

## **Commercial Metal 5-Tier Plans**

### **2020 Prior Authorization (PA)**

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## Acitretin (SORIATANE)

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**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**  
**ACTEMRA**

**Covered Uses**

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

**Exclusion Criteria**

Tuberculosis (TB), or invasive fungal infections or other active serious infections, or history of 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 Actemra (tocilizumab). Using Actemra in combination with other TNF antagonists, IL-1R antagonists, janus kinase inhibitor, anti-cd20 monoclonal antibodies or selective co-stimulation modulators. At initiation of therapy, absolute neutrophil count (ANC) below 2000/mm<sup>3</sup>, platelet count below 100,000/mm<sup>3</sup>, or ALT or AST above 1.5 times the upper limit of normal.

**Required Medical Information**

Documentation of diagnosis, treatment history and TB evaluation. FDA-approved indications for Actemra IV include Polyarticular Juvenile Idiopathic Arthritis (PJIA), Rheumatoid Arthritis (RA), Systemic Juvenile Idiopathic Arthritis (SJIA). FDA-approved indications for Actemra SC include RA.

**Age Restriction**

RA: 18 years and older for RA. PJIA, SJIA: 2 years and older

**Prescriber Restriction**

Rheumatologist

**Coverage Duration**

Plan year

**Other Criteria**

APPROVE for PJIA if patient is already on Actemra IV or has failed to respond to, is intolerant of, or has a medical contraindication to ONE non-biologic disease modifying anti-rheumatic drug (DMARD) (such as methotrexate [MTX]) AND has had a trial of BOTH Humira AND Enbrel. APPROVE for RA if patient is already on Actemra IV/Actemra SC or has had an inadequate response to ONE non-biological DMARD (e.g., hydroxychloroquine [HCQ], sulfasalazine, MTX, leflunomide, azathioprine, cyclosporine) or a tumor necrosis factor (TNF) antagonist drug AND has had a trial of BOTH Humira AND Enbrel. APPROVE for SJIA if patient is already on Actemra IV or has failed to respond to or has a medical contraindication to ONE nonsteroidal anti-inflammatory drug (NSAID) or corticosteroid AND has failed to respond to or has a medical contraindication to Enbrel and Humira. Patient has been tested for TB and latent TB has been ruled out or is being treated. Dosing as per FDA approved labeling.

## **ACTIMMUNE (interferon gamma-1B)**

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### **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**

## ADCIRCA (tadalafil (Pulmonary Hypertension))

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### **Drugs**

*tadalafil (pulm. hypertension)*

### **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**  
**ADDYI**

**Covered Uses**

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

**Exclusion Criteria**

Concomitant use of alcohol. Concomitant use with moderate or strong CYP3A4 inhibitors (eg, ciprofloxacin, clarithromycin, diltiazem, fluconazole, itraconazole, ketoconazole, ritonavir, verapamil). Hepatic impairment (e.g., a Child-Pugh score of 6 points or greater).

**Required Medical Information**

ADocumentation of diagnosis and that the patient is a premenopausal female. Documentation that the patient has no known history of alcohol abuse or has abstained from alcohol abuse for the past 6 months. Prescriber must be certified/enrolled in the Addyi REMS program.

**Age Restriction**

**Prescriber Restriction**

3 months

**Coverage Duration**

Plan year

**Other Criteria**

Addyi will NOT be approved if low sexual desire is due to any of the following: 1) a co-existing medical or psychiatric condition, 2) problems within the relationship, 3) the effects of a medication or other drug substance.

## Adefovir (HEPSERA)

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### **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**

## ALINIA (nitazoxanide)

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### **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**

## **Alosteron (LOTRONEX)**

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### **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)

## **AMPYRA (dalfampridine)**

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### **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**  
**ANADROL-50**

**Covered Uses**

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

**Exclusion Criteria**

1. Carcinoma of the prostate or breast in male patients. 2. Carcinoma of the breast in females with hypercalcemia, androgenic anabolic steroids may stimulate osteolytic resorption of bones. 3. Pregnancy 4. Nephrosis or the nephrotic phase of nephritis. 5. Severe hepatic dysfunction.

**Required Medical Information**

Acquired Aplastic Anemia: 1. History of failure to erythropoietic stimulating agent, OR 2. Used in combination with antilymphocyte globulin or both antilymphocyte globulin and corticosteroid treatment. Hypoplastic Anemia: 1. Diagnosis of hypoplastic anemia due to myelotoxic drugs, AND 2. Failure to erythropoietic stimulating agent. Pure Red Cell Aplasia: Failure of immunosuppressive therapy. Anemia of Chronic Renal Failure: Failure to an erythropoietic stimulating agent. Preferred Erythropoietin Stimulating Agent: Procrit. Tablet should not replace correcting iron, folic acid, and vitamin B12.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**

Plan year

**Other Criteria**

**Drugs**  
**METHITEST****Covered Uses**

All FDA-approved indications not otherwise excluded by Health Plan. Replacement therapy in congenital or acquired conditions associated with a deficiency or absence of endogenous testosterone, such as: Primary hypogonadism (congenital or acquired): Testicular failure caused by cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, orchiectomy, Klinefelter syndrome, chemotherapy, or toxic damage from alcohol or heavy metals. These men usually have low serum testosterone levels and gonadotropins (follicle-stimulating hormone [FSH], LH) above the normal range. Secondary hypogonadism (congenital or acquired): Idiopathic gonadotropin or luteinizing hormone (LH)releasing hormone (LHRH) deficiency or pituitary-hypothalamic injury from tumors, trauma, or radiation. These men have low serum testosterone concentrations but have gonadotropins in the normal or low range.o The U.S. Food and Drug Administration (FDA) cautions that prescription testosterone products are approved only for men who have low testosterone levels caused by certain medical conditions. The benefit and safety of these medications have not been established for the treatment of low testosterone levels due to aging, even if a mans symptoms seem related to low testosterone. We are requiring that the manufacturers of all approved prescription testosterone products change their labeling to clarify the approved uses of these medications. We are also requiring these manufacturers to add information to the labeling about a possible increased risk of heart attacks and strokes in patients taking testosterone. Health care professionals should prescribe testosterone therapy only for men with low testosterone levels caused by certain medical conditions and confirmed by laboratory tests. [FDA Drug Safety Communication (03-03-2015)]

**Exclusion Criteria**

Use in women Men with carcinoma of the breast or known or suspected carcinoma of the prostate Low testosterone due to aging (per FDA, this is not included in the indication of idiopathic hypogonadism)

**Required Medical Information**

Clinical documentation (notes and lab results) of testosterone deficiency diagnosis based on FDA approved indication and monitoring for safety and efficacy of testosterone therapy: Clinical documentation required for initial authorization includes:1) Documentation of FDA-approved indication as described under Covered Use.2) Written description of symptoms and signs relating to possible androgen deficiency with evaluation of other causes of symptoms AND 3) At least two morning serum testosterone levels (total) below the normal range for the laboratory OR at least one morning serum testosterone level (total) below the normal range for the laboratory with elevated or low FSH and/or LH a. if alterations in SHBG is suspected (i.e. due to obesity or diabetes) then a free, testosterone level may be needed4) Baseline hematocrit must be less than 50% AND 5) Prostate-specific antigen (PSA): a. Patients with palpable prostate nodule or induration or PSA more than 4 ng/mL or PSA more than 3 ng/mL in men at high risk of prostate cancer require urological evaluation prior to approval, and/or b. Men older than 40 years with baseline PSA more than 0.6 ng/mL will require prostate exam and PSA measurement prior to treatment approval AND6) Assessment of patients past medical history (i.e. breast or prostate cancer, age, cardiovascular disease, liver disease, diabetes, age, obesity, obstructive sleep apnea, BPH) and documented discussion about the risks and benefits of testosterone therapy

**Age Restriction**

18 years or older

**Prescriber Restriction****Coverage Duration**

Initial: 6 months, Reauthorization: 1 year

**Other Criteria**

Studies have suggested an increased risk of cardiovascular events among groups of men prescribed testosterone therapy. The Endocrine Society suggests it may be prudent to avoid testosterone therapy in men who have experienced a cardiovascular event (e.g., myocardial infarction [MI], stroke, acute coronary syndrome) in the past 6 months. These risks are currently under review by the FDA. The Endocrine Society recommends against starting testosterone therapy in patients with untreated severe obstructive sleep apnea, severe untreated BPH with International Prostate Symptom Score of more than 19, or uncontrolled or poorly controlled heart failure.

**APTIOM (eslicarbazepine acetate)**

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**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**

**ARANESP (IN POLYSORBATE)**

**Covered Uses**

All FDA-approved indications not otherwise excluded from Health Plan, anemia due to myelodysplastic syndromes (MDS).

**Exclusion Criteria**

Patients receiving chemotherapy with curative intent. Patients with myeloid cancer.

**Required Medical Information**

For all uses: 1) Pretreatment (no erythropoietin treatment in previous month) Hgb is less than 10 g/dL, AND 2) For reauthorizations (patient received erythropoietin in previous month), an increase in Hgb of at least 1 g/dL after at least 12 weeks of therapy. Additional requirements for anemia due to myelosuppressive cancer chemotherapy: 1) For initial therapy, at least 2 more months of chemotherapy is expected, AND 2) For reauthorizations, current Hgb is less than 11 g/dL. Additional requirements for CKD not on dialysis reauthorization: 1) Current Hgb is less than or equal to 10 g/dL OR Hgb is greater than 10 but less than or equal to 12 g/dL AND prescriber will reduce or interrupt dose. Additional requirements for MDS: 1) Patient has symptomatic anemia, AND 2) Pretreatment serum erythropoietin level is less than or equal to 500 mU/mL, AND 3) For reauthorizations, current Hgb is less than or equal to 11 g/dL OR Hgb is greater than 11 but less than or equal to 12 g/dL AND prescriber will reduce or interrupt dose.

