthorization will be for 1 year.

Other Criteria

Drugs
KALETRA

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
KALYDECO ORAL GRANULES IN PACKET 50 MG, 75 MG, KALYDECO ORAL TABLET

Covered Uses
All FDA-approved indications not otherwise excluded from Health Plan.

Exclusion Criteria

Required Medical Information
Medical documentation of cystic fibrosis AND member has a G551D, G1244E, G1349D, G178R, G551S, R117H, S1251N, S1255P, S549N, or S549R mutation in the CFTR gene AND member does not have a Homozygous F508del mutation in CFTR gene.

Age Restriction
Ivacaftor oral granules are approved in patients 2 years of age and older. Ivacaftor oral tablets are approved in patients 6 years of age and older.

Prescriber Restriction
Endocrinologist or Pulmonologist

Coverage Duration
Plan year

Other Criteria

Drugs
KESIMPTA PEN

Covered Uses

Exclusion Criteria

Required Medical Information
Diagnosis of relapsing forms of multiple sclerosis (relapsing-remitting MS or progressive-relapsing MS, or secondary-progresive MS)

Age Restriction

Prescriber Restriction

Coverage Duration
Through end of benefit year

Other Criteria

Drugs
KISQALI, **KISQALI FEMARA CO-PACK**

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

Exclusion Criteria

Required Medical Information
Documentation that the member has tried and failed or has a contraindication to Ibrance.

Age Restriction

Prescriber Restriction

Coverage Duration
Through end of benefit year

Other Criteria

Drugs
KOSELUGO ORAL CAPSULE 10 MG, 25 MG

Covered Uses

Exclusion Criteria

Required Medical Information
Documentation that the member has neurofibromatosis type 1 (NF1) who have symptomatic, inoperable plexiform neurofibromas (PN).

Age Restriction

Prescriber Restriction
Oncologist

Coverage Duration
3 months

Other Criteria

Drugs
KUVAN ORAL TABLET,SOLUBLE

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information

Age Restriction
1 month and older

Prescriber Restriction

Coverage Duration
Initial: 2 months. Renewal: through plan year

Other Criteria
For initial approval, Patient will have phenylalanine levels measured one week after starting therapy and periodically for up to two months of therapy to determine response. For renewal, patient has been determined to be a responder to therapy (i.e. phenylalanine levels have decreased by at least 30% from baseline) and phenylalanine levels will be measured periodically during therapy.

Drugs
lamivudine oral solution, *lamivudine oral tablet 100 mg, 150 mg, 300 mg*

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
LEDIPASVIR-SOFOSBUVIR

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

Exclusion Criteria

Required Medical Information
Provider must submit medical records documenting the following: 1) medical diagnosis of Chronic Hepatitis C with labs documenting genotype and subtype, AND 2) medical records documenting viral load taken within 6 months of beginning therapy, AND 3) fibrosis score to confirm appropriate duration of treatment, AND 4) documentation of previous HCV therapies to confirm appropriate duration of treatment.

Age Restriction
Patient must be 12 years of age or older

Prescriber Restriction
Prescribed by, a gastroenterologist, hepatologist, or infectious disease physician.

Coverage Duration
12 to 24 weeks based on the AASLD treatment guidelines

Other Criteria
Criteria and coverage durations will be applied consistent with current AASLD/IDSA guidance.

Drugs
LENVIMA

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Through benefit year

Other Criteria

Drugs
ambrisentan, **LETAIRIS**

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria
Known or suspected pregnancy. Treat women of child-bearing potential only after a negative pregnancy test and treat only women who are using two reliable methods of contraception OR have had a tubal sterilization OR a Copper T 380A IUD or LNg 20 IUD inserted.

Required Medical Information
Diagnosis of Pulmonary Arterial Hypertension (PAH) AND pregnancy must be excluded prior to the start of therapy and will be prevented thereafter with two forms of reliable contraception in female patients of reproductive potential. Trial and failure of Revatio or Adcirca.

Age Restriction
18 years and older

Prescriber Restriction

Coverage Duration
3 months

Other Criteria

Drugs
LEUKINE INJECTION RECON SOLN

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria
Chemotherapy or radiotherapy within 24 hours or concomitantly, excess leukemic myeloid blasts in the bone marrow or blood (10% or greater), hypersensitivity to granulocyte-macrophage colony-stimulating factor (GM-CSF) or yeast-derived products, allergic or anaphylactoid reactions to the medication in the past.

Required Medical Information
Medical statement indicating diagnosis AND trial and failure of preferred agent neupogen AND Absolute Neutrophil Count less than 10,000/mm3 and CBC with differential.

Age Restriction
Patients requiring prophylaxis of febirle neutropenia in acute myelogenous leukemia following induction chemotherapy must be at least 55 years of age, other diagnoses do not specify an age restriction

Prescriber Restriction
Oncologist or Hematologist

Coverage Duration
Plan year

Other Criteria

LEUPROLIDE INJECTION SOLUTION

Drugs
leuprolide

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria
Pregnancy in patients with child-bearing potential. Breastfeeding. Undiagnosed abnormal vaginal bleeding.

Required Medical Information
Diagnosis of one of the following: A) Advanced or metastatic prostate cancer (7.5 mg 1-month, 22.5 mg 3-month, 30 mg 4-month, & 45 mg 6-month depots only), or B) Central precocious puberty (Lupron Depot-Ped) AND submission of pubertal gonadal sex steroid levels (testosterone greater than 30 ng/dL, estradiol greater than 20 pg/mL AND a pubertal LH increase upon native GnRH stimulation AND pelvic ultrasound assessment (girls) is required for approval along with notes indicating premature development of secondary sexual characteristics at or before the age of 8 yrs in girls and 9 yrs in boys and significant advancement of bone age and/or a poor adult height prediction AND other causes of sexual precocity must be excluded.

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
fosamprenavir, **LEXIVA**

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria
Any pertinent clinical situation as defined by the product label that could affect patient safety and/or therapeutic efficacy (i.e. contraindications, warnings, precautions, adverse effects, renal or hepatic function, drug interactions, lab values, required prior or concomitant therapy, inappropriate dosing and/or duration, etc).

Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

LIDOCAINE PRODUCTS

Drugs
lidocaine topical adhesive patch,medicated 5 %, *lidocaine topical ointment*

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
linezolid

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria
Patients that are currently myelosuppressed due to any cause

Required Medical Information
Culture and sensitivity reports verifying: 1. VRE infections within past 30 days. 2. Nosocomial pneumonia (MRSA) within past 30 days. 3. Nosocomial or CAP (MSSA or S. pneumoniae) within past 30 days and failure/resistance to 2 preferred antibiotics 4. Complicated SSI without osteomyelitis (MRSA) within past 30 days. 5. Uncomplicated SSI (MRSA) within past 30 days or empirical treatment of uncomplicated or community-acquired complicated SSI without osteomyelitis (MRSA likely) and failure/resistance to 2 preferred antibiotics. 6. Uncomplicated or complicated SSI without osteomyelitis (MSSA, S. pyogenes, or S. agalactiae (complicated SSI only)) within past 30 days and failure/resistance to 2 preferred antibiotics.

Age Restriction

Prescriber Restriction
Presribing physician must be an infectious disease specialist

Coverage Duration
Non-MRSA nosocomial or community acquired pneumonia, SSI: 14 days Other uses: 28 days

Other Criteria
Nosocomial or community acquired pneumonia (MSSA or S. pneumoniae) preferred antibiotics: Amoxicilin/Clavulanate, Azithromycin, Cephalexin, Clarithromycin, Levaquin. Uncomplicated SSI (MRSA) or empirical treatment of patients with uncomplicated or community-acquired complicated SSI without osteomyelitis (MRSA likely) preferred antibiotics: Trimethoprim/sulfamethoxazole, Tetracycline, Doxycycline, Minocycline, Clindamycin. Uncomplicated or complicated SSI without osteomyelitis (MSSA, S. pyogenes, or S. agalactiae (complicated SSI only)) preferred antibiotics: Amoxicillin/clavulanate, Cephalexin, Ciprofloxacin, Clindamycin, Levaquin, Trimethoprim/Sulfamethoxazole, Dicloxacillin.

Drugs
LOKELMA

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

Exclusion Criteria

Required Medical Information
Documentation of elevated serum potassium (greater than 5.0 mEq/L) and the beneficiary has failure, contraindication or intolerance to sodium polystyrene sulfonate oral suspension.

Age Restriction
18 years and older

Prescriber Restriction

Coverage Duration
6 months

Other Criteria

Drugs
LORBRENA ORAL TABLET 100 MG, 25 MG

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

Exclusion Criteria

Required Medical Information
Documentation of anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer (NSCLC) whose disease has progressed on one of the following: 1. crizotinib and at least one other ALK inhibitor for metastatic disease: or 2. alectinib as the first ALK inhibitor therapy for metastatic disease: or 3. ceritinib as the first ALK inhibitor therapy for metastatic disease.

Age Restriction

Prescriber Restriction
Oncology

Coverage Duration
3 months

Other Criteria

Drugs
LUPRON DEPOT, **LUPRON DEPOT (3 MONTH)**, **LUPRON DEPOT (4 MONTH)**, **LUPRON DEPOT (6 MONTH)**, **LUPRON DEPOT-PED**, **LUPRON DEPOT-PED (3 MONTH)**

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria
Pregnancy in patients with child-bearing potential. Breastfeeding. Undiagnosed abnormal vaginal bleeding.

Required Medical Information
Diagnosis of one of the following: A) Advanced or metastatic prostate cancer (7.5 mg 1-month, 22.5 mg 3-month, 30 mg 4-month, & 45 mg 6-month depots only), or B) Endometriosis (3.75 mg 1-month & 11.25 mg 3-month depots only) AND 1. For initial authorization, patient has had an inadequate pain control response or has an intolerance or contraindication to one of the following: Danazol or combination [estrogen/progesterone] oral contraceptives or progestins, or 2. For retreatment course, patient is experiencing recurrence of symptoms after an initial course of therapy with leuprolide acetate and norethindrone acetate 5 mg daily will be co-administered, or C) Anemia due to uterine Leiomyomata (Fibroids) (3.75 mg 1-month &11.25 mg 3-month depots only) AND patient is preoperative AND has tried and had an inadequate response to monotherapy with iron, or D) Central precocious puberty (Lupron Depot-Ped) AND submission of pubertal gonadal sex steroid levels (testosterone greater than 30 ng/dL, estradiol greater than 20 pg/mL AND a pubertal LH increase upon native GnRH stimulation AND pelvic ultrasound assessment (girls) is required for approval along with notes indicating premature development of secondary sexual characteristics at or before the age of 8 yrs in girls and 9 yrs in boys and significant advancement of bone age and/or a poor adult height prediction AND other causes of sexual precocity must be excluded.

