Health First
Health Plans

6450 U.S. Highway 1
Rockledge, FL 32955
myHFHP.org

Commercial Metal Plans

2021 Prior Authorization Criteria

36194_MPINFO7674(10/19)

Drugs
acitretin

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

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

Required Medical Information
Documented diagnosis of severe psoriasis

Age Restriction
18 years of age or older

Prescriber Restriction

Coverage Duration
Plan year

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

Drugs
ACTIMMUNE

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

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

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

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
tadalafil (pulm. hypertension)

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.

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, *everolimus (antineoplastic) oral tablet 2.5 mg, 5 mg, 7.5 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) Advanced metastatic renal cell carcinoma and patient has failed therapy (disease progressed) with Sutent or Nexavar (Afinitor only), or B) Progressive pancreatic, nonfunctional GI or lung neuroendocrine tumors (NET) that are unresectable, locally advanced or metastatic (Afinitor only), or C) Renal angiomyolipoma with tuberous sclerosis complex (TSC) and patient does not require immediate surgery (Afinitor only), or D) Advanced hormone receptor-positive, HER2-negative breast cancer and patient is a postmenopausal woman and patient has failed treatment with Femara or Arimidex and the medication will be used in combination with Aromasin (Afinitor only), or E) Subependymal giant cell astrocytoma (SEGA) associated with TSC that requires therapeutic intervention but is not a candidate for curative surgical resection (Afinitor or Afinitor Disperz only).

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

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
ALINIA

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

Exclusion Criteria

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

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

Prescriber Restriction

Coverage Duration
30 days

Other Criteria

Drugs
ALIQOPA

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction
Oncologist or Hematologist

Coverage Duration
Through end of benefit year

Other Criteria

Drugs
alosetron

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

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

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

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

Prescriber Restriction
Prescriber must be specially trained gastrointestinal physician

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

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

Drugs
dalfampridine

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

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

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

Age Restriction

Prescriber Restriction
Neurologist

Coverage Duration
Initial: 3 months. Renewal: Plan year

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

Drugs
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.

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) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML, **ARANESP (IN POLYSORBATE) INJECTION SYRINGE**

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 treatmentwith rilonacept.

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

Age Restriction
12 years of age and older

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

Coverage Duration
Plan year

Other Criteria
Approve doses based on FDA labeling.

Drugs
armodafinil

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

Exclusion Criteria

Required Medical Information
Documentation of diagnosis and treatment history.

Age Restriction
Patient must be at least 17 years or older

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

Coverage Duration
Plan year

Other Criteria

Drugs
AUBAGIO

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

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

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

Age Restriction

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

Coverage Duration
Plan year

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

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

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
3 Months

Other Criteria

Drugs
AVONEX INTRAMUSCULAR PEN INJECTOR, **AVONEX INTRAMUSCULAR PEN INJECTOR KIT**, **AVONEX INTRAMUSCULAR SYRINGE**, **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 ORAL TABLET 100 MG, 200 MG, 300 MG

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
Oncologist, Allergist, Immunologist