**Age Restriction**

**Prescriber Restriction**

MDS anemia, prescribed by or in consultation with, a hematologist or oncologist.

**Coverage Duration**

Plan year

**Other Criteria**

**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 treatment with 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.

## Armodafinil (NUVIGIL)

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### **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**  
**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).

## **Austedo**

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### **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**



## **BANZEL (rufinamide)**

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### **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)

**BARACLUDE (entecavir)**

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**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**

## **BENLYSTA**

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### **Drugs**

#### **BENLYSTA SUBCUTANEOUS SYRINGE**

### **Covered Uses**

All FDA-approved indications not otherwise excluded 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**

## Benznidazole

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### **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**

## Benzodiazepines

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### 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

## **BETASERON (interferon beta-1b)**

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### **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**

## Brand Antipsychotics

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### **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

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### 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

## **BROVANA (arformoterol tartrate)**

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### **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**

## **BUPHENYL (sodium phenylbutyrate)**

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### **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**

## Buprenorphine Products

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### 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

**BUSULFEX (busulfan)**

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**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**

## Calquence

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### **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**

## **CAPRELSA (vandetanib)**

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### **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**

**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 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**

**CIALIS ORAL TABLET 2.5 MG, 5 MG**

**Covered Uses**

All FDA-approved indication not otherwise excluded by Health Plan. Use for Erectile Dysfunction is not covered.

**Exclusion Criteria**

Concurrent use of organic nitrate (regularly and/or intermittently) or guanylate cyclase stimulators (e.g. riociguat).

**Required Medical Information**

Documentation of Benign prostatic hyperplasia (BPH) diagnosis and history BPH treatment.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**

Plan year

**Other Criteria**

Use for Erectile Dysfunction is not covered. Must have tried and failed at least 2 other formulary medications for BPH such as tamsulosin, alfuzosin, dutasteride, finasteride, doxazosin, terazosin.

**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**

## **CINRYZE (C1 inhibitor (human))**

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### **Drugs CINRYZE**

#### **Covered Uses**

All FDA-approved indications not otherwise excluded from Health Plan

#### **Exclusion Criteria**

#### **Required Medical Information**

#### **Age Restriction**

13 years of age or older

#### **Prescriber Restriction**

Must be prescribed by Dermatologist, Hematologist, or Allergist/Immunologist

#### **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**

## clozapine oral disintegrating tablet (FAZACLO)

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### **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**  
**COMETRIQ**

**Covered Uses**

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

**Exclusion Criteria**

Gastrointestinal perforation. Fistula. Severe hemorrhage.

**Required Medical Information**

Documented diagnosis of progressive metastatic, medullary thyroid cancer.

**Age Restriction**

18 years or older

**Prescriber Restriction**

Oncologist/Hematologist

**Coverage Duration**

3 Months

**Other Criteria**

For authorization, please submit to EviCore at [evicore.com](http://evicore.com) or call at 877-825-7722.

**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**  
**CRESEMBA**

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

**Exclusion Criteria**

**Required Medical Information**  
Documentation of diagnosis.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**  
Plan year

**Other Criteria**

**CYCLOSET (bromocriptine mesylate (diabetes))**

---

**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**

**CYSTADANE (betaine)**

---

**Drugs**  
**CYSTADANE**

**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**  
**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**  
**CYSTARAN**

**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**

**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**

**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

## Diazoxide

---

### 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 malignancy 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

## Diclofenac sodium topical gel 3 % (SOLARAZE)

---

### **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**  
**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**

## Doxercalciferol (HECTOROL)

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### **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**

**Doxorubicin**

---

**Drugs**  
**DOXORUBICIN INTRAVENOUS SOLUTION 2 MG/ML**

**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**

## DRONABINOL (MARINOL)

---

### 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**

**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.



## EDECIN (Ethacrynic Acid)

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### Drugs

**EDECIN**, *ethacrynic acid*

### 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.

## Eligard (Leuprolide)

---

### 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**

## EMCYT (Estramustine Phosphate Sodium)

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### **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**

## EMEND (Aprepitant)

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### Drugs

*aprepitant*, 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**

**ENBREL SUBCUTANEOUS RECON SOLN, ENBREL SUBCUTANEOUS SOLUTION, 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 serious infections, or history of 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 monoclonal antibodies 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 had 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.

**Endari (Glutamine Powder)**

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**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**  
**ERIVEDGE**

**Covered Uses**

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

**Exclusion Criteria**

**Required Medical Information**

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

**Age Restriction**

18 years or older

**Prescriber Restriction**

**Coverage Duration**

12 months

**Other Criteria**

For authorization, please submit to EviCore at [evicore.com](http://evicore.com) or call at 877-825-7722.

**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.

**Etoposide**

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**Drugs**  
*etoposide intravenous*

**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**  
**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, COTELLIC, GLEOSTINE ORAL CAPSULE 10 MG, 100 MG, 40 MG, HYCAMTIN, IDAMYCIN PFS, INLYTA, IRESSA, LONSURF, NINLARO, ROZLYTREK ORAL CAPSULE 100 MG, 200 MG, RUBRACA, RYDAPT, SANCUSO, TAGRISSE ORAL TABLET 40 MG, 80 MG, TOPOSAR, VALCHLOR, VENCLEXTA ORAL TABLET 10 MG, 100 MG, 50 MG, VENCLEXTA STARTING PACK, XERMELO, ZEJULA, ZELBORAF

**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](http://evicore.com) or call at 877-825-7722.

**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  $50 \times 10^9/L$ . 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**

**FANAPT (Iloperidone)**

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**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**  
**FARYDAK**

**Covered Uses**

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

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**

12 months

**Other Criteria**

For authorization, please submit to EviCore at [evicore.com](http://evicore.com) or call at 877-825-7722.

**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/ $\mu$ L within previous 12 months or greater than or equal to 150 cells/ $\mu$ L 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**

## Fentanyl Citrate (ACTIQ)

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### 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), opioid 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 SOLUTION, 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  $1.5 \times 10^9/L$ .

**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  $0.5 \times 10^9/L$



**Drugs**  
**FETZIMA**

**Covered Uses**

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

**Exclusion Criteria**

**Required Medical Information**

Documentation of diagnosis and treatment history.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**

Plan year

**Other Criteria**

Approve with documented trial of any two generic antidepressants (e.g. bupropion, citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine, paroxetine CR, sertraline, duloxetine, venlafaxine).

**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 excluded 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**

## **Firdapse (Amidampridine)**

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### **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**

## Fondaparinux (ARIXTRA)

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### 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 from Part D.

**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**

Diagnosis of one of the following: A) Osteoporosis in a postmenopausal female, or B) Primary or hypogonadal osteoporosis in a male, or C) Osteoporosis associated with sustained systemic glucocorticoid therapy AND one or more of the following: 1) History of osteoporotic fracture, or 2) Documented trial and failure of bisphosphonate and Prolia, or 3) Documented contraindication or intolerance to bisphosphonate therapy and Prolia. Patient has not received more than 2 years of therapy with Forteo.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**

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

**Other Criteria**

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

**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**

**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**  
**GILOTRIF**

**Covered Uses**

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

**Exclusion Criteria**

**Required Medical Information**

Diagnosis of 1) metastatic non-small cell lung cancer whose tumors have non-resistant epidermal growth factor receptor (EGFR) mutations as detected by an FDA-approved test AND the medication will be used first-line or 2) metastatic squamous NSCLC progressing after platinum-based chemotherapy.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**

Plan year

**Other Criteria**

For authorization, please submit to EviCore at [evicore.com](http://evicore.com) or call at 877-825-7722.

### 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**

**NUTROPIN AQ NUSPIN SUBCUTANEOUS PEN INJECTOR 10 MG/2 ML (5 MG/ML), 20 MG/2 ML (10 MG/ML)**

**Covered Uses**

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

**Exclusion Criteria**

**Required Medical Information**

Criteria for use in children: Other reasons for short stature have been ruled out, AND Patient must have clinically diagnosed growth hormone deficiency (GHD) due to lack of endogenous growth hormone confirmed by subnormal response to at least two stimuli of GH release, AND Short stature defined by a height less than or equal to 2 standard deviations below the mean or at or below the 3rd percentile for age and gender, AND Predicted adult height more than 1.5 standard deviations below the mid-parental height, AND bone age at least 1 standard deviation below the normal, AND Clinically determined growth failure (growth rate velocity less than 7cm/year if less than 3 yrs old, and greater than 5cm/year if greater than 3 yrs old), AND one of the following: Epiphyses are not closed OR diagnosed Turner's Syndrome whose epiphyses are not closed and bone age less than 14 years OR growth failure associated with chronic renal insufficiency in patients whose epiphysis is not closed. For continuation of therapy in children: Epiphysis must not be closed, AND growth rate velocity must be equal to or greater than 2.5cm/year. Criteria for use in adults: growth hormone deficiency alone or with multiple hormone deficiencies (hypopituitarism) as a result of pituitary disease, AND patient must exhibit clinical features of adult GHD, AND documentation of response less than 3ng/ml to two provocative stimulation tests, AND Baseline IGF. Continuation goals of therapy for adults: IGF-1 is in normal range for age and gender based on specific lab reference values (If above normal, dose reduction required) AND Evidence of improvement in factors such as: body composition, increase in bone density, reduction of cardiovascular risk factors, improvement of lipid profile, increase in exercise capacity.