Age Restriction

Prescriber Restriction
Oncologist, Endocrinologist, or Gynecologist to prescribe

Coverage Duration
Plan year

Other Criteria
For endometriosis and uterine fibroids, patient will be using nonhormonal contraception during and for 12 weeks after therapy.

Drugs
LYNPARZA ORAL TABLET

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

Exclusion Criteria

Required Medical Information
1. Documentation of deleterious germline BRCA mutated ovarian cancer AND 2. Documentation of at least 3 prior chemotherapy regimens that have been ineffective or not tolerated AND 3. Lynparza will be used as monotherapy.

Age Restriction

Prescriber Restriction

Coverage Duration
Through end of benefit year

Other Criteria

Drugs
MAKENA (PF), **MAKENA INTRAMUSCULAR OIL 250 MG/ML (1 ML)**

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

Exclusion Criteria

Required Medical Information
Clinical documentation of singleton pregnancy (i.e. one fetus) AND a history of singleton spontaneous preterm birth defined as delivery prior to 37 weeks gestation AND the pregnancy is between 16 weeks, 0 days and 20 weeks, 6 days gestation AND the requested dose and frequency is in accordance with FDA-approved labeling.

Age Restriction
16 years of age or older

Prescriber Restriction

Coverage Duration
coverage is provided until week 37 (through 36 weeks, 6 days) of gestation

Other Criteria

Drugs
MAVENCLAD (10 TABLET PACK), **MAVENCLAD (4 TABLET PACK)**, **MAVENCLAD (5 TABLET PACK)**, **MAVENCLAD (6 TABLET PACK)**, **MAVENCLAD (7 TABLET PACK)**, **MAVENCLAD (8 TABLET PACK)**, **MAVENCLAD (9 TABLET PACK)**

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

Exclusion Criteria
Individual with current malignancy OR human immunodeficiency virus (HIV) infection OR an active chronic infection (e.g., hepatitis or tuberculosis)

Required Medical Information
Documentation of diagnosis of relapsing multiple sclerosis, including relapsing-remitting disease or active secondary progressive disease AND the patient has had a trial and inadequate response or intolerance to at least one alternative drug indicated for the treatment of multiple sclerosis.

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria
Will only be approved for 2 treatment cycles.

Drugs
MAVYRET

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

Exclusion Criteria
For retreatment, patient was non-adherent to initial regimen as evidenced by medical record and/or pharmacy claims OR patient continues to engage in high risk behavior and experienced reinfection secondary to high risk behavior.

Required Medical Information
Provider must submit medical records documenting the following: 1) medical diagnosis of Chronic Hepatitis C with labs documenting genotype and subtype, AND 2) medical records documenting viral load taken within 6 months of beginning therapy, AND 3) documentation of previous HCV therapies to confirm appropriate duration of treatment. Authorization for retreatment requires the following: 1)Evidence of failure to achieve a sustained virologic response (SVR) or lack of efficacy during treatment (polymerase chain reaction (PCR) assay, 12 or more weeks after completing treatment or a 10-fold increase of viral load at week 6 of treatment) OR evidence of adverse event that required therapy discontinuation (Laboratory results and/or clinical presentation), AND 2) Member was adherent to previous therapy as evidenced by pharmacy claims, AND 3) Submission of psychological support/treatment for a minimum of six months for substance abuse related failure (i.e. NA, AA), AND 4)Patient has abstained from the use of illicit drugs and alcohol for a minimum of 3 months as evidenced by negative urine or blood confirmation tests, collected monthly for the past 90 days prior to initiation of therapy.

Age Restriction

Prescriber Restriction
Prescribed by, a gastroenterologist, hepatologist, or infectious disease physician.

Coverage Duration
based on the AASLD treatment guidelines

Other Criteria
Criteria and coverage durations will be applied consistent with current AASLD/IDSA guidance.

Drugs
MEKTOVI

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

Exclusion Criteria

Required Medical Information
Documentation of unresectable or metastatic melanoma with a BRAF V600E or V600K mutation, as detected by an FDA-approved test and that Mektovi will be used in combination with encorafenib.

Age Restriction

Prescriber Restriction
Oncology

Coverage Duration
3 months

Other Criteria

Drugs
MENEST

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria
Any pertinent clinical situation as defined by the product label that could affect patient safety and/or therapeutic efficacy (i.e. contraindications, warnings, precautions, adverse effects, renal or hepatic function, drug interactions, lab values, required prior or concomitant therapy, inappropriate dosing and/or duration, etc).

Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction
18 years and older

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria
For treatment of vaginal atrophy - must have documented failure, intolerance or contraindication to at least 1 formulary vaginal estrogen. (Estrace cream, Premarin cream, Vagifem tab)

Drugs
miglustat

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

Exclusion Criteria

Required Medical Information
Documentation of mild to moderate type 1 Gaucher disease AND patient is symptomatic (i.e. radiologic evidence of skeletal disease, platelet count less than 60,000 microL, liver greater than 2.5 times normal size, spleen greater than 15 times normal size) AND enzyme replacement therapy is not a therapeutic option (e.g. due to allergy, hypersensitivity, or poor venous access).

Age Restriction
18 years of age or older

Prescriber Restriction

Coverage Duration
3 Months

Other Criteria

Drugs
modafinil

Covered Uses
All FDA-Approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Documentation of diagnosis and prior therapies used

Age Restriction

Prescriber Restriction
Idiopathic hypersomnia-- approve if the diagnosis is confirmed by a sleep specialist physician or at an institution that specializes in sleep disorders (i.e., sleep center)

Coverage Duration
Plan year

Other Criteria

Drugs
MOVANTIK

Covered Uses
All FDA-approved indications not otherwise excluded from Health Plan

Exclusion Criteria
Known or suspected gastrointestinal obstruction and at increased risk of recurrent obstruction, due to the potential for gastrointestinal perforation. Concomitantly taking strong CYP3A4 inhibitors (e.g., clarithromycin, ketoconazole)

Required Medical Information
Documentation of diagnosis and treatment history.

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria
Approve if member has been taking an opioid for at least 4 weeks and has tried lifestyle changes (e.g. maintaining a diet rich in fiber and/or fiber supplementation along with adequate fluid intake) and has tried a bowel regimen of an osmostic laxative (e.g. PEG 3350) or a stimulant laxative (e.g. bisacodyl) with or without a stool softener (e.g. docusate).

Drugs
MULPLETA

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

Exclusion Criteria

Required Medical Information
Documentation that the medication will be used for the treatment of thrombocytopenia in adult patients with chronic liver disease who are scheduled to undergo a procedure and had a platelet count less than 50 × 10^9/L

Age Restriction

Prescriber Restriction

Coverage Duration
3 Months

Other Criteria

Drugs
NAGLAZYME

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
NERLYNX

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

Exclusion Criteria

Required Medical Information
NERLYNX is indicated for the extended adjuvant treatment of adult patients with early stage HER2-overexpressed/amplified breast cancer, to follow adjuvant trastuzumab based therapy.

Age Restriction

Prescriber Restriction
Oncologist

Coverage Duration
Through the end of benefit year

Other Criteria

Drugs
NEULASTA

Covered Uses
All FDA-approved indications not otherwise excluded from Health Plan.

Exclusion Criteria

Required Medical Information
Documentation of diagnosis.

Age Restriction

Prescriber Restriction

Coverage Duration
3 months and is renewable in situations where it continues to provide clinical benefit

Other Criteria

Drugs
NEUPOGEN

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction

Prescriber Restriction

Coverage Duration
Varies by indication.

Other Criteria

Drugs
nevirapine

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
NEXAVAR

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria
Combination use with other tyrosine kinase inhibitors such as sorafenib, sunitinib. Squamous cell lung cancer being treated with carboplatin and paclitaxel.

Required Medical Information
Diagnosis of one of the following: A) Advanced renal cell carcinoma, or B) Locally recurrent or metastatic, progressive, differentiated thyroid carcinoma refractory to radioactive iodine treatment, or C) Unresectable hepatocellular carcinoma.

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

Prescriber Restriction

Coverage Duration
Initial: 3 months, Renewal: through end of benefit year w/ stable disease

Other Criteria

Drugs
NEXLETOL

Covered Uses

Exclusion Criteria

Required Medical Information
Clinical documentation (e.g., chart notes, laboratory values) required for initial authorization includes: 1. Documentation of one of the following diagnoses: A) Primary Hyperlipidemia (Including Heterozygous Familial Hypercholesterolemia), OR B) Atherosclerotic cardiovascular disease (ASCVD), AND 2. Documentation of any one of the following: a) Patient has been receiving statin therapy at a maximally tolerated dose and (maximally tolerated dose may include no statin therapy) OR b) Patient has a documented labeled contraindication to all statins OR c) Patient has experienced rhabdomyolysis, AND 3. Patient has tried and failed ezetimibe. Clinical documentation required for reauthorization includes: 1. Physician attestation of medication's efficacy.

Age Restriction
18 years or older

Prescriber Restriction

Coverage Duration
Through end of benefit year

Other Criteria
Other Criteria: Primary Hyperlipidemia (Including Heterozygous Familial Hypercholesterolemia): The patient has a low-density lipoprotein cholesterol (LDL-C level) greater than or equal to 100 mg/dL. C) ASCVD: The patient has a low-density lipoprotein cholesterol (LDL-C) greater than or equal to 70 mg/dL (after treatment with antihyperlipidemic agents. ASCVD diagnosis is confirmed by one of the following: acute coronary syndromes, history of myocardial infarction, stable or unstable angina, coronary or other arterial revascularization, stroke, transient ischemic attack, peripheral arterial disease presumed to be of atherosclerotic origin.

Drugs
NEXLIZET

Covered Uses

Exclusion Criteria

Required Medical Information
Clinical documentation (e.g., chart notes, laboratory values) required for initial authorization includes: 1. Documentation of one of the following diagnoses: A) Heterozygous familial hypercholesterolemia, OR B) Atherosclerotic cardiovascular disease (ASCVD) established, AND 2. Documentation of any one of the following: a) Patient has been receiving statin therapy at a maximally tolerated dose (maximally tolerated dose may include no statin therapy), OR b) Patient has a documented labeled contraindication to all statins, OR c) Patient has experienced rhabdomyolysis. Clinical documentation required for reauthorization includes: 1. Physician attestation of medication's efficacy.

Age Restriction
18 years and older.