Coverage Duration
3 months

Other Criteria

Drugs
BALVERSA

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

Exclusion Criteria

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

Age Restriction
8 years or older

Prescriber Restriction

Coverage Duration
3 Months

Other Criteria

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

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

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

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

Age Restriction
Must be 1 years of age or older

Prescriber Restriction

Coverage Duration
Plan year

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

Drugs
BARACLUDE ORAL SOLUTION, **ENTECAVIR**

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

Exclusion Criteria

Required Medical Information
Documentation of diagnosis

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
BAVENCIO

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Oncologist

Coverage Duration
3 Months

Other Criteria

Drugs
BELSOMRA

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction

Coverage Duration
Through end of benefit year

Other Criteria

Drugs
BENLYSTA SUBCUTANEOUS SYRINGE

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

Exclusion Criteria

Required Medical Information
Documentation from the medical record of diagnosis

Age Restriction

Prescriber Restriction

Coverage Duration
3 months

Other Criteria

Drugs
benznidazole

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

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

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

Age Restriction

Prescriber Restriction

Coverage Duration
60 days

Other Criteria

Drugs
DIAZEPAM INTENSOL, *diazepam oral concentrate*

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

Exclusion Criteria

Required Medical Information
Documentation of diagnosis

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
BETASERON SUBCUTANEOUS KIT

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

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

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

Age Restriction

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

Coverage Duration
Plan year

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

Drugs
BLENREP

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

Exclusion Criteria
1. Member has been diagnosed with relapsed or refractory multiple myeloma AND 2. Member had disease progression on at least four prior anti-myeloma treatment (including a proteasome inhibitor, immunomodulatory agent, and anti-CD38 monoclonal antibody AND 3. Member has an ophthalmic exam (i.e. visual acuity) at baseline, prior to each infusion AND 4 Member has no current corneal epithelial disease (excluding mild punctatekeratopathy) AND 5 Member has not had a prior allogeneic stem cell transplant AND 6. Member does not have active POEMS syndrome or active plasma cell leukemia AND 7. Member enrolled in BLENREP REM program AND 8. Therapy will be used in combination with preservative-free lubricant eye drops AND 9. medication will be used as single-agent therapy

Required Medical Information

Age Restriction
Member is age 18 years or older

Prescriber Restriction
Oncologist

Coverage Duration
3 months

Other Criteria

Drugs
BOSULIF ORAL TABLET 100 MG, 400 MG, 500 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
BRAFTOVI ORAL CAPSULE 50 MG, 75 MG

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction
Oncology

Coverage Duration
3 months

Other Criteria

Drugs
CAPLYTA

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction

Coverage Duration
Through end of benefit year

Other Criteria

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

Drugs
raloxifene, *tamoxifen*

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

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

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

Age Restriction
35 years and older

Prescriber Restriction

Coverage Duration
5 years

Other Criteria

Drugs
BROVANA

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

Exclusion Criteria

Required Medical Information
Documentation of diagnosis

Age Restriction
18 years and older.

Prescriber Restriction

Coverage Duration
Plan year

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

Drugs
BRUKINSA

Covered Uses

Exclusion Criteria

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

Age Restriction

Prescriber Restriction
Oncology

Coverage Duration
3 Months

Other Criteria

Drugs
BUPHENYL ORAL TABLET, *sodium phenylbutyrate oral tablet*

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Buprenorphine Products

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

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

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

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

Age Restriction
Must be 16 years of age or older.

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

Coverage Duration
12 months

Other Criteria

Drugs
BUSULFEX

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

Exclusion Criteria

Required Medical Information
Documentation of diagnosis

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

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

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction

Coverage Duration
Through end of benefit year

Other Criteria

Drugs
CALQUENCE

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction
Oncologist or hematologist

Coverage Duration
3 Months

Other Criteria

Drugs
capecitabine

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

Exclusion Criteria

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

Age Restriction
18 years and older.

Prescriber Restriction
Oncologist

Coverage Duration
Plan year

Other Criteria

Drugs
CAPRELSA ORAL TABLET 100 MG, 300 MG

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

Exclusion Criteria
Congenital long QT syndrome

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

Age Restriction
18 years or older

Prescriber Restriction
Oncologist or endocrinologist

Coverage Duration
3 Months

Other Criteria

CASPOFUNGIN

Drugs
caspofungin

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction

Coverage Duration
3 months

Other Criteria

Drugs
CAYSTON

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

Exclusion Criteria

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

Age Restriction
7 years of age and older

Prescriber Restriction

Coverage Duration
Plan year

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

Drugs
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
CIMZIA, **CIMZIA POWDER FOR RECONST**, **CIMZIA STARTER KIT**

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

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

Required Medical Information
Documentation of diagnosis, treatment history and TB evaluation.

Age Restriction
18 years of age or older

Prescriber Restriction
Must be prescribed by or in consultation with a rheumatologist or a gastroenterologist.