**Age Restriction**

**Prescriber Restriction**

Prescribed by endocrinologist only or pediatric nephrologists (for GHD in chronic renal failure)

**Coverage Duration**

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

**Other Criteria**

**Drugs**

HUMIRA PEN, HUMIRA PEN CROHNS-UC-HS START, HUMIRA PEN PSOR-UEVITS-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 serious infections, or history of 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 treatment. Using in combination with other TNF antagonists, IL-1R antagonists, janus kinase inhibitor, anti-cd20 monoclonal antibodies 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.

## Hydromorphone ER (EXALGO)

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### **Drugs**

*hydromorphone oral tablet extended release 24 hr*

### **Covered Uses**

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

### **Exclusion Criteria**

### **Required Medical Information**

Clinical documentation of diagnosis and failure of preferred generic formulary long-acting opioid alternatives.

### **Age Restriction**

### **Prescriber Restriction**

### **Coverage Duration**

Plan year

### **Other Criteria**

**Drugs**  
**HYQVIA**

**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**  
**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**

## ICLUSIG (Ponatinib)

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### Drugs

**ICLUSIG ORAL TABLET 15 MG, 45 MG**

### Covered Uses

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

### Exclusion Criteria

#### Required Medical Information

Diagnosis of one of the following: A) Chronic myelogenous leukemia (CML) and patient has tried and failed or has an intolerance to two first-line tyrosine kinase inhibitors OR patient has a known T315I mutation, or B) Philadelphia chromosome-positive acute lymphoblastic leukemia and the patient has tried and failed or had an intolerance to two previous tyrosine kinase inhibitors OR patient has a known T315I mutation.

#### Age Restriction

18 years or older

#### Prescriber Restriction

Prescribed by a hematologist/oncologist

#### Coverage Duration

12 Months

#### Other Criteria

For authorization, please submit to EviCore at [evicore.com](http://evicore.com) or call at 877-825-7722.

**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**

**IMBRUVICA (Ibrutinib)**

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**Drugs**

**IMBRUVICA ORAL CAPSULE 140 MG, 70 MG, IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG, 560 MG**

**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****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 Kaposi 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**

## INVEGA (paliperidone)

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### 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**  
**ISENTRESS HD**

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

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**  
Through the end of benefit 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**

## Itraconazole (Sporanox)

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### 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

**GAMASTAN S/D, GAMMAGARD LIQUID, GAMMAGARD S-D (IGA < 1 MCG/ML)**

### 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  $50 \times 10^9/L$  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**

**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-progressive 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**

## Koselugo (Selumetinib)

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### 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**  
**LACRISERT**

**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**

*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.

**LENVIMA (Lenvatinib)**

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**Drugs**

**LENVIMA ORAL CAPSULE 10 MG/DAY (10 MG X 1), 12 MG/DAY (4 MG X 3), 14 MG/DAY(10 MG X 1-4 MG X 1), 18 MG/DAY (10 MG X 1-4 MG X2), 20 MG/DAY (10 MG X 2), 24 MG/DAY(10 MG X 2-4 MG X 1), 4 MG, 8 MG/DAY (4 MG X 2)**

**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**

**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/mm<sup>3</sup> and CBC with differential.

**Age Restriction**

Patients requiring prophylaxis of febrile 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**

**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**

LIDOCAINE PRODUCTS

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**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

Prescribing 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: Amoxicillin/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**  
**LIVALO**

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

**Exclusion Criteria**

**Required Medical Information**  
Stated failure of generic formulary alternatives.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**  
Plan year

**Other Criteria**

**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**  
LUPANETA PACK (1 MONTH), LUPANETA PACK (3 MONTH)

**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**

**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.

## LYNPARZA

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### 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

## **Makena (hydroxyprogesterone caproate injection)**

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### **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**

## Mavenclad (Cladribine)

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### 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.

## MEKINIST (Trametinib Dimethyl Sulfoxide)

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### Drugs

**MEKINIST ORAL TABLET 0.5 MG, 2 MG**

### Covered Uses

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

### Exclusion Criteria

Patients who have received prior BRAF-inhibitor therapy.

### Required Medical Information

Diagnosis of unresectable or metastatic melanoma, positive BRAF V600E or V600K mutation as detected by an FDA-approved test (THxID-BRAF Kit) or Clinical Laboratory Improvement Amendments (CLIA)-approved facility, and the patient has not received prior BRAF-inhibitor therapy.

### Age Restriction

18 years or older

### Prescriber Restriction

Oncologist

### Coverage Duration

12 months

### Other Criteria

For authorization, please submit to EviCore at [evicore.com](http://evicore.com) or call at 877-825-7722.

**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**



## **MENEST (Esterified Estrogens)**

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### **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)

**Meropenem (MERREM)**

---

**Drugs**

*meropenem*

**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**

Cultures and sensitivities

**Age Restriction**

**Prescriber Restriction**

Infectious disease

**Coverage Duration**

Per treatment

**Other Criteria**

**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**

## Modafinil (PROVIGIL)

---

### **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 osmotic laxative (e.g. PEG 3350) or a stimulant laxative (e.g. bisacodyl) with or without a stool softener (e.g. docusate).

**Drugs**  
**MOZOBIL**

**Covered Uses**

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

**Exclusion Criteria**

**Required Medical Information**

Diagnosis: Harvesting of peripheral blood stem cells, In patients with non-Hodgkin's lymphoma and multiple myeloma. Patients weight for dosage determination. Concurrent Treatments: used in combination with granulocyte-colony stimulating factor

**Age Restriction**

Approve for those patients 18 years of age or older

**Prescriber Restriction**

Prescriber must be an oncologist or hematologist.

**Coverage Duration**

Plan year

**Other Criteria**

The patient must have a documented treatment failure (i.e. failure to reach and/or maintain a target ANC) which is consistent with pharmacy claims data with an adequate trial (including dates, doses of therapy) of Neupogen. Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

## Mulpleta

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### **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  $50 \times 10^9/L$

#### **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**



## NATPARA (Parathyroid Hormone (Recombinant))

---

### **Drugs** **NATPARA**

#### **Covered Uses**

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

#### **Exclusion Criteria**

Because of the potential risk of osteosarcoma, recommended only for patients who cannot be well-controlled on calcium supplements and active forms of vitamin D alone, has not been studied in patients with hypoparathyroidism caused by calcium-sensing receptor mutations or in patients with acute postsurgical hypoparathyroidism.

#### **Required Medical Information**

Documented diagnosis of hypocalcemia secondary to hypoparathyroidism, AND hypocalcemia is not corrected by calcium supplements and active forms of vitamin D alone, AND member is concurrently taking a calcium supplement and an active form of vitamin D

#### **Age Restriction**

18 years and older

#### **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**

## NEULASTA (Pegfilgrastim)

---

### **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**  
**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.

**NORPACE CR (Disopyramide Phosphate)**

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**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**  
**NORTHERA**

**Covered Uses**

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

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

18 years of age or older

**Prescriber Restriction**

**Coverage Duration**

Plan year

**Other Criteria**

For renewal, Patient does not have persistent or sustained supine hypertension (SBP more than 180 mmHg or DBP more than 110 mmHg), Patient does not have persistent or sustained standing or sitting hypertension (SBP more than 180 mmHg or DBP more than 110 mmHg), and Patient had improvement in symptoms of NOH. Sustained mean elevated blood pressure that persists for longer than 5 minutes after change in position. Persistent means elevated BP that occurs on more than one occasion on separate physician office visits

**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**

Documentation of non-metastatic castration resistant prostate cancer (nmCRPC).

**Age Restriction**

**Prescriber Restriction**

Oncologist

**Coverage Duration**

3 months

**Other Criteria**

**Drugs**

**NUCALA SUBCUTANEOUS AUTO-INJECTOR, NUCALA SUBCUTANEOUS SYRINGE**

**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/ $\mu$ L within previous 12 months or greater than or equal to 150 cells/ $\mu$ L 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**

## NUCYNTA (Tapentadol)

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### 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**  
**NUEDEXTA**

**Covered Uses**

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

**Exclusion Criteria**

Currently prescribed an MAOI or within 14 days of stopping an MAOI. Diagnosis of AV block (without implanted pacemaker, or patients at high risk of complete AV block), heart failure, QT prolongation or history of torsades de pointes. Concomitant use with drugs that both prolong QT interval and are metabolized by CYP2D6 (e.g., thioridazine or pimozide).

**Required Medical Information**

Initial Authorization Requirement: Trial and failure of at least 1 formulary alternative with evidence for clinical effectiveness in treatment of PBA off label (e.g., fluoxetine, citalopram, sertraline, amitriptyline or nortriptyline) AND Clinical diagnosis of Pseudobulbar affect (PBA) as evidenced by ALL of the following: A) episodes causing clinically significant distress or impairment in social or occupational functioning, AND B) PBA Symptom frequency of 4 or more episodes per day, AND C) Baseline score of at least 13 on the Center for Neurologic Studies-Lability Scale (CNS-LS), AND D) Neurologic disease or brain injury (e.g., traumatic brain injury, stroke, dementia, multiple sclerosis, amyotrophic lateral sclerosis (ALS), Parkinson's disease). Reauthorization Requirement: Documentation of clinical benefit with decrease in episodes per day.

**Age Restriction**

18 years or older

**Prescriber Restriction**

Neurologist

**Coverage Duration**

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

**Other Criteria**

**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*, **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**  
**ODOMZO**

**Covered Uses**

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

**Exclusion Criteria**

Pregnancy

**Required Medical Information**

Documentation of diagnosis and treatment history. For females of reproductive potential, pregnancy has been ruled out with a negative pregnancy test result.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**

12 months

**Other Criteria**

For authorization, please submit to EviCore at [evicore.com](http://evicore.com) or call at 877-825-7722.