Prescriber Restriction

Coverage Duration
Through end of benefit year

Other Criteria
Other Criteria: Primary Hyperlipidemia (Including Heterozygous Familial Hypercholesterolemia): The patient has a low-density lipoprotein cholesterol (LDL-C level) greater than or equal to 100 mg/dL. C) ASCVD: The patient has a low-density lipoprotein cholesterol (LDL-C) greater than or equal to 70 mg/dL (after treatment with antihyperlipidemic agents. ASCVD diagnosis is confirmed by one of the following: acute coronary syndromes, history of myocardial infarction, stable or unstable angina, coronary or other arterial revascularization, stroke, transient ischemic attack, peripheral arterial disease presumed to be of atherosclerotic origin.

Drugs
NORPACE CR

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Documentation of diagnosis and treatment history including reason why disopyramide IR cannot be used.

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
NORVIR ORAL CAPSULE, **NORVIR ORAL SOLUTION**

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
NOXAFIL

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction
13 years and older.

Prescriber Restriction

Coverage Duration
Per treatment OR up to through plan year.

Other Criteria
Fluconazole preferred for candida. Voriconazole preferred for aspergillus.

Drugs
NUBEQA

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

Exclusion Criteria

Required Medical Information
Documenation of non-metastatic castration resistant prostate cancer (nmCRPC).

Age Restriction

Prescriber Restriction
Oncologist

Coverage Duration
3 months

Other Criteria

Drugs
NUCALA SUBCUTANEOUS AUTO-INJECTOR

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

Exclusion Criteria

Required Medical Information
Documentation that either A) patient has asthma with an eosinophilic phenotype defined as blood eosinophils greater than or equal to 300 cells/µL within previous 12 months or greater than or equal to 150 cells/µL within 6 weeks of dosing AND medication will be used in combination with a corticosteroid inhaler and long acting beta2-agonist AND Patient must have experienced two or more exacerbations in the previous year OR require daily oral corticosteroids OR B)patient has eosinophilic granulomatosis with polyangiitis (EGPA)AND documented trial and failure of or contraindication to treatment with at least one immunosuppressants (azathioprine, cyclophosphamide, or methotrexate).

Age Restriction

Prescriber Restriction

Coverage Duration
6 months

Other Criteria

Drugs
NUCYNTA, **NUCYNTA ER**

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Documentation of diagnosis and treatment history.

Age Restriction
18 years and older.

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria
Documented failure to tramadol or tramadol extended-release.

Drugs
NULOJIX

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria
Transplant recipients who are Epstein-Barr virus (EBV) seronegative or with unknown EBV serostatus.

Required Medical Information
For prophylaxis of organ rejection in adults receiving kidney transplant, in combination with basiliximab induction, mycophenolate mofetil, and corticosteroids, AND documentation of patient's EBV serostatus.

Age Restriction
18 years of age or older

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
NURTEC ODT

Covered Uses

Exclusion Criteria

Required Medical Information
Documentation that the medication will be used for the acute treatment of migraine with or without aura in adults AND the member has tried and failed three alternatives two of which were triptans, unless contraindicated.

Age Restriction

Prescriber Restriction

Coverage Duration
Through end of benefit year

Other Criteria
Reauthorization requires documentation of medication efficacy.

Drugs
NYMALIZE ORAL SYRINGE

Covered Uses

Exclusion Criteria

Required Medical Information
Diagnosis of Subarachnoid hemorrhage: For the improvement of neurological outcome by reducing the incidence and severity of ischemic deficits in adult patients with subarachnoid hemorrhage (SAH) from ruptured intracranial berry aneurysms regardless of their postictus neurological condition (ie, Hunt and Hess grades I to V)

Age Restriction

Prescriber Restriction

Coverage Duration
Through end of benefit year

Other Criteria

Drugs
octreotide acetate injection solution

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Diagnosis of one of the following: A) Acromegaly and patient had an inadequate response or cannot be treated with surgical resection, pituitary irradiation, and/or bromocriptine mesylate at maximally tolerated doses, or B) Metastatic carcinoid tumor requiring symptomatic treatment of severe diarrhea and flushing episodes, or C) Vasoactive intestinal peptide tumor requiring treatment of profuse watery diarrhea.Acromegaly: Documentation of inadequate response to surgery and/or radiotherapy, or documentation that patient is not a candidate for surgery and/or radiotherapy. Reauthorization will require statement indicating growth hormone (GH) levels are stabilized at less than 5.0ng/mL and IGF-1 levels are normalized (male less than 1.9U/mL or female less than 2.2 U/mL) as matched by age and gender, or the patient has a documented clinical response defined by a reduction of tumor mass, a reduction in the signs and symptoms of acromegaly, or an improvement in significant comorbidities.

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria
For renewal of acromegaly, IGF-1 level has normalized or improved. For renewal of metastatic carcinoid tumor, patient has improvement in diarrhea and flushing episodes. For renewal of vasoactive intestinal peptide tumor, improvement in diarrhea episodes.

Drugs
ODEFSEY

Covered Uses
All FDA-approved indications not otherwise excluded from Health Plan

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
OMNIPOD DASH 5 PACK POD, **OMNIPOD DASH PDM KIT**, **OMNIPOD INSULIN MANAGEMENT**, **OMNIPOD INSULIN REFILL**

Covered Uses

Exclusion Criteria

Required Medical Information
Initial Therapy 1)Diagnosis of Type 1 Diabetes2)Member has previously been on a maintenance program involving at least three injections of insulin per day and frequent self-adjustments of insulin dosage or current use of an insulin pump3)Member performs glucose self-testing at least three times per day4)History of suboptimal blood sugar control despite appropriate management5)Member or caregiver has completed a physician-directed comprehensive diabetes management programContinued Therapy1)There is documented evidence of improvement in control of diabetes (specific to baseline status of disease for individual members)

Age Restriction
None

Prescriber Restriction
Endocrinologist

Coverage Duration
12 months

Other Criteria
If request is for more than 10 pods per 30 days additional documentation is required to provide clinical rationale for higher quantity

Drugs
ORFADIN ORAL CAPSULE 10 MG, 2 MG, 5 MG

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Medical statement of diagnosis of hereditary tyrosinemia type 1 (HT-1) AND current patient weight as dose must be within FDA approved dosing range: maximum dosage for all patients is 2 mg/kg/day. When initiating therapy, Serum tyrosine should be below 500 mmol/L to avoid toxic effects, and urinary succinylacetone levels should be undetectable.

Age Restriction

Prescriber Restriction

Coverage Duration
3 Months

Other Criteria

Drugs
ORKAMBI

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

Exclusion Criteria
Use in combination with Kalydeco

Required Medical Information
The patient is positive for the F508del mutation on both alleles of the CFTR gene.

Age Restriction
6 years of age or older

Prescriber Restriction

Coverage Duration
Through end of benefit year.

Other Criteria

Drugs
OTEZLA, **OTEZLA STARTER**

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

Exclusion Criteria

Required Medical Information
Documented trial and failure of preferred TNF inhibitors (Enbrel and Humira)AND patient is free of any clinically important active infections.

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria

Drugs
oxandrolone oral tablet 10 mg, 2.5 mg

Covered Uses
All medically accepted indications not otherwise excluded from Health Plan.

Exclusion Criteria
Pregnancy Category X

Required Medical Information
Statement indicating use to promote weight gain after weight loss following extensive surgery, chronic infections, or severe trauma, and in some patients who without definite pathophysiologic reasons fail to gain or to maintain normal weight, and to offset the protein catabolism associated with prolonged administration of corticosteroids. Statement indicating use for orphan drug indication, short stature associated with Turner syndrome, constitutional delay of growth and puberty, moderate or severe acute alcoholic hepatitis, Duchenne and Becker muscular dystrophy. Initial Therapy for AIDS Wasting: Diagnosis of AIDS wasting/cachexia. For treatment of anorexia associated with weight loss in patients with HIV: 1. Patient is receiving AIDS anti-retroviral therapy AND 2. experienced as least a. 7.5% unintentional weight loss over 6 months b. 10% unintentional weight loss over 12 months c. 5% body cell mass (BCM) loss within 6 months d. BMI less than 20 kg/m2 e. BCM less than 35% male (less than 23% female) and a BMI less than27 kg/m2 AND 3. documentation of trial and failure, contraindication, or intolerance to megestrol at doses up to 800mg daily.

Age Restriction

Prescriber Restriction

Coverage Duration
HIV Wasting: 3 months. All other indications: Through the Benefit Year

Other Criteria

Drugs
OXERVATE

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

Exclusion Criteria

Required Medical Information
Member has a diagnosis (documented in chart notes) of stage 2 (recurrent/persistent epithelial defect) or stage 3 (corneal ulcer) neurotrophic keratitis in the affected eye(s) AND Member is refractory to at least ONE conventional non-surgical treatment for neurotrophic keratitis (e.g. preservative-free artificial tears, topical antibiotic eyedrops, therapeutic contact lenses, etc.)

Age Restriction
Member is 2 years of age or older

Prescriber Restriction
The medication is prescribed by an ophthalmologist

Coverage Duration
8 weeks

Other Criteria

Drugs
PALYNZIQ

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

Exclusion Criteria
Not to be used in combination with sapropterin dihydrochloride (Kuvan)

Required Medical Information
Documented Diagnosis of Phenylketonuria (PKU), AND blood phenylalanine concentration greater than 600 micromol/L, AND physician agrees to assess patient tolerability, blood phenylalanine concentration, dietary protein and phenylalanine intake throughout treatment, AND prescriber and patient must be enrolled with the Palynziq REMS Program.

Age Restriction
18 years of age and older

Prescriber Restriction

Coverage Duration
3 Months

Other Criteria

Drugs
pamidronate

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment and treatment history. For treatment of hypercalcemia of malignancy, documentation of corrected total serum calcium greater than or equal to 12 mg/dL. For treament of bone metastases, diagnosis of breast cancer or multiple myeloma. For Paget's disease, must have symptomatic form of disease.

Age Restriction
18 years and older

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria
For Paget's disease, must have documented failure, intolerance or contraindication to oral agents: alendronate or risedronate.

Drugs
PANRETIN

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information

Age Restriction
18 years and older

Prescriber Restriction
Oncologist or HIV specialist

Coverage Duration
Plan year

Other Criteria

Drugs
paricalcitol oral

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Documentation of diagnosis and treatment history.

Age Restriction
18 years and older.

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria
Documented failure or intolerance to calcitriol.

Drugs
PEGINTRON SUBCUTANEOUS KIT 50 MCG/0.5 ML

Covered Uses
All medically accepted indications not otherwise excluded from Health Plan.

Exclusion Criteria
Uncontrolled depression. Autoimmune hepatitis. Known hypersensitivity reactions (urticaria, angioedema, bronchoconstriction, anaphylaxis, or Stevens-Johnson syndrome) to alpha interferons or any of its components. Hepatic decompensation in cirrhotic patients.