Coverage Duration
Plan year

Other Criteria
APPROVE for AS if patient is already on Cimzia or has had an inadequate response, intolerance or contraindication to one or more NSAIDs (e.g. ibuprofen, naproxen, meloxicam, celecoxib) and has had a trial of BOTH Humira AND Enbrel. APPROVE CD if patient is already on Cimzia or has had an inadequate response, intolerance, or contraindication to two or more of the following: corticosteroids (e.g., prednisone, methylprednisolone) or non-biologic disease modifying anti-rheumatic drug (DMARD) (e.g., azathioprine, methotrexate [MTX], mercaptopurine) and has tried Humira. APPROVE for PsA if patient is already on Cimzia or has had an inadequate response, intolerance, or contraindication to MTX and has had a trial of BOTH Humira AND Enbrel. APPROVE for RA if patient is already on Cimzia 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. Patient has been tested for TB and latent TB has been ruled out or is being treated. Dosing as per FDA approved labeling.

Drugs
cinacalcet oral tablet 30 mg, 60 mg, 90 mg

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction

Coverage Duration
3 months

Other Criteria

Drugs
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
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 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
Diagnosis of 1 of the following: A) Mod-severe chronic plaque psoriasis (affecting more than 5% of body surface area or crucial body areas such as the hands, feet, face, or genitals) and trial of at least 1 of the following: phototherapy (including but not limited to Ultraviolet A with a psoralen [PUVA] and/or retinoids [RePUVA] for at least 1 continuous month or 1 or more oral systemic treatments (e.g., MTX, cyclosporine, acitretin, sulfasalazine) for at least 3 months, OR B) Psoriatic arthritis and patient had an inadequate response, intolerance, or contraindication to methotrexate, OR C) Ankylosing spondylitis and patient had an inadequate response, intolerance or contraindication to at least two NSAIDs, OR D) Non-radiographic Axial Spondyloarthritis and patient had an inadequate response, intolerance or contraindication to at least two NSAIDs.

Age Restriction

Prescriber Restriction

Coverage Duration
12 months.

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

Drugs
CYCLOSET

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

Exclusion Criteria

Required Medical Information
Documented diagnosis of type 2 diabetes mellitus

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
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
DANYELZA

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

Exclusion Criteria

Required Medical Information
1. Medication will be used in combination with granulocyte-macrophage colony-stimulating factor (GM-CSF) AND 2 documented diagnosis of pediatric patients 1 year of age and older and adult patients with relapsed or refractory high-risk neuroblastoma in the bone or bone marrow AND 3. patient has demonstrated a partial response, minor response, or stable disease to prior therapy.

Age Restriction

Prescriber Restriction
Oncologist

Coverage Duration
3 months

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

Exclusion Criteria

Required Medical Information
Documented diagnosis of Dravet syndrome. Not appropriate for monotherapy. DIACOMIT is to be used as an add-on therapy to clobazam for seizures associated with Dravet syndrome when these are not adequately controlled.

Age Restriction
2 years and older

Prescriber Restriction

Coverage Duration
Through end of benefit year

Other Criteria
Dosing should not exceed 50 mg/kg/day, administered by mouth in 2or 3 divided doses.

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 ORAL TABLET

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

Exclusion Criteria

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

Age Restriction
18 years or older

Prescriber Restriction

Coverage Duration
10 Days

Other Criteria

Drugs
doxercalciferol oral

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

Exclusion Criteria

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

Age Restriction
18 years and older.

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
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

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

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

Exclusion Criteria

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

Age Restriction
18 or older

Prescriber Restriction
Dermatologist or allergist/immunologist

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

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

Drugs
EDECRIN, *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.

Drugs
ELZONRIS

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

Exclusion Criteria

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

Age Restriction
Patient is 2 years of age or older

Prescriber Restriction

Coverage Duration
6 months

Other Criteria

Drugs
EMCYT

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

Exclusion Criteria

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

Age Restriction
18 years or older

Prescriber Restriction
Oncologist prescriber

Coverage Duration
6 months

Other Criteria

Drugs
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
Using in combination with other TNF antagonists,IL-1R antagonists, janus kinase inhibitor, anti-cd20 monoclonalantibodies or selective co-stimulation modulators.