**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

**ONFI (Clobazam)**

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**Drugs**  
**ONFI ORAL SUSPENSION, ONFI ORAL TABLET 10 MG, 20 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**  
**OPSUMIT**

**Covered Uses**

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

**Exclusion Criteria**

Pregnancy

**Required Medical Information**

Clinically diagnosed with pulmonary arterial hypertension WHO Group 1 that was confirmed by right heart catheterization. Patient has WHO Functional Class II - IV symptoms, AND Patient is not using tobacco products, AND The patient has had a vasoreactivity test unless the provider indicates that the patient has a contraindication to the test or indicates clinical inappropriateness to the vasoreactivity test, AND Must have tried and failed or has a contraindication to the use of a calcium channel blocker if they have a positive vasoreactivity test, AND If functional class II or III, must have tried and failed or intolerant to sildenafil, or provide documentation as to why contraindicated to initiation of sildenafil.

**Age Restriction**

Patient must be at least 18 years of age

**Prescriber Restriction**

Prescribed by a pulmonologist, a cardiologist, or a physician specializing in pulmonary arterial hypertension.

**Coverage Duration**

3 Months

**Other Criteria**

**Drugs**

**ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 0.25 MG, 1 MG, 2.5 MG**

**Covered Uses**

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

**Exclusion Criteria**

Pregnancy

**Required Medical Information**

Patient has a diagnosis of PAH (WHO Group I) WHO/NYHA Class IV patients OR 1.) Patient has a diagnosis of PAH (WHO Group I) WHO/NYHA Class II-III who do not respond adequately to, are unable to tolerate, or are not candidates for endothelin receptor antagonists (e.g. TRACLEER [bosentan] or LETAIRIS [ambrisentan]) and phosphodiesterase-5 (PDE-5) inhibitors (e.g. REVATIO [sildenafil], ADCIRCA [tadalafil]).

**Age Restriction**

Patient must be at least 18 years of age.

**Prescriber Restriction**

Prescribed by a pulmonologist or a cardiologist

**Coverage Duration**

3 Months

**Other Criteria**

Medication is eligible for B vs. D determination

**Drugs**

**ORFADIN ORAL CAPSULE**

**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**  
**OSPHERA**

**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**

Plan documents must show coverage for sexual dysfunction medications. Must have diagnosis of moderate to severe dyspareunia caused by vulvovaginal atrophy and documented trial with an OTC vaginal lubricant as well as a vaginal estrogen product for at least 90 days.

**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**

## Oxandrolone (OXANDRIN)

---

### 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/m<sup>2</sup> e. BCM less than 35% male (less than 23% female) and a BMI less than 27 kg/m<sup>2</sup> 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**

## Oxycodone ER (OXYCONTIN)

---

### Drugs

*oxycodone oral tablet, oral only, ext. rel. 12 hr*

### Covered Uses

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

### Exclusion Criteria

Patient is being treated for substance abuse (including treatment with buprenorphine or buprenorphine-naloxone).

### Required Medical Information

Documentation of diagnosis along with current and past treatment history.

### Age Restriction

### Prescriber Restriction

### Coverage Duration

Plan year

### Other Criteria

An adequate trial of or documented intolerance to morphine sustained-release and oxymorphone sustained-release is required. For quantity greater than 2 per day or a combined opiate dose of 120 MEQ or greater (in addition to all other criteria) patient must have a clinically documented medical need for the increased quantity and/or large dose and must have tried and failed the standard approved dosing, frequency, and duration. For continuation of therapy clinical documentation must show the following: 1) the patient's pain has been recently re-assessed and there continues to be a medical need for the medication, 2) the patient is tolerating and responding to medication, 3) the patient has improved functioning and is meeting treatment goals, and 4) patient is not exhibiting addictive behaviors and is not being treated for substance abuse.

**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**

## PAMIDRONATE

---

### **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 treatment 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.



**PANRETIN (Alitretinoin)**

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**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**

## paricalcitol (ZEMPLAR)

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### **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**

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

## **Covered Uses**

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

## **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) 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) If unable to tolerate a high intensity statin, patient has been receiving at least 12 consecutive weeks of statin therapy at a maximally tolerated dose and will continue to receive statin at maximally tolerated dose (a maximally tolerated dose may include alternative dosing strategies such as every other day or once weekly dosing) c) Patient has a documented labeled contraindication to all statins, d) Patient has experienced rhabdomyolysis, AND 3. Documentation of and one of the following a) The patient is on ezetimibe, b) Patient has a document contraindication to ezetimibe, c) The patient's LDL is elevated to an extent that ezetimibe will be unable to bring them to goal ( greater than 120% percent guideline recommended goal). Clinical documentation required for "reauthorization" includes: 1. Patient continues to remain adherent to statin at maximally tolerated dose (unless patient has documented inability to take statins) and ezetimibe, 2. Submission of medical records documenting LDL-C reduction while on Repatha therapy (40% LDL-C reduction).

### **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, Lipid specialist

### **Coverage Duration**

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

### **Other Criteria**

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.

**Drugs**

**PEGASYS SUBCUTANEOUS SOLUTION, PEGASYS SUBCUTANEOUS SYRINGE, 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

## **PENTAM (Pentamidine Isethionate)**

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### **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**

## PERFOROMIST (Formoterol)

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### **Drugs** **PERFOROMIST**

#### **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**

Inhalation Solution: 18 years and older. Dry Powder Inhalation: 5 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.



## Perseris (risperidone)

---

### **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**

## PICATO (Ingenol Mebutate)

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### **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**

**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**

Documentation that the member has been diagnosed with relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults.

**Age Restriction**

Age 18 years and older

**Prescriber Restriction**

Neurologist

**Coverage Duration**

6 months

**Other Criteria**

## POMALYST (Pomalidomide)

---

### **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 myeloma 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**

## **Pramipexole ER (MIRAPEX ER)**

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### **Drugs**

*pramipexole oral tablet extended release 24 hr*

### **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**

**PREVACID SOLUTAB**

**Covered Uses**

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

**Exclusion Criteria**

**Required Medical Information**

Documentation of diagnosis and that the patient is unable to swallow solid oral dosage forms.

**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 25 MG**

**Covered Uses**

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

**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 immunosuppressive therapy.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**

3 Months

**Other Criteria**

**Drugs**

**PROMACTA ORAL POWDER IN PACKET 12.5 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 immunosuppressive therapy.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**

3 Months

**Other Criteria**

## PROTOPIC (tacrolimus topical)

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### **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**

**REGRANEX (Becaplermin)**

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**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**

## RELENZA (Zanamivir)

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### 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 from Part D.

**Exclusion Criteria**

Pregnancy

**Required Medical Information**

Patient has a diagnosis of PAH (WHO Group I) WHO/NYHA Class IV patients OR 1.) Patient has a diagnosis of PAH (WHO Group I) WHO/NYHA Class II-III who do not respond adequately to, are unable to tolerate, or are not candidates for endothelin receptor antagonists (e.g. TRACLEER [bosentan] or LETAIRIS [ambrisentan]) and phosphodiesterase-5 (PDE-5) inhibitors (e.g. REVATIO [sildenafil], ADCIRCA [tadalafil]).

**Age Restriction**

Patient must be at least 18 years of age.

**Prescriber Restriction**

Prescribed by a pulmonologist or a cardiologist.

**Coverage Duration**

3 Months

**Other Criteria**

**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 older who 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**  
**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**  
**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.

## RIBAVIRIN

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### **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**

## **RISPERDAL CONSTRA (risperidone)**

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### **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.

## SABRIL (Vigabatrin)

---

### 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, ethosuximide, 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

## **SAMSCA (Tolvaptan)**

---

### **Drugs**

**SAMSCA**, *tolvaptan oral tablet 30 mg*

### **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 euvoletic): 1. Diagnosis of significant hyponatremia (euvoletic or hypervolemic), AND 2. Treatment has been initiated or re-initiated in a hospital setting prior to discharge. Reauthorization for hypervolemic and euvoletic hyponatremia: 1. Documentation of clinical benefit, AND 2. Treatment has been 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.



## **SAPHRIS (Asenapine Maleate )**

---

### **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

## SEROQUEL XR (Quetiapine)

---

### **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**

**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**

Documentation of Cushing's Disease diagnosis AND pituitary surgery is not an option or has not been curative

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**

Plan year

**Other Criteria**

For renewal, patient had a clinically meaningful reduction in 24-hour urinary free cortisol levels and/or improvement in signs or symptoms of the disease

**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 excluded 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.

**SOMAVERT (Pegvisomant)**

---

**Drugs**  
**SOMAVERT**

**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**  
**STIVARGA**

**Covered Uses**

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

**Exclusion Criteria**

**Required Medical Information**

Diagnosis of one of the following: A) Metastatic colorectal cancer AND patient has previously treated with fluoropyrimidine-, oxaliplatin-, and irinotecan-based therapy, an anti-vascular endothelial growth factor (VEGF) therapy, and, if KRAS wild type, an anti-epidermal growth factor receptor (EGFR) therapy, or B) Gastrointestinal stromal tumors that is locally advanced, unresectable or metastatic and patient has tried and had an inadequate response, contraindication or intolerance to Gleevec or Sutent.

**Age Restriction**

18 years and older

**Prescriber Restriction**

Oncologist

**Coverage Duration**

3 Months

**Other Criteria**

Hepatic function will be monitored prior to and during treatment and, if patient has elevated liver function tests of hepatocellular necrosis, therapy will be interrupted and then reduced or discontinued. For authorization, please submit to EviCore at [evicore.com](http://evicore.com) or call at 877-825-7722.

**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**

## **SUTENT (Sunitinib Malate)**

---

### **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**

**TABLOID (Thioguanine )**

---

**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 induction and consolidation treatment

**Other Criteria**

## TAFINLAR (Dabrafenib Mesylate)

---

### **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](http://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**

## TARCEVA (Erlotinib)

---

### 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

**TARGRETIN (Bexarotene)**

---

**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 Philadelphia 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  $30 \times 10^9/L$  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-progressive 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**

## Temozolomide (TEMODAR)

---

### **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**

*tetrabenazine*

### **Covered Uses**

All medically accepted indications not otherwise excluded by Health Plan.