Required Medical Information
Documentation of diagnosis

Age Restriction

Prescriber Restriction
All patients with hepatitis C or hepatitis B, peginterferon must be prescribed by an infectious disease physician, gastroenterologist, hepatologist, or a transplant physician or in consultation with these physicians

Coverage Duration
12 Weeks to 12 Months

Other Criteria

Drugs
PEMAZYRE

Covered Uses

Exclusion Criteria

Required Medical Information
Documentation that the member has been diagnosed with previously treated, unresectable locally advanced or metastatic cholangiocarcinoma with a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement as detected by an FDA-approved test.

Age Restriction

Prescriber Restriction
Oncologist

Coverage Duration
3 Months

Other Criteria

Penicillamine capsule

Drugs
penicillamine oral capsule, *penicillamine oral tablet*

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
3 months

Other Criteria

Drugs
PENTAM

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction
4 months and older

Prescriber Restriction

Coverage Duration
Per treatment

Other Criteria

Drugs
PERSERIS

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

Exclusion Criteria

Required Medical Information
Documented trial of any of the two following drugs: aripiprazole, clozapine, olanzapine, risperidone, quetiapine, ziprasidone

Age Restriction

Prescriber Restriction

Coverage Duration
Through the benefit year

Other Criteria

Drugs
PICATO

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction
18 years or older

Prescriber Restriction

Coverage Duration
Per treatment

Other Criteria
Must have failed 5-FU cream

Drugs
PIQRAY ORAL TABLET 200 MG/DAY (200 MG X 1), 250 MG/DAY (200 MG X1-50 MG X1), 300 MG/DAY (150 MG X 2)

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

Exclusion Criteria

Required Medical Information
Documentation that the patient is a postmenopausal female or a male AND has advanced or metastatic breast cancer AND has HR-positive disease AND has HER2-negative disease AND has PIK3CA-mutated breast cancer as detected by a FDA approved test AND has progressed on or after at least one prior endocrine-based regimen AND the medication will be used in combination with fulvestrant.

Age Restriction

Prescriber Restriction
Oncologist

Coverage Duration
3 Months

Other Criteria

Drugs
PLEGRIDY

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

Exclusion Criteria

Required Medical Information
Diagnosis of relapsing forms of multiple sclerosis (relapsing-remitting MS or progressive-relapsing MS, or secondary-progresive MS)

Age Restriction

Prescriber Restriction

Coverage Duration
Through end of benefit year

Other Criteria

Drugs
POMALYST

Covered Uses
All FDA-approved indications not otherwise excluded from Health Plan.

Exclusion Criteria

Required Medical Information
Patient has a diagnosis of multiple myleoma and the patient has received two prior therapies, including Revlimid and Velcade unless the patient has a contraindication or intolerance to Revlimid or Velcade and the patient has demonstrated disease progression on or within 60 days of completion of last therapy.

Age Restriction

Prescriber Restriction

Coverage Duration
3 Months

Other Criteria
Prescriber, pharmacist, and patient must be enrolled in the Pomalyst REMS program.

Drugs
POTELIGEO

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

Exclusion Criteria

Required Medical Information
Documentation of relapsed or refractory mycosis fungoides (MF) or Sézary syndrome (SS) after at least one prior systemic therapy.

Age Restriction
18 years or older

Prescriber Restriction

Coverage Duration
3 Months

Other Criteria

Drugs
pramipexole oral tablet extended release 24 hr 0.375 mg, 0.75 mg, 1.5 mg, 3 mg, 4.5 mg

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Documented diagnosis and treatment history.

Age Restriction
18 years and older

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria
Failure to pramipexole IR

Drugs
PREZCOBIX

Covered Uses
All FDA-approved indications not otherwise excluded from Health Plan

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
PREZISTA ORAL SUSPENSION, **PREZISTA ORAL TABLET 150 MG, 600 MG, 75 MG, 800 MG**

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
PROCRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML, 40,000 UNIT/ML

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria
Uncontrolled hypertension. Pure red cell aplasia that begins after ESA treatment.

Required Medical Information
Pre-treatment hemoglobin level less than 10 g/dL AND Patient has adequate iron stores prior to initiation of therapy defined as ferritin more than 100 mcg/L or serum transferrin saturation greater than 20% AND other causes of anemia such as iron deficiency, folate deficiency or B12 deficiency, hemolysis, gastrointestinal bleeding, other active or occult bleeding, or underlying hematologic disease (such as sickle cell anemia, thalassemia, and porphyria) have been ruled out AND Diagnosis of one of the following: A) Anemia due to chronic kidney disease (CKD) with or without hemodialysis, OR B) Anemia in patients with non-myeloid malignancies where anemia is due to the effect of concomitant myelosuppressive chemotherapy and two additional months of chemotherapy is anticipated, C) Treatment of anemic in a patient at high risk for perioperative blood loss from elective, noncardiac, nonvascular surgery to reduce the need for allogeneic blood transfusion, D) Anemia in zidovudine-treated HIV infection with serum erythropoietin levels 500 mUnits/mL or less and zidovudine doses 4,200 mg/week or less.

Age Restriction

Prescriber Restriction
CKD - prescribed by a nephrologist or hematologist. Non-myeloid malignancies - prescribed by an oncologist/hematologist. Surgery - Prescribed by a surgeon. HIV - Prescribed by an infectious disease specialist.

Coverage Duration
Initial: 3 months. Renewal: CKD-12 months, Non-myeloid cancers, HIV-4 months. Surgery-3 months

Other Criteria
For renewal of CKD (dialysis patients): Hb less than 11 g/dL or physician will decrease or interrupt dose. For renewal of CKD (non-dialysis patients): Hb less than 10 g/dL or physician will decrease or interrupt dose. For renewal of non-myeloid malignancies: Concurrent myelosuppressive chemotherapy and Hb is 12g/dL or less and there is measurable response after eight weeks (defined as an increase in Hb 1 g/dL or more or a reduction in red blood cell transfusion requirements). For renewal of zidovudine-treated HIV, Hb is 12g/dL or less AND Zidovudine dose remains 4,200 mg/week or less and there is a measurable response after eight weeks (defined as an increase in Hb or a reduction in RBC transfusion requirements or documented dose escalation [up to max of 300 units/kg/dose]).

Drugs
PROMACTA ORAL POWDER IN PACKET 12.5 MG, 25 MG, **PROMACTA ORAL TABLET**

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Diagnosis of one of the following: A) Relapsed/refractory chronic immune (idiopathic) thrombocytopenic purpura (ITP) for greater than 6 months AND Baseline platelet count is less than 50,000/mcL AND Degree of thrombocytopenia and clinical condition increase the risk of bleeding AND Patient had an insufficient response, intolerance, contraindication to corticosteroids or immune globulin or inadequate response or contraindication to splenectomy, or B) Chronic hepatitis C and patient has thrombocytopenia defined as platelets less than 90,000/mcL for initiation (pre-treatment) of interferon therapy, or C) Severe aplastic anemia and patient has insufficient response to immunosupressive therapy.

Age Restriction

Prescriber Restriction

Coverage Duration
3 Months

Other Criteria

Drugs
tacrolimus topical

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction
16 years and older (0.1%) or 2 years and older (0.03%)

Prescriber Restriction

Coverage Duration
8 weeks

Other Criteria

Drugs
PULMOZYME

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of Cystic Fibrosis diagnosis

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria
Pulmozyme should be used in conjunction with standard therapies for CF. For renewal, Patient is benefiting from treatment (i.e. improvement in lung function [FEV1], decreased number of pulmonary exacerbations).

Drugs
QINLOCK

Covered Uses

Exclusion Criteria
Must have previously received treatment with more than 3 kinase inhibitors, including imatinib

Required Medical Information
Required diagnosis of Gastrointestinal stromal tumor, advanced.

Age Restriction
For adults only

Prescriber Restriction

Coverage Duration
Through end of benefit year

Other Criteria

Drugs
REGRANEX

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Documentation of diagnosis

Age Restriction
16 years and older

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
RELENZA DISKHALER

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction

Prescriber Restriction

Coverage Duration
Per treatment (up to 28 days)

Other Criteria

Drugs
REMODULIN

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction
18 years and older.

Prescriber Restriction

Coverage Duration
3 months

Other Criteria

Drugs
REPATHA PUSHTRONEX, **REPATHA SURECLICK**, **REPATHA SYRINGE**

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

Exclusion Criteria
Concurrent use of Repatha with Praluent (alirocumab injection for SC use), Juxtapid (lomitapide capsules) or Kynamro (mipomersen injection). The efficacy and safety of Praluent, Juxtapid and Kynamro in combination with Repatha have not been established.

Required Medical Information
Clinical documentation (e.g., chart notes, laboratory values) required for "initial" authorization includes: 1. Documentation of one of the following diagnoses: A) Homozygous familial hypercholesterolemia (HoFH), B) Heterozygous familial hypercholesterolemia (HeFH), OR C) Atherosclerotic cardiovascular disease (ASCVD), AND 2. Documentation of any one of the following: a) Patient has been receiving at least 12 consecutive weeks of high intensity statin therapy and will continue to receive high-intensity statin at maximally tolerated dose, b) Patient is unable to tolerate high-intensity statin, c) Patient has been receiving at least 12 consecutive weeks of moderate-intensity statin therapy and will continue to receive a moderate-intensity statin d) Patient has a documented labeled contraindication to all statins, e)Patient has experienced rhabdomyolysis or muscle symptoms with statin treatment, f)Patient has undergone a trial of statin rechallenge with another low-intensity statin with documented reappearance of muscle symptoms (only 2 trials of a statin can be required prior to the approval of a PCSK9). Clinical documentation required for "reauthorization" includes: 1. Patient continues to receive statin at maximally tolerated dose (unless patient has documented inability to take statins), 2. Submission of medical records documenting LDL-C reduction while on Repatha therapy.

Age Restriction
HeFH,ASCVD: 18 years and older. HoFH: 13 years and older

Prescriber Restriction
Prescribed by or in consultation with or recommendation of a Cardiologist, Endocrinologist, or Lipid specialist.

Coverage Duration
Initial Authorization will be for 6 months. Reauthorization will be for 1 year.