### **Exclusion Criteria**

Actively suicidal. Untreated or inadequately treated depression. Impaired hepatic function. Concomitant use of monoamine oxidase inhibitors. Concomitant use of reserpine or within 20 days of discontinuing reserpine.

### **Required Medical Information**

Diagnosis of chorea associated with Huntington's disease AND any medication possibly contributing to the underlying symptoms of chorea has been discontinued (e.g., antipsychotics, metoclopramide, amphetamines, methylphenidate, dopamine agonists, etc.) unless cessation would be detrimental to the underlying condition.

### **Age Restriction**

### **Prescriber Restriction**

Huntington's: Prescribed by a neurologist. Tardive dyskinesia, Tourette's: Prescribed by neurologist or psychiatrist.

### **Coverage Duration**

Initial Therapy: 3 months. Reauthorization: through plan year

### **Other Criteria**

Should not be used in patients who have inadequately treated depression, or patients who are actively suicidal.

## THALOMID (Thalidomide)

---

### **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**

## **TIGAN (Trimethobenzamide)**

---

### **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**

**Tobramycin Inhalant Solution (TOBI)**

---

**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**

## TRACLEER (Bosentan)

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### **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**  
**TRACLEER**

**Covered Uses**

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

**Exclusion Criteria**

PENDING CMS APPROVAL: 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**

PENDING CMS APPROVAL: Diagnosis of pulmonary arterial hypertension (PAH) WHO Group I AND New York Heart Association (NYHA) Functional Class II-IV, AND Patient is not using tobacco products, AND The patient has had a vasoreactivity test unless the provider indicates that the patient has a contraindication to the test or indicates clinical inappropriateness to the vasoreactivity test, AND Must have tried and failed or has a contraindication to the use of a calcium channel blocker if they have a positive vasoreactivity test, AND If functional class II or III, must have tried and failed or intolerant to sildenafil, or provide documentation as to why contraindicated to initiation of sildenafil.

**Age Restriction**

Greater than 12 years of age

**Prescriber Restriction**

PENDING CMS APPROVAL: Available only to those enrolled in the Tracleer REMS program. Prescription is written by or in consultation with a pulmonologist, a cardiologist.

**Coverage Duration**

3 Months

**Other Criteria**

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



## Tranexamic acid (CYKLOKAPRON)

---

### 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

## Tretinoin (chemotherapy)

---

### 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**  
**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**  
**TYSABRI**

**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, or Copaxone is not covered.

**Required Medical Information**

Diagnosis of one of the following: A) Relapsing form of multiple sclerosis and medication will be used as monotherapy and patient had an inadequate response, intolerance, or contraindication to conventional therapy with one of the following: An interferon beta product, Copaxone, Tecfidera, Gilenya, or B) Moderate to severe active Crohn's disease and medication will not be used in combination with immunosuppressants or inhibitors of tumor necrosis factor-alfa and patient had an inadequate response, intolerance, or contraindication to 5-aminosalicylic acid, glucocorticoid (budesonide ER), and at least one TNF-alpha (Humira, Remicade) therapy.

**Age Restriction**

18 years and older.

**Prescriber Restriction**

Neurologist or a Certified MS Specialist

**Coverage Duration**

Plan year

**Other Criteria**



## Ubrelvy (Ubrogepant)

---

### **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.

## VALCYTE (valganciclovir)

---

### Drugs

**VALCYTE ORAL RECON SOLN**, *valganciclovir*

### 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

## vancomycin oral (VANCOCIN)

---

### 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

## VARUBI (rolapitant)

---

### **Drugs** **VARUBI ORAL**

#### **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**

Oncologist

#### **Coverage Duration**

12 months

#### **Other Criteria**

For authorization, please submit to EviCore at [evicore.com](http://evicore.com) or call at 877-825-7722.

## VECTICAL (calcitriol topical)

---

### **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)

## VELPHORO (Sucroferric Oxyhydroxide)

---

### **Drugs** **VELPHORO**

#### **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**

Documentation of diagnosis, serum phosphorus levels and statement that patient is receiving dialysis.

#### **Age Restriction**

#### **Prescriber Restriction**

#### **Coverage Duration**

Plan year

#### **Other Criteria**

## **VENTAVIS (Iloprost)**

---

### **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**

## VIMPAT (Lacosamide)

---

### 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**

**VITRAKVI ORAL CAPSULE, VITRAKVI ORAL SOLUTION**

**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**

## VORICONAZOLE (VFEND)

---

### **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, gemcitabine, 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**  
**VRAYLAR**

**Covered Uses**

All FDA-approved indications not otherwise excluded from Health Plan

**Exclusion Criteria**

A Documentation of diagnosis and treatment history.

**Required Medical Information**

Documentation of diagnosis and treatment history.

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**

Plan year

**Other Criteria**

Approve with documented trial of any of the two following drugs: aripiprazole, clozapine, olanzapine, risperidone, quetiapine, ziprasidone

**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**

## **Xcopri (Cenobamate)**

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### **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**

**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**

**XELJANZ ORAL TABLET 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**

Concurrent use with a biologic for an inflammatory condition (eg, tocilizumab, anakinra, abatacept, rituximab) or a TNF inhibitor (eg, certolizumab pegol, etanercept, adalimumab, infliximab, golimumab).

**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**

12 months

**Other Criteria**

**Drugs**  
**XGEVA**

**Covered Uses**

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

**Exclusion Criteria**

Hypocalcemia (calcium less than 8.0 mg/dL).

**Required Medical Information**

Diagnosis of one of the following: A) Solid tumor (e.g., breast cancer, castrate-resistant prostate cancer, thyroid carcinoma, kidney, or non-small cell lung cancer) and patient has bone metastases and medication will be used for the prevention of skeletal-related events (e.g., spinal cord compression, hypercalcemia, bone pain or lesions requiring radiation or surgery), or B) Giant cell tumor of bone that is unresectable or surgical resection is likely to result in severe morbidity, or C) Treatment of hypercalcemia of malignancy refractory to bisphosphonate therapy (i.e. alendronate, ibandronate, risedronate).

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**

Plan year

**Other Criteria**



**Drugs**

**XIFAXAN ORAL TABLET 200 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 antidiarrheals (e.g. loperamide, diphenoxylate-atropine), antispasmodics (e.g. dicyclomine), bile acid sequestrants (e.g. cholestyramine, 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**

**XIFAXAN ORAL TABLET 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 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 antidiarrheal (e.g. loperamide, diphenoxylate-atropine), antispasmodics (e.g. dicyclomine), bile acid sequestrants (e.g. cholestyramine, 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**

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**

## **Xospata (gilteritinib)**

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### **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, armodafinil, 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**



## ZANOSAR (Streptozocin)

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### **Drugs** **ZANOSAR**

#### **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**

18 years and 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**

## **ZEMAIRA (Alpha1-Proteinase Inhibitor (Human))**

---

### **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**

## Zoledronic acid (RECLAST)

---

### 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.

## ZOLINZA (Vorinostat)

---

### **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.

## ZORTRESS (Everolimus)

---

### 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

## ZYDELIG (Idelalisib)

---

### **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](http://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.

## ZYKADIA (Ceritinib)

---

### Drugs

#### ZYKADIA 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

For authorization, please submit to EviCore at [evicore.com](http://evicore.com) or call at 877-825-7722.

## ZYTIGA (Abiraterone)

---

### Drugs

*abiraterone*, ZYTIGA ORAL TABLET 250 MG, 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

|                                      |     |   |     |   |     |
|--------------------------------------|-----|---|-----|---|-----|
| <b>Index</b>                         |     |   |     |   |     |
| <i>abiraterone</i> .....             | 307 | <b>BUPHENYL ORAL TABLET</b> .....               | 38  | <b>ELIGARD (6 MONTH)</b> .....              | 74  |
| <i>acitretin</i> .....               | 2   | <i>buprenorphine HCl sublingual</i> .....       | 39  | <b>ELZONRIS</b> .....                       | 75  |
| <b>ACTEMRA</b> .....                 | 3   | <i>buprenorphine-naloxone sublingual</i>        |     | <b>EMCYT</b> .....                          | 76  |
| <b>ACTIMMUNE</b> .....               | 4   | <i>film 12-3 mg, 2-0.5 mg, 4-1 mg, 8-2</i>      |     | <b>EMEND ORAL CAPSULE,DOSE</b>              |     |
| <b>ADDYI</b> .....                   | 6   | <i>mg</i> .....                                 | 39  | <b>PACK</b> .....                           | 77  |
| <b>ADEFOVIR</b> .....                | 7   | <b>BUSULFEX</b> .....                           | 40  | <b>EMSAM</b> .....                          | 78  |
| <b>ADEMPAS</b> .....                 | 8   | <b>BYNFEZIA</b> .....                           | 41  | <b>ENBREL SUBCUTANEOUS</b>                  |     |
| <b>AFINITOR ORAL TABLET 10 MG,</b>   |     | <b>CABOMETYX ORAL TABLET 20</b>                 |     | <b>RECON SOLN</b> .....                     | 79  |
| <b>2.5 MG, 5 MG, 7.5 MG</b> .....    | 9   | <b>MG, 40 MG, 60 MG</b> .....                   | 90  | <b>ENBREL SUBCUTANEOUS</b>                  |     |
| <b>AIMOVIG AUTOINJECTOR</b> .....    | 42  | <i>calcitriol topical</i> .....                 | 269 | <b>SOLUTION</b> .....                       | 79  |
| <b>AJOVY AUTOINJECTOR</b> .....      | 42  | <b>CALQUENCE</b> .....                          | 43  | <b>ENBREL SUBCUTANEOUS</b>                  |     |
| <b>AJOVY SYRINGE</b> .....           | 42  | <i>capecitabine</i> .....                       | 44  | <b>SYRINGE 25 MG/0.5 ML (0.5), 50</b>       |     |
| <b>AKYNZEO (FOSNETUPITANT)</b>       |     | <b>CAPLYTA</b> .....                            | 34  | <b>MG/ML (1 ML)</b> .....                   | 79  |
| <b>INTRAVENOUS RECON SOLN</b> .....  | 90  | <b>CAPRELSA ORAL TABLET 100</b>                 |     | <b>ENBREL SURECLICK</b> .....               | 79  |
| <b>AKYNZEO (NETUPITANT)</b> .....    | 90  | <b>MG, 300 MG</b> .....                         | 45  | <b>ENDARI</b> .....                         | 80  |
| <b>ALECENSA</b> .....                | 90  | <i>caspofungin</i> .....                        | 46  | <b>ENTECAVIR</b> .....                      | 26  |
| <b>ALINIA</b> .....                  | 10  | <b>CAYSTON</b> .....                            | 47  | <b>ENTRESTO</b> .....                       | 81  |
| <b>ALIQOPA</b> .....                 | 11  | <b>CESAMET</b> .....                            | 48  | <b>EPCLUSA ORAL TABLET 400-</b>             |     |
| <i>alose tron</i> .....              | 12  | <b>CIALIS ORAL TABLET 2.5 MG, 5</b>             |     | <b>100 MG</b> .....                         | 82  |
| <b>ALTRENO</b> .....                 | 258 | <b>MG</b> .....                                 | 49  | <b>EPIDIOLEX</b> .....                      | 83  |
| <b>ALUNBRIG ORAL TABLET 180</b>      |     | <i>cinacalcet</i> .....                         | 50  | <b>ERIVEDGE</b> .....                       | 84  |
| <b>MG, 30 MG, 90 MG</b> .....        | 90  | <b>CINRYZE</b> .....                            | 51  | <b>ERLEADA</b> .....                        | 85  |
| <b>ALUNBRIG ORAL</b>                 |     | <b>CLOVIQUE</b> .....                           | 52  | <i>erlotinib</i> .....                      | 242 |
| <b>TABLETS,DOSE PACK</b> .....       | 90  | <i>clozapine oral tablet,disintegrating</i> ... | 53  | <b>ERTACZO</b> .....                        | 86  |
| <b>AMBRISENTAN</b> .....             | 137 | <b>COMETRIQ</b> .....                           | 54  | <b>ESBRIET</b> .....                        | 87  |
| <b>ANADROL-50</b> .....              | 14  | <b>COPAXONE SUBCUTANEOUS</b>                    |     | <i>ethacrynic acid</i> .....                | 73  |
| <i>aprepitant</i> .....              | 77  | <b>SYRINGE 20 MG/ML, 40 MG/ML</b> ...           | 55  | <i>etoposide intravenous</i> .....          | 88  |
| <b>APTIOM</b> .....                  | 16  | <b>COPIKTRA</b> .....                           | 56  | <b>EVENITY</b> .....                        | 89  |
| <b>ARANESP (IN POLYSORBATE)</b> .... | 17  | <b>CORLANOR ORAL SOLUTION</b> ....              | 57  | <i>everolimus (antineoplastic)</i> .....    | 9   |
| <b>ARCALYST</b> .....                | 18  | <b>COSENTYX</b> .....                           | 58  | <i>everolimus (immunosuppressive)</i> ..    | 303 |
| <i>armodafinil</i> .....             | 19  | <b>COSENTYX (2 SYRINGES)</b> .....              | 58  | <b>EXJADE</b> .....                         | 91  |
| <b>AUBAGIO</b> .....                 | 20  | <b>COSENTYX PEN</b> .....                       | 58  | <b>FANAPT ORAL TABLET</b> .....             | 92  |
| <b>AUSTEDO ORAL TABLET 12 MG,</b>    |     | <b>COSENTYX PEN (2 PENS)</b> .....              | 58  | <b>FANAPT ORAL TABLETS,DOSE</b>             |     |
| <b>6 MG, 9 MG</b> .....              | 21  | <b>COTELLIC</b> .....                           | 90  | <b>PACK</b> .....                           | 92  |
| <b>AVONEX INTRAMUSCULAR PEN</b>      |     | <b>CRESEMBA</b> .....                           | 59  | <b>FARYDAK</b> .....                        | 93  |
| <b>INJECTOR KIT</b> .....            | 22  | <b>CYCLOSET</b> .....                           | 60  | <b>FASENRA PEN</b> .....                    | 94  |
| <b>AVONEX INTRAMUSCULAR</b>          |     | <b>CYSTADANE</b> .....                          | 61  | <i>fentanyl citrate buccal lozenge on a</i> |     |
| <b>SYRINGE KIT</b> .....             | 22  | <b>CYSTAGON</b> .....                           | 62  | <i>handle</i> .....                         | 95  |
| <b>AYVAKIT</b> .....                 | 23  | <b>CYSTARAN</b> .....                           | 63  | <b>FERRIPROX ORAL SOLUTION</b> ....         | 96  |
| <b>BALVERSA</b> .....                | 24  | <i>dalfampridine</i> .....                      | 13  | <b>FERRIPROX ORAL TABLET 500</b>            |     |
| <b>BANZEL ORAL SUSPENSION</b> .....  | 25  | <b>DAURISMO ORAL TABLET 100</b>                 |     | <b>MG</b> .....                             | 96  |
| <b>BANZEL ORAL TABLET 200 MG,</b>    |     | <b>MG, 25 MG</b> .....                          | 64  | <b>FETZIMA</b> .....                        | 97  |
| <b>400 MG</b> .....                  | 25  | <b>DIACOMIT ORAL CAPSULE</b> .....              | 65  | <b>FINTEPLA</b> .....                       | 98  |
| <b>BARACLUDE ORAL SOLUTION</b> ...   | 26  | <b>DIAZEPAM INTENSOL</b> .....                  | 31  | <b>FIRDAPSE</b> .....                       | 100 |
| <b>BAVENCIO</b> .....                | 27  | <i>diazepam oral concentrate</i> .....          | 31  | <i>fondaparinux subcutaneous syringe</i>    |     |
| <b>BELSOMRA</b> .....                | 28  | <i>diazoxide</i> .....                          | 66  | <i>10 mg/0.8 mL, 2.5 mg/0.5 mL, 5</i>       |     |
| <b>BENLYSTA SUBCUTANEOUS</b>         |     | <i>diclofenac sodium topical gel 3 %</i> ....   | 67  | <i>mg/0.4 mL, 7.5 mg/0.6 mL</i> .....       | 101 |
| <b>SYRINGE</b> .....                 | 29  | <b>DIFICID</b> .....                            | 68  | <b>FORTEO</b> .....                         | 102 |
| <i>benznidazole</i> .....            | 30  | <i>doxercalciferol oral</i> .....               | 69  | <b>FYCOMPA ORAL SUSPENSION</b> .            | 103 |
| <b>BETASERON SUBCUTANEOUS</b>        |     | <b>DOXORUBICIN INTRAVENOUS</b>                  |     | <b>FYCOMPA ORAL TABLET 10</b>               |     |
| <b>KIT</b> .....                     | 32  | <b>SOLUTION 2 MG/ML</b> .....                   | 70  | <b>MG, 12 MG, 2 MG, 4 MG, 6 MG, 8</b>       |     |
| <i>bexarotene</i> .....              | 243 | <i>dronabinol oral capsule 10 mg, 2.5</i>       |     | <b>MG</b> .....                             | 103 |
| <i>bosentan</i> .....                | 255 | <i>mg, 5 mg</i> .....                           | 71  | <b>GAMASTAN S/D</b> .....                   | 126 |
| <b>BOSULIF ORAL TABLET 100</b>       |     | <b>DUPIXENT PEN</b> .....                       | 72  | <b>GAMMAGARD LIQUID</b> .....               | 126 |
| <b>MG, 400 MG, 500 MG</b> .....      | 90  | <b>DUPIXENT SYRINGE</b> .....                   | 72  | <b>GAMMAGARD S-D (IGA &lt; 1</b>            |     |
| <b>BRAFTOVI ORAL CAPSULE 50</b>      |     | <b>EDECRIN</b> .....                            | 73  | <b>MCG/ML)</b> .....                        | 126 |
| <b>MG, 75 MG</b> .....               | 33  | <b>ELIGARD</b> .....                            | 74  | <b>GILENYA ORAL CAPSULE 0.5</b>             |     |
| <b>BROVANA</b> .....                 | 36  | <b>ELIGARD (3 MONTH)</b> .....                  | 74  | <b>MG</b> .....                             | 104 |
| <b>BRUKINSA</b> .....                | 37  | <b>ELIGARD (4 MONTH)</b> .....                  | 74  | <b>GILOTRIF</b> .....                       | 105 |