Other Criteria
A) HoFH: Patient meets one of the following: a) Patient has genetic confirmation of two mutant alleles at LDLR, APOB, PCSK9 or LDLRAP1 gene locus OR b) Patient has an untreated LDL-C level greater than 500 mg/dL (prior to treatment with antihyperlipidemic agents) OR c) Patient has a treated LDL-C level greater than or equal to 300 mg/dL (after treatment with antihyperlipidemic agents but prior to agents such as Repatha, Kynamro, or Juxtapid OR d) Patient has clinical manifestations of HoFH (e.g., cutaneous xanthomas, tendon xanthomas, arcus cornea, tuberous xanthomas or xanthelasma B) HeFH: The patient has a low-density lipoprotein cholesterol (LDL-C level) greater than or equal to 160 mg/dL (after treatment with antihyperlipidemic agents but prior to PCSK9 inhibitor therapy. C) ASCVD: The patient has a low-density lipoprotein cholesterol (LDL-C) greater than or equal to 70 mg/dL (after treatment with antihyperlipidemic agents but prior to PCSK9 inhibitor therapy. ASCVD diagnosis is confirmed by one of the following: acute coronary syndromes, history of myocardial infarction, stable or unstable angina, coronary or other arterial revascularization, stroke, transient ischemic attack, peripheral arterial disease presumed to be of atherosclerotic origin. Examples of high-intensity statin therapy include atorvastatin 40-80 mg, Crestor (rosuvastatin) 20-40 mg. Examples of moderate-intensity statin therapy include atorvastatin 10-20 mg, Crestor (rosuvastatin) 5-10 mg, simvastatin greater than or equal to 20 mg, pravastatin greater than or equal 40 mg, lovastatin 40 mg, Lescol XL (fluvastatin XL) 80 mg, or fluvastatin 40 mg twice daily. Provider attestation is sufficient for defining statin intolerance.

Drugs
RETEVMO ORAL CAPSULE 40 MG, 80 MG

Covered Uses

Exclusion Criteria

Required Medical Information
Diagnosis of one of the following, and treatment in the following populations:A) Non-small cell lung cancer, metastatic, RET fusion-positive: Treatment of metastatic RET fusion-positive non-small cell lung cancer (NSCLC) in adults. B) Thyroid cancer, medullary, RET-mutant: Treatment of advanced or metastatic RET-mutant medullary thyroid cancer (MTC) in adults and pediatric patients 12 years of age or older who require systemic therapy. OR C)Thyroid cancer, RET fusion-positive: Treatment of advanced or metastatic RET fusion-positive thyroid cancer in adults and pediatric patients 12 years of age or olderwho require systemic therapy and who are refractory to radioactive iodine (if radioactive iodine is appropriate).

Age Restriction

Prescriber Restriction

Coverage Duration
Through end of benefit year

Other Criteria

Drugs
RETROVIR INTRAVENOUS

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment.Clinical documentation of FDA approved indication for treatment.

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
REVLIMID

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria
Pregnancy (category X)

Required Medical Information
Diagnosis of one of the following: A) Multiple myeloma used in combination with dexamethasone, or B) Diagnosis of transfusion-dependent anemia due to low- or intermediate-1-risk myelodysplastic syndromes associated with a deletion 5q cytogenetic abnormality with or without additional cytogenetic abnormalities, or C) Mantle cell lymphoma and patient's disease has relapsed or progressed after trying at least two prior therapies (Velcade and one of the following: bendamustine, cladribine, fludarabine, rituximab) AND patient is enrolled in the Revlimid REMS Program.

Age Restriction
18 years and older

Prescriber Restriction
Hematologist/oncologist. Registered in Revlimid REMS.

Coverage Duration
3 Months

Other Criteria

Drugs
REYATAZ ORAL CAPSULE 150 MG, 200 MG, 300 MG, **REYATAZ ORAL POWDER IN PACKET**

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
REYVOW

Covered Uses

Exclusion Criteria

Required Medical Information
Documentation that the medication will be used for the acute treatment of migraine with or without aura in adults AND the member has tried and failed three alternatives two of which were triptans, unless contraindicated.

Age Restriction

Prescriber Restriction

Coverage Duration
Through end of benefit year

Other Criteria
Reauthorization requires documentation of medication efficacy.

Drugs
ribavirin oral capsule, *ribavirin oral tablet 200 mg*

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction

Prescriber Restriction

Coverage Duration
Per treatment (up to 48 weeks)

Other Criteria

Drugs
RISPERDAL CONSTA

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment. Documented trial of any of the two following drugs: aripiprazole, clozapine, olanzapine, risperidone, quetiapine, ziprasidone.

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria
Must be unable or unwilling to tolerate oral medications.

Drugs
SABRIL ORAL TABLET, *vigabatrin oral powder in packet*

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Documentation of diagnosis of refractory complex partial seizures (CPS) or infantile spasms (IS). Previously tried and failed two medications for the diagnosis of refractory complex partial seizures including carbamazepine, ethotoin, felbamate, fosphenytoin, gabapentin, lacosamide, lamotrigine, levetiracetam, oxcarbazepine, phenytoin, pregabalin, primidone, tiagabine, topiramate, valproic acid, divalproex sodium, zonisamide.

Age Restriction
10 years and older for CPS diagnosis. Children aged 1 month to 2 years old for IS.

Prescriber Restriction
Neurologist registered with the Sabril REMS program

Coverage Duration
Plan year

Other Criteria

Drugs
SAMSCA

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria
Samsca not approved as an intervention to raise serum sodium urgently to prevent or to treat serious neurological symptoms. Samsca cannot be initiated or re-initiated outside of a hospital setting.

Required Medical Information
Serum sodium levels. Initial therapy for hyponatremia (hypervolemic and euvolemic): 1. Diagnosis of significant hyponatremia (euvolemic or hypervolemic), AND 2. Treatment has been initiated or re-initiated in a hospital setting prior to discharge. Reauthorization for hypervolemic and euvolemic hyponatremia: 1. Documentation of clinical benefit, AND 2. Treatment hasbeen initiated or re-initiated in a hospital setting prior to discharge.

Age Restriction

Prescriber Restriction

Coverage Duration
1 month

Other Criteria
Documentation of trial and failure of fluid restriction required.

Drugs
SANDOSTATIN LAR DEPOT INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Diagnosis of one of the following: A) Acromegaly and patient had an inadequate response or cannot be treated with surgical resection, pituitary irradiation, and/or bromocriptine mesylate at maximally tolerated doses, or B) Metastatic carcinoid tumor requiring symptomatic treatment of severe diarrhea and flushing episodes, or C) Vasoactive intestinal peptide tumor requiring treatment of profuse watery diarrhea.Acromegaly: Documentation of inadequate response to surgery and/or radiotherapy, or documentation that patient is not a candidate for surgery and/or radiotherapy. Reauthorization will require statement indicating growth hormone (GH) levels are stabilized at less than 5.0ng/mL and IGF-1 levels are normalized (male less than 1.9U/mL or female less than 2.2 U/mL) as matched by age and gender, or the patient has a documented clinical response defined by a reduction of tumor mass, a reduction in the signs and symptoms of acromegaly, or an improvement in significant comorbidities.

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria
For renewal of acromegaly, IGF-1 level has normalized or improved. For renewal of metastatic carcinoid tumor, patient has improvement in diarrhea and flushing episodes. For renewal of vasoactive intestinal peptide tumor, improvement in diarrhea episodes.

Drugs
SAPHRIS, **SECUADO**

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Documentation of diagnosis and treatment history

Age Restriction
18 years and older

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria
Member needs to have documented trial of any of the two following drugs: aripiprazole, clozapine, olanzapine, risperidone, quetiapine, ziprasidone

Drugs
SELZENTRY ORAL TABLET 150 MG, 25 MG, 300 MG, 75 MG

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria
Documented lab assay verifying HIV is CCR5-tropic positive strain.

Drugs
quetiapine oral tablet extended release 24 hr, **SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR**

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Documentation of diagnosis and treatment history

Age Restriction
10 years and older

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria
Documentation of reason why quetiapine IR cannot be used.

Drugs
SIGNIFOR LAR

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

Exclusion Criteria

Required Medical Information
Documented diagnosis of acromegaly who have had an inadequate response to surgery and/or for whom surgery is not an option

Age Restriction
18 years of age and older

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria
For renewal, patient's growth hormone level or insulin-like growth factor 1 (IGF-1) level for age and gender has normalized/improved.

SILDENAFIL (REVATIO)

Drugs
sildenafil (pulm.hypertension) oral tablet

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria
Should not be used in combination with organic nitrates. This product is only indicated for Pulmonary Hypertension and is not to be used for Erectile Dysfunction.

Required Medical Information
Statement of FDA approved diagnosis of pulmonary arterial hypertension

Age Restriction
18 years and older

Prescriber Restriction
Cardiologist or Pulmonologist

Coverage Duration
Plan year

Other Criteria

Drugs
SOFOSBUVIR-VELPATASVIR

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

Exclusion Criteria

Required Medical Information
Provider must submit medical records documenting the following: 1) medical diagnosis of Chronic Hepatitis C with labs documenting genotype and subtype, AND 2) medical records documenting viral load taken within 6 months of beginning therapy

Age Restriction
18 years of age and older

Prescriber Restriction
Prescribed by, or in consultation with, a gastroenterologist, hepatologist, or infectious disease physician.

Coverage Duration
12 weeks or as defined by current AASLD/IDSA guidance

Other Criteria
Criteria and coverage durations will be applied consistent with current AASLD/IDSA guidance.

Drugs
SOMATULINE DEPOT

Covered Uses
All FDA-approved indications not otherwise exluded by Health Plan.

Exclusion Criteria

Required Medical Information
Diagnosis of A) acromegaly AND Inadequate response to surgery and/or radiation therapy or patient cannot be treated with surgery and/or radiotherapy, or B) unresectable, well or moderately differentiated, locally advanced or metastatic gastroenteropancreatic neuroendocrine tumors (GEP-NETs).

Age Restriction
18 years of age and older

Prescriber Restriction

Coverage Duration
3 months initial. Continuation 6 months if no progression

Other Criteria
For renewal, patient's IGF-1 levels has normalized or improved.

Drugs
Somavert subcutaneous recon soln 10 mg, **SOMAVERT SUBCUTANEOUS RECON SOLN 15 MG, 20 MG, 25 MG, 30 MG**

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction
18 years and older

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
SPRYCEL

Covered Uses
All FDA-approved indications not otherwise excluded from Health Plan.

Exclusion Criteria

Required Medical Information
Diagnosis of one of the following: A) Newly diagnosed Philadelphia chromosome-positive (Ph+) chronic myeloid leukemia (CML) in chronic phase, or B) Chronic, accelerated, or myeloid or lymphoid blast phase Ph+ CML AND failure, resistance, or intolerance to imatinib, or C) Philadelphia chromosome-positive (Ph+) acute lymphoblastic leukemia (ALL) with resistance or intolerance to imatinib.

Age Restriction
18 years or older

Prescriber Restriction
Prescriber must be an oncologist.