|   |     |  |     |   |     |
|---|-----|--|-----|---|-----|
| <b>GLEOSTINE ORAL CAPSULE 10 MG, 100 MG, 40 MG</b> .....  | 90  | <b>KALYDECO ORAL GRANULES IN PACKET 50 MG, 75 MG</b> .....   | 129 | <i>miglustat</i> .....  | 155 |
| <b>HARVONI ORAL TABLET 90-400 MG</b> .....  | 107 | <b>KALYDECO ORAL TABLET</b> .....  | 129 | <i>modafinil</i> .....  | 156 |
| <b>HERCEPTIN HYLECTA</b> .....  | 108 | <b>KESIMPTA PEN</b> .....  | 130 | <b>MOVANTIK</b> .....   | 157 |
| <b>HUMIRA PEN</b> .....   | 110 | <b>KISQALI</b> .....   | 131 | <b>MOZOBIL</b> .....  | 158 |
| <b>HUMIRA PEN CROHNS-UC-HS START</b> .....  | 110 | <b>KISQALI FEMARA CO-PACK</b> .....  | 131 | <b>MULPLETA</b> .....   | 159 |
| <b>HUMIRA PEN PSOR-UEITS-ADOL HS</b> .....  | 110 | <b>KOSELUGO ORAL CAPSULE 10 MG, 25 MG</b> .....  | 132 | <b>NAGLAZYME</b> .....  | 160 |
| <b>HUMIRA SUBCUTANEOUS SYRINGE KIT 10 MG/0.2 ML, 20 MG/0.4 ML, 40 MG/0.8 ML</b> .....                                 | 110 | <b>KUVAN ORAL TABLET,SOLUBLE</b> .....   | 133 | <b>NATPARA</b> .....  | 161 |
| <b>HUMIRA(CF) PEDI CROHNS STARTER</b> .....   | 110 | <b>LACRISERT</b> .....   | 134 | <b>NERLYNX</b> .....  | 162 |
| <b>HUMIRA(CF) PEN CROHNS-UC-HS</b> .....  | 110 | <i>ledipasvir-sofosbuvir</i> .....   | 135 | <b>NEULASTA</b> .....   | 163 |
| <b>HUMIRA(CF) PEN PSOR-UV-ADOL HS</b> .....   | 110 | <b>LENVIMA ORAL CAPSULE 10 MG/DAY (10 MG X 1), 12 MG/DAY (4 MG X 3), 14 MG/DAY(10 MG X 1-4 MG X 1), 18 MG/DAY (10 MG X 1-4 MG X2), 20 MG/DAY (10 MG X 2), 24 MG/DAY(10 MG X 2-4 MG X 1), 4 MG, 8 MG/DAY (4 MG X 2)</b> ..... | 136 | <b>NEUPOGEN</b> .....   | 164 |
| <b>HUMIRA(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML, 80 MG/0.8 ML</b> .....                                  | 110 | <b>LETAIRIS</b> .....  | 137 | <b>NEXAVAR</b> .....  | 165 |
| <b>HUMIRA(CF) SUBCUTANEOUS SYRINGE KIT 10 MG/0.1 ML, 20 MG/0.2 ML, 40 MG/0.4 ML</b> .....                             | 110 | <b>LEUKINE INJECTION RECON SOLN</b> .....  | 138 | <b>NEXLETOL</b> .....   | 166 |
| <b>HYCAMTIN</b> .....   | 90  | <i>leuprolide</i> .....  | 139 | <b>NEXLIZET</b> .....   | 167 |
| <i>hydromorphone oral tablet extended release 24 hr</i> .....   | 111 | <i>lidocaine topical adhesive patch,medicated 5 %</i> .....  | 140 | <b>NINLARO</b> .....  | 90  |
| <b>HYQVIA</b> .....   | 112 | <i>lidocaine topical ointment</i> .....  | 140 | <b>NORPACE CR</b> .....   | 168 |
| <b>IBRANCE</b> .....  | 113 | <i>linezolid</i> .....   | 141 | <b>NORTHERA</b> .....   | 169 |
| <i>icatibant</i> .....  | 99  | <b>LIVALO</b> .....  | 142 | <b>NOXAFIL</b> .....  | 170 |
| <b>ICLUSIG ORAL TABLET 15 MG, 45 MG</b> .....   | 114 | <b>LOKELMA</b> .....   | 143 | <b>NUBEQA</b> .....   | 171 |
| <b>IDAMYCIN PFS</b> .....   | 90  | <b>LONSURF</b> .....   | 90  | <b>NUCALA SUBCUTANEOUS AUTO-INJECTOR</b> .....  | 172 |
| <b>IDHIFA</b> .....   | 115 | <b>LORBRENA ORAL TABLET 100 MG, 25 MG</b> .....  | 144 | <b>NUCALA SUBCUTANEOUS SYRINGE</b> .....  | 172 |
| <i>imatinib oral tablet 100 mg, 400 mg</i> .....  | 116 | <b>LUPANETA PACK (1 MONTH)</b> .....   | 145 | <b>NUCYNTA</b> .....  | 173 |
| <b>IMBRUVICA ORAL CAPSULE 140 MG, 70 MG</b> .....   | 117 | <b>LUPANETA PACK (3 MONTH)</b> .....   | 145 | <b>NUCYNTA ER</b> .....   | 173 |
| <b>IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG, 560 MG</b> .....   | 117 | <b>LUPRON DEPOT</b> .....  | 146 | <b>NUDEXTA</b> .....  | 174 |
| <b>INBRIJA</b> .....  | 118 | <b>LUPRON DEPOT (3 MONTH)</b> .....  | 146 | <b>NULOJIX</b> .....  | 175 |
| <b>INCRELEX</b> .....   | 119 | <b>LUPRON DEPOT (4 MONTH)</b> .....  | 146 | <b>NURTEC ODT</b> .....   | 176 |
| <b>INLYTA</b> .....   | 90  | <b>LUPRON DEPOT (6 MONTH)</b> .....  | 146 | <b>NUTROPIN AQ NUSPIN SUBCUTANEOUS PEN INJECTOR 10 MG/2 ML (5 MG/ML), 20 MG/2 ML (10 MG/ML)</b> ..... | 109 |
| <b>INREBIC</b> .....  | 120 | <b>LUPRON DEPOT-PED</b> .....  | 146 | <b>NYMALIZE ORAL SYRINGE</b> .....  | 177 |
| <b>INTRON A INJECTION</b> .....   | 121 | <b>LUPRON DEPOT-PED (3 MONTH)</b> .....  | 146 | <i>octreotide acetate injection solution</i> .....  | 178 |
| <b>INVEGA SUSTENNA</b> .....  | 122 | <b>LYNPARZA ORAL TABLET</b> .....  | 147 | <b>ODOMZO</b> .....   | 179 |
| <b>IRESSA</b> .....   | 90  | <b>MAKENA (PF)</b> .....   | 148 | <b>OMNIPOD DASH 5 PACK POD</b> .....  | 180 |
| <b>ISENTRESS HD</b> .....   | 123 | <b>MAKENA INTRAMUSCULAR OIL 250 MG/ML (1 ML)</b> .....   | 148 | <b>OMNIPOD DASH PDM KIT</b> .....   | 180 |
| <b>ISTURISA ORAL TABLET 1 MG, 10 MG, 5 MG</b> .....   | 124 | <b>MAVENCLAD (10 TABLET PACK)</b> .....  | 149 | <b>OMNIPOD INSULIN MANAGEMENT</b> .....   | 180 |
| <i>itraconazole oral capsule</i> .....  | 125 | <b>MAVENCLAD (4 TABLET PACK)</b> .....   | 149 | <b>OMNIPOD INSULIN REFILL</b> .....   | 180 |
| <b>JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG</b> .....  | 127 | <b>MAVENCLAD (5 TABLET PACK)</b> .....   | 149 | <b>OMNITROPE</b> .....  | 106 |
| <b>JYNARQUE ORAL TABLETS, SEQUENTIAL 45 MG (AM)/ 15 MG (PM), 60 MG (AM)/ 30 MG (PM), 90 MG (AM)/ 30 MG (PM)</b> ..... | 128 | <b>MAVENCLAD (6 TABLET PACK)</b> .....   | 149 | <b>ONFI ORAL SUSPENSION</b> .....   | 181 |
|   |     | <b>MAVENCLAD (7 TABLET PACK)</b> .....   | 149 | <b>ONFI ORAL TABLET 10 MG, 20 MG</b> .....  | 181 |
|   |     | <b>MAVENCLAD (8 TABLET PACK)</b> .....   | 149 | <b>OPSUMIT</b> .....  | 182 |
|   |     | <b>MAVENCLAD (9 TABLET PACK)</b> .....   | 149 | <b>ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 0.25 MG, 1 MG, 2.5 MG</b> .....                   | 183 |
|   |     | <b>MAVYRET</b> .....   | 150 | <b>ORFADIN ORAL CAPSULE</b> .....   | 184 |
|   |     | <b>MEKINIST ORAL TABLET 0.5 MG, 2 MG</b> .....   | 151 | <b>ORKAMBI</b> .....  | 185 |
|   |     | <b>MEKTOVI</b> .....   | 152 | <b>OSPHENA</b> .....  | 186 |
|   |     | <b>MENEST</b> .....  | 153 | <b>OTEZLA</b> .....   | 187 |
|   |     | <i>meropenem</i> .....   | 154 | <b>OTEZLA STARTER</b> .....   | 187 |
|   |     | <b>METHITEST</b> .....   | 15  | <i>oxandrolone oral tablet 10 mg, 2.5 mg</i> .....  | 188 |
|   |     |  |     | <b>OXERVATE</b> .....   | 189 |
|   |     |  |     | <i>oxycodone oral tablet,oral only,ext.rel.12 hr</i> .....  | 190 |