Coverage Duration
Plan year

Other Criteria

Drugs
stavudine oral capsule

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
STRIBILD

Covered Uses
All FDA-approved indications not otherwise excluded from Health Plan

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
SUNOSI

Covered Uses

Exclusion Criteria

Required Medical Information
Clinical documentation of narcolepsy or obstructive sleep apnea AND failed at least TWO alternatives (e.g. methylphenidate, dextroamphetamine, modafinil and armodafinil).

Age Restriction

Prescriber Restriction

Coverage Duration
Through the plan year

Other Criteria

Drugs
SUSTIVA

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
SUTENT

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria
Combination use with other kinase inhibitors (for example, sorafenib, etc).

Required Medical Information
Diagnosis of one of the following: A) Advanced/metastatic renal cell carcinoma, or B) Gastrointestinal stromal tumors after disease progression on or intolerance to Gleevec, or C) Progressive, well-differentiated pancreatic neuroendocrine tumors in a patient with unresectable locally advanced or metastatic disease.

Age Restriction
Patient must be at least 18 years of age.

Prescriber Restriction
Must be prescribed by oncologist

Coverage Duration
3 months initial, then renewable in 6 month increments

Other Criteria

Drugs
SYNERA

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
TABLOID

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction

Prescriber Restriction

Coverage Duration
Through chemotherapy remission inducation and consolidation treatment

Other Criteria

Drugs
TAFINLAR

Covered Uses
All FDA-approved indications not otherwise excluded from Health Plan.

Exclusion Criteria

Required Medical Information
Diagnosis of unresectable or metastatic melanoma along with BRAF V600E or BRAF V600K mutation status as detected by a US Food and Drug Administration-approved test.

Age Restriction
18 years or older

Prescriber Restriction
Oncologist

Coverage Duration
3 Months

Other Criteria
For authorization, please submit to EviCore at evicore.com or call at 877-825-7722.

Drugs
TAKHZYRO

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

Exclusion Criteria

Required Medical Information
Documentation that medication is being used to prevent attacks of hereditary angioedema (HAE).

Age Restriction
12 years of age or older

Prescriber Restriction

Coverage Duration
3 Months

Other Criteria

Drugs
TALZENNA ORAL CAPSULE 0.25 MG, 1 MG

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

Exclusion Criteria

Required Medical Information
Documentation of deleterious or suspected deleterious germline breast cancer susceptibility gene (BRCA)-mutated (gBRCAm) human epidermal growth factor receptor 2 (HER2)-negative locally advanced or metastatic breast cancer.

Age Restriction

Prescriber Restriction
Oncology

Coverage Duration
3 months

Other Criteria

Drugs
ERLOTINIB, **TARCEVA**

Covered Uses
All FDA approved indications not otherwise excluded by Health Plan. First line for Non-Small Cell Lung Cancer (NSCLC).

Exclusion Criteria

Required Medical Information
Diagnosis of one of the following: A) Locally advanced, unresectable, or metastatic pancreatic cancer and Tarceva will be used in combination with gemcitabine, or B) First-line treatment of metastatic non-small cell lung cancer in which tumors have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations as detected by an Food and Drug Administration (FDA)-approved test, or C) Maintenance treatment of locally advanced or metastatic non-small cell lung cancer when disease has not progressed after 4 cycles of platinum-based first-line chemotherapy, or D) Treatment of locally advanced or metastatic non-small cell lung cancer after failure of at least 1 prior chemotherapy regimen.

Age Restriction
18 years or older

Prescriber Restriction
Prescriber must be an oncologist.

Coverage Duration
Plan year

Other Criteria

Drugs
bexarotene, **TARGRETIN TOPICAL**

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Documentation of diagnosis and treatment history.

Age Restriction
18 years and older.

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
TASIGNA ORAL CAPSULE 150 MG, 200 MG

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria
Long QT syndrome. Uncorrected hypokalemia. Uncorrected hypomagnesemia. Concomitant use with a drug known to prolong the QT interval or strong cytochrome P450 3A4 inhibitors.

Required Medical Information
Diagnosis of one of the following: A) Newly diagnosed adult patients with Philadephia chromosome positive chronic myeloid leukemia (Ph+ CML) in chronic phase, or B) Ph+ chronic or accelerated phase chronic myeloid leukemia (CML) in adult patients resistant to or intolerant to prior therapy that included imatinib.

Age Restriction
18 years and older

Prescriber Restriction
Must be prescribed by Oncologist

Coverage Duration
Initial: 3 months, Renewal: 6 months with documentation of continued benefit

Other Criteria

Drugs
TAVALISSE

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

Exclusion Criteria

Required Medical Information
Documented Platelet count less than 30x10^9/L and member had an insufficient response to previous treatment (corticosteroids, immunoglobulins, splenectomy, and/or a thrombopoietin receptor agonists)

Age Restriction
18 years or older

Prescriber Restriction
Hematologist

Coverage Duration
Initial Authorization will be for 3 months. Reauthorization will be for 1 year.

Other Criteria

Drugs
TAZVERIK

Covered Uses

Exclusion Criteria

Required Medical Information
Documentation of metastatic or locally advanced epithelioid sarcoma that is not eligible for complete resection.

Age Restriction

Prescriber Restriction
Oncology

Coverage Duration
3 months

Other Criteria

Drugs
TECFIDERA ORAL CAPSULE,DELAYED RELEASE(DR/EC) 120 MG, 120 MG (14)- 240 MG (46), 240 MG

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria
Treatment of primary progressive MS is not covered. Combination therapy with a beta interferon product, Gilenya, Aubagio, Tecfidera, Tysabri or Copaxone is not covered.

Required Medical Information
Diagnosis of relapsing forms of multiple sclerosis (relapsing-remitting MS or progressive-relapsing MS, or secondary-progresive MS) OR patient has experienced a first clinical episode and has MRI features consistent with multiple sclerosis.

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
temozolomide

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction
18 years and older

Prescriber Restriction

Coverage Duration
3 Months

Other Criteria

Drugs
THALOMID

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria
Pregnancy (category X)

Required Medical Information
Diagnosis of one of the following: A) Multiple myeloma that is newly diagnosed and is receiving concurrent dexamethasone, or B) Acute treatment of cutaneous manifestations of moderate to severe erythema nodosum leprosum (ENL) AND the medication will not be used as monotherapy if the member has moderate to severe neuritis, or C) Maintenance therapy for prevention and suppression of cutaneous manifestations of ENL recurrence.

Age Restriction
12 years of age and older

Prescriber Restriction
Candidates must follow Thalomid REMS program requirements. Provider and pharmacy must be registered with this program.

Coverage Duration
3 months

Other Criteria

Drugs
THYMOGLOBULIN

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction
18 years and older

Prescriber Restriction

Coverage Duration
Up to 14 days.

Other Criteria

Drugs
TIBSOVO

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

Exclusion Criteria

Required Medical Information
Documentation of relapsed or refractory acute myeloid leukemia (AML) with a susceptible isocitrate dehydrogenase-1 (IDH1) mutation as detected by an FDA-approved test.

Age Restriction

Prescriber Restriction
Oncology

Coverage Duration
3 months

Other Criteria

Drugs
TIGAN INTRAMUSCULAR

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction
Use not recommended in children

Prescriber Restriction

Coverage Duration
Per treatment

Other Criteria

Drugs
TIVICAY

Covered Uses
All FDA-approved indications not otherwise excluded from Health Plan

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
tobramycin in 0.225 % NaCl

Covered Uses
All FDA-approved indications not otherwise excluded from Health Plan.

Exclusion Criteria

Required Medical Information
Documented diagnosis of cystic fibrosis with Pseudomonas

Age Restriction

Prescriber Restriction

Coverage Duration
Plan yer

Other Criteria

Drugs
bosentan, **TRACLEER**

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria
Receiving concomitant cyclosporine A or glyburide therapy. Aminotransferase elevations are accompanied by signs or symptoms of liver dysfunction or injury or increases in bilirubin at least 2 times the upper limit of normal. For female patients, pregnancy must be excluded prior to the start of therapy and will be prevented thereafter with reliable contraception.

Required Medical Information
Diagnosis of pulmonary arterial hypertension (PAH) WHO Group I AND New York Heart Association (NYHA) Functional Class II-IV

Age Restriction
Greater than 12 years of age

Prescriber Restriction
Available only to those enrolled in the Tracleer REMS Program. Prescription is written by or in consultation with a pulmonologist or cardiologist

Coverage Duration
3 Months

Other Criteria
Liver aminotransferases will be measured prior to initiation of treatment and then monthly.

Drugs
tranexamic acid intravenous

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Documentation of hemophilia diagnosis as appropriate

Age Restriction

Prescriber Restriction

Coverage Duration
8 days

Other Criteria

Drugs
ALTRENO, *tretinoin (antineoplastic)*

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Patients diagnosed with acne vulgaris after trying and failing at least 1 preferred alternatives (such as generic acne products - erythromycin/benzoyl peroxide, clindamycin, etc) or other non-cosmetic diagnosis.

Age Restriction

Prescriber Restriction

Coverage Duration
3 months

Other Criteria

Drugs
TRIKAFTA

Covered Uses

Exclusion Criteria
Use in combination with other CFTR modulator (Orkambi, Kalydeco, or Symdeko)

Required Medical Information
Documentation of Cystic Fibrosis AND confirmation of presence of at least one F508del mutation in CFTR gene through genetic testing.

Age Restriction
12 years of age or older

Prescriber Restriction
Prescribed by pulmonologist or a physician who specializes in the treatment of Cystic fibrosis

Coverage Duration
Through end of benefit year

Other Criteria

Drugs
TRIUMEQ

Covered Uses
All FDA-approved indications not otherwise excluded from Health Plan

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
abacavir-lamivudine-zidovudine

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria
Documented negative HLA-B*5701 screening.

Drugs
TRUVADA

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
TUKYSA

Covered Uses

Exclusion Criteria

Required Medical Information
Used for medical treatment of Breast cancer, human epidermal growth factor receptor 2 positive, advanced unresectable or metastatic:advanced unresectable or metastatic human epidermal growth factor receptor 2 (HER2)-positive breast cancer (in combination with trastuzumab and capecitabine) in adults with or without brain metastases who have received 1 or more prior anti-HER2-based regimens in the metastatic setting.

Age Restriction

Prescriber Restriction

Coverage Duration
Through end of benefit year

Other Criteria

Drugs
TURALIO

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

Exclusion Criteria

Required Medical Information
Documentation of symptomatic tenosynovial giant cell tumor (TGCT) associated with severe morbidity or functional limitations and not amenable to improvement with surgery.

Age Restriction

Prescriber Restriction
Oncologist

Coverage Duration
3 months

Other Criteria

Drugs
TYKERB

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Diagnosis of breast cancer with tumors that overexpress human epidermal growth factor receptor 2 (HER2) AND 1. the medication will be used in combination with Xeloda in a patient with advanced or metastatic disease and the patient has received prior therapy including an anthracycline, a taxane, and trastuzumab, or 2) The medication will be used in combination with Femara for the treatment of a postmenopausal woman with hormone receptor-positive metastatic disease for whom hormonal therapy is indicated.

Age Restriction
18 years or older

Prescriber Restriction
Must be prescribed by Oncologist and Oncologist must monitor treatment

Coverage Duration
Initial: 3 months, Renewal: 6 months with documentation of continued benefit

Other Criteria

Drugs
TYMLOS

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

Exclusion Criteria

Required Medical Information
Diagnosis of one of the following: A) Osteoporosis in a postmenopausal female AND one or more of the following: 1) History of osteoporotic fracture, or 2) Documented trial and failure of bisphosphonate or 3) Documented contraindication or intolerance to bisphosphonate therapy. Patient has not received more than 2 years of therapy with Tymlos.

Age Restriction

Prescriber Restriction

Coverage Duration
Initial: 1 year. Renewal: 1 year not to exceed 2 years of total

Other Criteria

Drugs
UBRELVY

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

Exclusion Criteria

Required Medical Information
Documentation that the medication will be used for the acute treatment of migraine with or without aura in adults AND the member has tried and failed three alternatives two of which were triptans, unless contraindicated.

Age Restriction

Prescriber Restriction

Coverage Duration
Through end of benefit year

Other Criteria
Reauthorization requires documentation of medication efficacy.

Drugs
VALCYTE ORAL RECON SOLN, *valganciclovir oral tablet*

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction
4 months and older.

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
vancomycin oral capsule

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Diagnosis of A) Clostridium difficile-associated diarrhea, AND Stool culture report within the previous 30 days indicating positive C. difficile toxin, AND documented trial and failure or contraindication to preferred agent, metronidazole, or B) Staphylococcus aureus (including methicillin-resistant strains)enterocolitis

Age Restriction

Prescriber Restriction

Coverage Duration
14 days, Patients with multiple relapses: 6 weeks

Other Criteria

Drugs
calcitriol topical

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria
Any pertinent clinical situation as defined by the product label that could affect patient safety and/or therapeutic efficacy (i.e. contraindications, warnings, precautions, adverse effects, renal or hepatic function, drug interactions, lab values, required prior or concomitant therapy, inappropriate dosing and/or duration, etc).

Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria
Must have tried and failed at least 2 topical steroids (at least one mid potency and at least one high potency)

Drugs
VENTAVIS

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Diagnosis of Pulmonary Arterial Hypertension (PAH) AND has WHO Group I PAH AND Patient has New York Heart Association (NYHA) Functional Class III or IV. Trial and failure of Revatio or Adcirca.

Age Restriction
18 years or older

Prescriber Restriction
Must be prescribed by a cardiologist or pulmonologist

Coverage Duration
3 months.

Other Criteria

Drugs
VERZENIO

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

Exclusion Criteria

Required Medical Information
Documented diagnosis of one of the following: A)hormone receptor -positive, human epidermal growth factor receptor 2 -negative advanced or metastatic breast cancer and must ne used in combination with fulvestrant unless there is disease progression following endocrine therapy and prior chemotherapy in the metastatic setting.

Age Restriction

Prescriber Restriction
Oncologist

Coverage Duration
3 Months

Other Criteria

Drugs
VIBERZI

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

Exclusion Criteria

Required Medical Information
Clinically diagnosed with irritable bowel syndrome with diarrhea supported by documentation from the patient's medical records AND Other GI medical conditions that could explain the symptoms have been ruled out AND Failed conventional non-pharmacological therapies including (Dietary changes, stress reduction, or behavioral changes)AND Failed conventional pharmacological therapies including: Antidiarrheals, Antidepressants, and Antispasmodics AND Must have tried and failed rifaximin

Age Restriction

Prescriber Restriction

Coverage Duration
Initial Authorization will be for 3 months. Reauthorization will be for 1 year.

Other Criteria

Drugs
VIMPAT ORAL SOLUTION, **VIMPAT ORAL TABLET**, **VIMPAT ORAL TABLETS,DOSE PACK**

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information

Age Restriction
17 years of age or older

Prescriber Restriction

Coverage Duration
Through the benefit year

Other Criteria
Max dose 400mg/day

Drugs
VIRACEPT ORAL TABLET

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria
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Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
nevirapine

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
VIREAD

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
tenofovir disoproxil fumarate

Covered Uses
All FDA-approved indications not otherwise excluded from Health Plan

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
VITRAKVI ORAL CAPSULE

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

Exclusion Criteria

Required Medical Information
Clinical documentation of unresectable or metastatic solid tumors that have a neurotrophic receptor tyrosine kinase (NTRK) gene fusion and have no satisfactory alternative treatments or that have progressed following treatment.

Age Restriction

Prescriber Restriction
Oncology

Coverage Duration
3 months

Other Criteria

Drugs
VIZIMPRO

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

Exclusion Criteria

Required Medical Information
Documentation that medication will be used for the first-line treatment of patients with metastatic non-small cell lung cancer (NSCLC) with epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 L858R substitution mutations as detected by an FDA-approved test.

Age Restriction

Prescriber Restriction
Oncology

Coverage Duration
3 months

Other Criteria

Drugs
voriconazole oral

Covered Uses
All medically-accepted indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Documentation of invasive aspergillosis, bronchopulmonary aspergillosis, candidemia and disseminated candidiasis in skin, abdomen, kidney, bladder wall and wounds, esophageal candidiasis, and serious Candida infections, infections caused by the emerging pathogens Scedosporium sp. and Fusarium sp., or rare and refractory fungal infections should be provided. Preferred alternative for Candida: oral fluconazole

Age Restriction
12 years or older

Prescriber Restriction

Coverage Duration
6 months

Other Criteria

Drugs
VOTRIENT

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Diagnosis of one of the following: A) Advanced/metastatic renal cell carcinoma, or B) Advanced soft tissue sarcoma and patient received at least one prior chemotherapy (e.g., doxorubicin, dacarbazine, ifosfamide, epirubicin, gemicitabine, docetaxel, or vinorelbine).

Age Restriction
18 years of age and older

Prescriber Restriction
Oncologist

Coverage Duration
Initial: 3 months, Renewal: 6 months with documentation of continued benefit

Other Criteria

Drugs
VUMERITY

Covered Uses

Exclusion Criteria
Concurrent use with other MS disease modifying agents (including Aubagio, Avonex, Betaseron, Copaxone/Glatiramer/Glatopa, Extavia, Gilenya, Lemtrada, Mavenclad, Mayzent, Ocrevus, Plegridy, Rebif, Tecfidera and Tysabri) OR Member with moderate or severe renal impairment (creatinine clearance less than 60 mL/min.

Required Medical Information
Documentation that the medication will be used for the treatment of relapsing forms of multiple sclerosis (MS)(including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease).

Age Restriction

Prescriber Restriction
Neurologist

Coverage Duration
Benefit Year

Other Criteria

Drugs
VYVANSE ORAL CAPSULE

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

Exclusion Criteria

Required Medical Information
Diagnosis of one of the following: A) ADHD and tried and failed two alternative medications FDA approved for the treatment of ADHD, or B) Moderate to severe Binge Eating Disorder AND the patient is receiving psychological counseling AND the patient must have tried and failed at least two antidepressant medications.

Age Restriction
ADHD: Must be older than 6 years of age, BED: Must be 18 years of age or older

Prescriber Restriction
BED: The medication must be prescribed by a psychiatrist or a psychiatric specialist.

Coverage Duration
12 months

Other Criteria

Drugs
VYXEOS

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

Exclusion Criteria
Documented diagnosis of newly-diagnosed therapy-related acute myeloid leukemia (t-AML) or AML with myelodysplasia-related changes (AML-MRC).

Required Medical Information

Age Restriction

Prescriber Restriction
oncologist or hematologist

Coverage Duration
3 Months

Other Criteria

Drugs
WAKIX

Covered Uses

Exclusion Criteria

Required Medical Information
Diagnosis of one of Excessive daytime sleepiness in patients with narcolepsy AND 1. Submission of sleep study with narcolepsy diagnosis, AND 2. currently NOT taking any sedative hypnotics or other CNS depressants AND 3. has experienced inadequate response or intolerable side effects to two preferred products (modafinil, armodofinil, methylphenidate, or dextroamphetamine).

Age Restriction

Prescriber Restriction

Coverage Duration
Initial: 3 months, Renewal: 6 months with documentation of continued benefit

Other Criteria
For renewal, the patient had a positive response to the medication (increased sleep quality for patients with narcolepsy).

Drugs
XALKORI

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Stated diagnosis of late-stage (locally advanced or metastatic), non-small cell lung cancers (NSCLC) with expression of the abnormal anaplastic lymphoma kinase (ALK) gene as detected by an FDA approved test.

Age Restriction
18 years and older

Prescriber Restriction
Oncologist

Coverage Duration
3 months

Other Criteria

Drugs
XCOPRI MAINTENANCE PACK, **XCOPRI TITRATION PACK**

Covered Uses

Exclusion Criteria

Required Medical Information
Diagnosed with partial-onset seizures and treatment failure of at least two other formulary medications used in the treatment of partial onset seizures.

Age Restriction

Prescriber Restriction

Coverage Duration
Through end of benefit year

Other Criteria

Drugs
XELJANZ ORAL TABLET 10 MG, 5 MG, XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HR 11 MG

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

Exclusion Criteria

Required Medical Information
Documented trial and failure of preferred TNF inhibitors (Enbrel and Humira)AND negative Tuberculin test prior to therapy AND patient is free of any clinically important active infections.

Age Restriction

Prescriber Restriction

Coverage Duration
Through end of benefit year

Other Criteria

Drugs
XIFAXAN ORAL TABLET 200 MG, 550 MG

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria
Allergy to rifamycin agents

Required Medical Information
Diagnosis of traveler's diarrhea and patient does not have fever or blood in the stool OR Diagnosis of hepatic encephalopathy and tried and failed lactulose therapy OR Diagnosis of irritable bowel syndrome with diarrhea (IBS-D) and failed at least TWO alternatives from TWO different classes such as anitdiarrheals (e.g. loperamide, diphenoxylate-atropine), antispasmodics (e.g. dicyclomine), bile acid sequestrants (e.g. cholestryramine, colestipol).