|  |     |  |          |  |     |
|--|-----|--|----------|--|-----|
| <i>paliperidone oral tablet extended release 24hr 1.5 mg, 3 mg, 6 mg, 9 mg</i> .....   | 122 | <b>SAMSCA</b> .....  | 224      | <b>TYSABRI</b> .....   | 264 |
| <b>PALYNZIQ</b> .....  | 191 | <b>SANCUSO</b> .....   | 90       | <b>UBRELVY</b> .....   | 265 |
| <i>pamidronate</i> .....   | 192 | <b>SANDOSTATIN LAR DEPOT INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON</b> .....                     | 178      | <b>VALCHLOR</b> .....  | 90  |
| <b>PANRETIN</b> .....  | 193 | <b>SAPHRIS</b> .....   | 225      | <b>VALCYTE ORAL RECON SOLN</b> ..  | 266 |
| <i>paricalcitol oral</i> .....   | 194 | <b>SECUADO</b> .....   | 225      | <i>valganciclovir</i> .....  | 266 |
| <b>PEGASYS SUBCUTANEOUS SOLUTION</b> .....   | 196 | <b>SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR</b> .....  | 226      | <i>vancomycin oral capsule</i> .....   | 267 |
| <b>PEGASYS SUBCUTANEOUS SYRINGE</b> .....  | 196 | <b>SIGNIFOR</b> .....  | 227      | <b>VARUBI ORAL</b> .....   | 268 |
| <b>PEGINTRON SUBCUTANEOUS KIT 50 MCG/0.5 ML</b> .....  | 196 | <b>SIGNIFOR LAR</b> .....  | 228      | <b>VELPHORO</b> .....  | 270 |
| <b>PEMAZYRE</b> .....  | 197 | <i>sildenafil (pulm.hypertension) oral tablet</i> .....  | 229      | <b>VENCLEXTA ORAL TABLET 10 MG, 100 MG, 50 MG</b> .....  | 90  |
| <i>penicillamine oral capsule</i> .....  | 198 | <i>sodium phenylbutyrate oral tablet</i> ....  | 38       | <b>VENCLEXTA STARTING PACK</b> ....  | 90  |
| <b>PENICILLAMINE ORAL TABLET</b> .....   | 198 | <i>sofosbuvir-velpatasvir</i> .....  | 230      | <b>VENTAVIS</b> .....  | 271 |
| <b>PENTAM</b> .....  | 199 | <b>SOMATULINE DEPOT</b> .....  | 231      | <b>VERZENIO</b> .....  | 272 |
| <b>PERFOROMIST</b> .....   | 200 | <b>SOMAVERT</b> .....  | 232      | <b>VIBERZI</b> .....   | 273 |
| <b>PERSERIS</b> .....  | 201 | <b>SPRYCEL</b> .....   | 233      | <i>vigabatrin oral powder in packet</i> ....   | 223 |
| <b>PICATO</b> .....  | 202 | <b>STIVARGA</b> .....  | 234      | <b>VIMPAT ORAL SOLUTION</b> .....  | 274 |
| <b>PIQRAY</b> .....  | 203 | <b>SUNOSI</b> .....  | 235      | <b>VIMPAT ORAL TABLET</b> .....  | 274 |
| <b>PLEGRIDY</b> .....  | 204 | <b>SUTENT</b> .....  | 236      | <b>VIMPAT ORAL TABLETS,DOSE PACK</b> .....   | 274 |
| <b>POMALYST</b> .....  | 205 | <b>SYNERA</b> .....  | 237      | <b>VITRAKVI ORAL CAPSULE</b> .....   | 275 |
| <b>POTELIGEO</b> .....   | 206 | <b>TABLOID</b> .....   | 238      | <b>VITRAKVI ORAL SOLUTION</b> .....  | 275 |
| <i>pramipexole oral tablet extended release 24 hr</i> .....  | 207 | <i>tacrolimus topical</i> .....  | 212      | <b>VIZIMPRO</b> .....  | 276 |
| <b>PREVACID SOLUTAB</b> .....  | 208 | <i>tadalafil (pulm. hypertension)</i> .....  | 5        | <i>voriconazole oral</i> .....   | 277 |
| <b>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</b> .. | 209 | <b>TAFINLAR</b> .....  | 239      | <b>VOTRIENT</b> .....  | 278 |
| <b>PROMACTA ORAL POWDER IN PACKET 12.5 MG</b> .....  | 211 | <b>TAGRISSO ORAL TABLET 40 MG, 80 MG</b> .....   | 90       | <b>VRAYLAR</b> .....   | 279 |
| <b>PROMACTA ORAL POWDER IN PACKET 25 MG</b> .....  | 210 | <b>TAKHZYRO</b> .....  | 240      | <b>VUMERITY</b> .....  | 280 |
| <b>PROMACTA ORAL TABLET</b> .....  | 211 | <b>TALZENNA ORAL CAPSULE 0.25 MG, 1 MG</b> .....   | 241      | <b>VYVANSE ORAL CAPSULE</b> .....  | 281 |
| <b>PULMOZYME</b> .....   | 213 | <i>tamoxifen</i> .....   | 35       | <b>VYXEOS</b> .....  | 282 |
| <b>QINLOCK</b> .....   | 214 | <b>TARCEVA</b> .....   | 242      | <b>WAKIX</b> .....   | 283 |
| <i>quetiapine oral tablet extended release 24 hr</i> .....   | 226 | <b>TARGRETIN TOPICAL</b> .....   | 243      | <b>XALKORI</b> .....   | 284 |
| <i>raloxifene</i> .....  | 35  | <b>TASIGNA ORAL CAPSULE 150 MG, 200 MG</b> .....   | 244      | <b>XCOPRI MAINTENANCE PACK</b> ..  | 285 |
| <b>REGRANEX</b> .....  | 215 | <b>TAVALISSE</b> .....   | 245      | <b>XCOPRI TITRATION PACK</b> .....   | 285 |
| <b>RELENZA DISKHALER</b> .....   | 216 | <b>TAZVERIK</b> .....  | 246      | <b>XELJANZ ORAL TABLET 10 MG</b> .....   | 286 |
| <b>REMODULIN</b> .....   | 217 | <b>TECFIDERA ORAL CAPSULE,DELAYED RELEASE(DR/EC) 120 MG, 120 MG (14)- 240 MG (46), 240 MG</b> .... | 247      | <b>XELJANZ ORAL TABLET 5 MG</b> ..   | 287 |
| <b>REPATHA PUSHTRONEX</b> .....  | 195 | <i>temozolomide</i> .....  | 248      | <b>XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HR 11 MG</b> .....   | 287 |
| <b>REPATHA SURECLICK</b> .....   | 195 | <i>tetrabenazine</i> .....   | 249      | <b>XERMELO</b> .....   | 90  |
| <b>REPATHA SYRINGE</b> .....   | 195 | <b>THALOMID</b> .....  | 250      | <b>XGEVA</b> .....   | 288 |
| <b>RETEVMO ORAL CAPSULE 40 MG, 80 MG</b> .....   | 218 | <b>THYMOGLOBULIN</b> .....   | 251      | <b>XIFAXAN ORAL TABLET 200 MG</b> .....  | 289 |
| <b>REVLIMID</b> .....  | 219 | <b>TIBSOVO</b> .....   | 252      | <b>XIFAXAN ORAL TABLET 550 MG</b> .....  | 290 |
| <b>REYVOW</b> .....  | 220 | <b>TIGAN INTRAMUSCULAR</b> .....   | 253      | <b>XOLAIR</b> .....  | 291 |
| <i>ribavirin oral capsule</i> .....  | 221 | <i>tobramycin in 0.225 % NaCl</i> .....  | 254      | <b>XOSPATA</b> .....   | 292 |
| <i>ribavirin oral tablet 200 mg</i> .....  | 221 | <i>tolvaptan oral tablet 30 mg</i> .....   | 224      | <b>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)</b> .... | 293 |
| <b>RISPERDAL CONSTA</b> .....  | 222 | <b>TOPOSAR</b> .....   | 90       | <b>XTANDI</b> .....  | 294 |
| <b>ROZLYTREK ORAL CAPSULE 100 MG, 200 MG</b> .....   | 90  | <b>TRACLEER</b> .....  | 255, 256 | <b>XYREM</b> .....   | 295 |
| <b>RUBRACA</b> .....   | 90  | <i>tranexamic acid intravenous</i> .....   | 257      | <b>YONSA</b> .....   | 296 |
| <b>RUZURGI</b> .....   | 100 | <i>tretinoin (antineoplastic)</i> .....  | 258      | <b>ZANOSAR</b> .....   | 297 |
| <b>RYDAPT</b> .....  | 90  | <b>TRIKAFTA</b> .....  | 259      | <b>ZAVESCA</b> .....   | 298 |
| <b>SABRIL ORAL TABLET</b> .....  | 223 | <b>TUKYSA</b> .....  | 260      | <b>ZEJULA</b> .....  | 90  |
|  |     | <b>TURALIO</b> .....   | 261      | <b>ZELBORAF</b> .....  | 90  |
|  |     | <b>TYKERB</b> .....  | 262      |  |     |
|  |     | <b>TYMLOS</b> .....  | 263      |  |     |

|                                       |     |
|---------------------------------------|-----|
| <b>ZEMAIRA</b> .....                  | 299 |
| <b>ZEPOSIA</b> .....                  | 300 |
| <b>ZEPOSIA STARTER KIT</b> .....      | 300 |
| <b>ZEPOSIA STARTER PACK</b> .....     | 300 |
| <i>zoledronic acid-mannitol-water</i> |     |
| <i>intravenous piggyback 5 mg/100</i> |     |
| <i>mL</i> .....                       | 301 |
| <b>ZOLINZA</b> .....                  | 302 |
| <b>ZORTRESS ORAL TABLET 0.25</b>      |     |
| <b>MG, 0.5 MG, 0.75 MG</b> .....      | 303 |
| <b>ZYDELIG</b> .....                  | 304 |
| <b>ZYFLO</b> .....                    | 305 |
| <b>ZYKADIA ORAL TABLET</b> .....      | 306 |
| <b>ZYTIGA ORAL TABLET 250 MG,</b>     |     |
| <b>500 MG</b> .....                   | 307 |

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**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 નિઃશુલ્ક 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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