Age Restriction
Traveler's diarrhea: 12 years of age or older, Hepatic encephalopathy and IBS-D: 18 years of age or older

Prescriber Restriction

Coverage Duration
Traveler's diarrhea: 3 days, Hepatic encephalopathy: 6 months, IBS-D: 6 weeks

Other Criteria

Drugs
XOLAIR

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Diagnosis of A) moderate to severe persistent allergic asthma AND Evidence of specific allergic sensitivity confirmed by positive skin test (i.e. prick/puncture test) or blood test (i.e. radioallergosorbent test) for a specific IgE or in vitro reactivity to a perennial aeroallergen AND Pretreatment serum IgE levels greater than 30 and less than 700 IU/mL AND Symptoms are not adequately controlled with at least ONE inhaled corticosteroid (ICS) plus long-acting beta2-agonist (LABA) (e.g. Advair, Symbicort) for at least 3 months unless patient is intolerant to such treatment or such treatment is contraindicated, or B) Treatment of chronic idiopathic urticaria in adults and adolescents 12 years and older who remain symptomatic despite H1 antihistamine treatment (i.e. loratidine, cetirizine, levocetirizine, fexofenadine, etc.).

Age Restriction
Patient must be 12 years of age or older

Prescriber Restriction
Initial drug order must be by an allergist/immunologist, dermatologist, or a pulmonologist

Coverage Duration
6 months

Other Criteria

Drugs
XOSPATA

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

Exclusion Criteria

Required Medical Information
Clinical documentation of relapsed or refractory acute myeloid leukemia (AML) with a FMS-like tyrosine kinase 3 (FLT3) mutation as detected by an FDA-approved test.

Age Restriction

Prescriber Restriction
Oncology

Coverage Duration
3 months

Other Criteria

Drugs
XPOVIO ORAL TABLET 100 MG/WEEK (20 MG X 5), 40 MG/WEEK (20 MG X 2), 40MG TWICE WEEK (80 MG/WEEK), 60 MG/WEEK (20 MG X 3), 60MG TWICE WEEK (120 MG/WEEK), 80 MG/WEEK (20 MG X 4), 80MG TWICE WEEK (160 MG/WEEK)

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

Exclusion Criteria

Required Medical Information
Documentation that the medication will be used in 1) combination with dexamethasone for the treatment of adult patients with relapsed or refractory multiple myeloma (RRMM) who have received at least four prior therapies and whose disease is refractory to at least two proteasome inhibitors, at least two immunomodulatory agents, and an anti-CD38 monoclonal antibody. OR 2)monotherapy for the treatment of adult patients with relapsed or refractory diffuse large B-cell lymphoma

Age Restriction

Prescriber Restriction
Oncologist

Coverage Duration
3 months

Other Criteria

Drugs
XTANDI

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Diagnosis of metastatic castration-resistant prostate cancer AND the patient has tried and had an inadequate response, contraindication or intolerance to Zytiga.

Age Restriction

Prescriber Restriction
Oncologist or urologist

Coverage Duration
3 months

Other Criteria
Must try and fail Zytiga first.

Drugs
XYREM

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria
Contraindications: Patient is being treated with sedative hypnotic agents, other CNS depressants, or using alcohol. Patient has succinic semialdehyde dehydrogenase deficiency. Patient has a history of drug abuse.

Required Medical Information
Diagnosis of one of the following: A) Excessive daytime sleepiness in patients with narcolepsy AND 1. Submission of sleep study with narcolepsy diagnosis, AND 2. currently NOT taking any sedative hypnotics or other CNS depressants AND 3. has experienced inadequate response or intolerable side effects to two preferred products (modafinil, armodofinil, methylphenidate, or dextroamphetamine) AND 4. The requested dose does not exceed the FDA indicated maximum (9gm/night), or B) Cataplexy in patients with narcolepsy AND 1. Submission of sleep study showing narcolepsy diagnosis, AND 2. currently NOT taking any sedative hypnotics or other CNS depressants, AND 3. does not have sleep apnea, AND 4. The dose does not exceed the FDA indicated maximum (9gm/night).

Age Restriction
18 years of age and older

Prescriber Restriction
Neurologist

Coverage Duration
Initial: 3 months, Renewal: 6 months with documentation of continued benefit

Other Criteria
Patient and physician must adhere to all regulations of the Xyrem REMS Program. For renewal, the patient had a positive response to the medication (increased sleep quality for patients with narcolepsy).

Drugs
YONSA

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

Exclusion Criteria

Required Medical Information
Documented diagnosis of metastatic castration resistant prostate cancer (CRPC)AND the medication is being used in combination with methylprednisolone AND medication not being used as dual therapy with another androgen receptor inhibitor.

Age Restriction
18 years of age or older

Prescriber Restriction

Coverage Duration
3 Months

Other Criteria

Drugs
ZAVESCA

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Medical statement of approved diagnosis: mild to moderate type 1 Gaucher disease for whom enzyme replacement therapy is not a therapeutic option (e.g., due to constraints such as allergy, hypersensitivity, or poor venous access).

Age Restriction
18 years or older

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
ZEMAIRA

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction
18 years and older.

Prescriber Restriction

Coverage Duration
3 months.

Other Criteria

Drugs
ZEPOSIA, **ZEPOSIA STARTER KIT**, **ZEPOSIA STARTER PACK**

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

Exclusion Criteria

Required Medical Information
Documentation of diagnosis of clinically-isolated syndrome multiple sclerosis OR relapsing multiple sclerosis, including relapsing-remitting disease or active secondary progressive disease AND the patient has had a trial AND a complete blood cell count and liver function test was completed, reviewed, and deemed appropriate for Zeposia treatment by the prescriber AND patient has had ECG to assess for preexisting cardiac conduction abnormalities prior to starting Zeposia AND inadequate response or intolerance to at least one alternative drug indicated for the treatment of multiple sclerosis.

Age Restriction
18 Years of age and older

Prescriber Restriction
Neurologist

Coverage Duration
Initial 3 months, Continuation of therapy: 12 months

Other Criteria

Drugs
abacavir oral tablet, **ZIAGEN ORAL SOLUTION**

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria
Documented negative HLA-B*5701 screening.

Drugs
zidovudine

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
zoledronic acid-mannitol-water intravenous piggyback 5 mg/100 mL

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment. For treatment of hypercalcemia of malignancy, must have documentation of corrected total serum calcium greater than or equal to 12 mg/dL. For Paget's disease, must have symptomatic form of disease.

Age Restriction
18 years and older

Prescriber Restriction

Coverage Duration
Per treatment

Other Criteria
For Paget's disease, must have documented failure, intolerance or contraindication to oral agent: alendronate OR risedronate. For osteoporosis, must have documented failure, intolerance or contraindication to at least 2 oral bisphosphonates.

Drugs
ZOLINZA

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction
18 years and older.

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria
Treatment may be continued as long as there is no evidence of progressive disease or unacceptable toxicity.

Drugs
everolimus (immunosuppressive), **ZORTRESS ORAL TABLET 0.25 MG, 0.5 MG, 0.75 MG**

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria
Any pertinent clinical situation as defined by the product label that could affect patient safety and/or therapeutic efficacy (i.e. contraindications, warnings, precautions, adverse effects, renal or hepatic function, drug interactions, lab values, required prior or concomitant therapy, inappropriate dosing and/or duration, etc).

Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction
18 years and older.

Prescriber Restriction

Coverage Duration
6 months.

Other Criteria

Drugs
ZYDELIG

Covered Uses
All FDA-approved indications not otherwise excluded from Health Plan.

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria
For authorization, please submit to EviCore at evicore.com or call at 877-825-7722.

Drugs
ZYFLO

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

Exclusion Criteria
Any pertinent clinical situation as defined by the product label that could affect patient safety and/or therapeutic efficacy (i.e. contraindications, warnings, precautions, adverse effects, renal or hepatic function, drug interactions, lab values, required prior or concomitant therapy, inappropriate dosing and/or duration, etc).

Required Medical Information
Documentation of diagnosis and treatment history.

Age Restriction
12 years and older.

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria
Must have failed montelukast and zafirlukast.

Drugs
abiraterone, **ZYTIGA ORAL TABLET 500 MG**

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Diagnosis of metastatic prostate cancer AND Patient has castration-resistant disease (defined by tumor growth/disease progression, risk in PsA levels, new metastases) AND Zytiga will be used in combination with prednisone.

Age Restriction

Prescriber Restriction

Coverage Duration
3 months

Other Criteria

Index

For more recent information or other questions, please contact Health First Health Plans Customer Service at 1.855.882.6467 or, for TTY users, 1.800.955.8771, weekdays from 8 a.m. to 8 p.m. and Saturdays from 8 a.m. to noon. From October 1 through March 31, we are available seven days a week from 8 a.m. to 8 p.m. or visit myAHplan.com.

Customer Service has language interpreter services available for non-English speakers at no cost.

This information is also available at no cost in other formats. By contacting Customer Service you may request your materials be read aloud, emailed, or mailed in large print.

You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, premium and/or copayments/coinsurance may change on January 1, 2021, and from time to time during the year.

Advent Health Advantage Plans is administered by Health First Health plans. Health First Health Plans is an HMO plan with a Medicare contract. Enrollment in Health First Health Plans depends on contract renewal.

The Formulary, pharmacy network, may change at any time. You will receive notice when necessary.

Nondiscrimination Notice

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

AdventHealth Advantage Plans:

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

If you need these services, please contact our Civil Rights Coordinator.

If you believe that AdventHealth Advantage Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Civil Rights Coordinator, 6450 US Highway 1, Rockledge, FL 32955, 321-434-4521, 1-800-955-8771 (TTY), Fax: 321-434-4362, civilrightscoordinator@hf.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance our Civil Rights Coordinator, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

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

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English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-882-6467 (TTY: 1-800-955-8771).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-882-6467 (TTY: 1-800-955-8771).

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-882-6467 (TTY: 1-800-955-8771).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-882-6467 (TTY: 1-800-955-8771).

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-882-6467 (TTY: 1-800-955-8771).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-882-6467（TTY：1-800-955-8771）。

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-882-6467 (ATS : 1-800-955-8771).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-882-6467 (TTY: 1-800-955-8771).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-882-6467 (телетайп: 1-800-955-8771).

Arabic:

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-882-6467 (رقم هاتف الصم والبكم: 1-800-955-8771).

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-882-6467 (TTY: 1-800-955-8771).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-882-6467 (TTY: 1-800-955-8771).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-882-6467 (TTY: 1-800-955-8771)번으로 전화해 주십시오.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-882-6467 (TTY: 1-800-955-8771).

Gujarati: સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-855-882-6467 (TTY: 1-800-955-8771).

Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-855-882-6467 (TTY: 1-800-955-8771).

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