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

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

Prescriber Restriction

Coverage Duration
12 months

Other Criteria

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
ENSPRYNG

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

Exclusion Criteria

Required Medical Information
a. Diagnosis of neuromyelitis optica spectrum disorder (NMOSD)AND b. Patient has a positive serologic test for anti-aquaporin-4 (AQP4) antibodies AND c. History of failure, contraindication, or intolerance to rituximab therapy AND d. One of the following:(1) History of one or more relapses that required rescue therapy during the previous 12 months OR (2) History of two or more relapses that required rescue therapy during the previous 24 months

Age Restriction

Prescriber Restriction
Prescribed by, or in consultation with, a neurologist

Coverage Duration
6 months

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 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

Drugs
etoposide intravenous, **TOPOSAR**

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 (NETUPITANT), **ALECENSA**, **ALUNBRIG ORAL TABLET 180 MG, 30 MG, 90 MG**, **ALUNBRIG ORAL TABLETS,DOSE PACK**, **CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG**, **COTELLIC**, **GLEOSTINE**, **HYCAMTIN**, **IDAMYCIN PFS**, **LONSURF ORAL TABLET 15-6.14 MG, 20-8.19 MG**, **NINLARO**, **ROZLYTREK ORAL CAPSULE 100 MG, 200 MG**, **RUBRACA**, **RYDAPT**, **SANCUSO**, **TAGRISSO**, **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 or call at 877-825-7722.

Drugs
EVRYSDI

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

Exclusion Criteria

Required Medical Information
a. Diagnosis of spinal muscular atrophy (SMA) AND b. Submission of medical records (e.g., chart notes, laboratory values) confirming the mutation or deletion of genes in chromosome 5q resulting in 1)homozygous gene deletion or mutation of SMN1 gene (e.g., homozygous deletion of exon 7 at locus 5q13)OR 2) heterozygous mutation of SMN1 gene (e.g., deletion of SMN1 exon 7 [allele 1] and mutation of SMN1 [allele 2])AND c. Patient is not dependent on either invasive ventilation or tracheostomy OR Use of non-invasive ventilation beyond use for naps and nighttime sleep AND d. Physician attests that Evrysdi is not to be initiated in a patient less than 2 month and e. Patient is not receiving concomitant chronic survival motor neuron (SMN)modifying therapy [e.g., Spinraza (nusinersen)] AND f. Patient has not previously received gene replacement therapy for the treatment of SMA [e.g., Zolgensma (onasemnogene abeparvovec-xioi)]-AND g. Submission of medical records (e.g., chart notes, laboratory values)documenting the baseline assessment

Age Restriction

Prescriber Restriction
Prescribed by a neurologist with expertise in the treatment of SMA

Coverage Duration
3 months

Other Criteria
Reauthorization: (1) Submission of medical records (e.g., chart notes, laboratory values) withthe most recent results documenting a positive clinical response to Evrysdi compared to pretreatment baseline status

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 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/μL within previous 12 months or greater than or equal to 150 cells/μL within 6 weeks of dosing AND medication will be used in combination with a corticosteroid inhaler and long acting beta2-agonist AND Patient must have experienced two or more exacerbations in the previous year OR require daily oral corticosteroids

Age Restriction

Prescriber Restriction

Coverage Duration
6 months

Other Criteria

Drugs
fentanyl citrate buccal lozenge on a handle

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

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

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

Age Restriction
16 years or older

Prescriber Restriction
Prescribed by an oncologist or pain specialist.

Coverage Duration
3 months

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

Drugs
FERRIPROX ORAL 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 x 109/L.

Age Restriction

Prescriber Restriction
Prescribed by a hematologist/oncologist or hepatologist

Coverage Duration
Per treatment

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

Drugs
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 exluded for part D

Exclusion Criteria

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

Age Restriction

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

Coverage Duration
3 months

Other Criteria

Drugs
FIRDAPSE, **RUZURGI**

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

Exclusion Criteria
Member has a history of seizures

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

Age Restriction

Prescriber Restriction
Neurologist

Coverage Duration
Through the benefit year

Other Criteria

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

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

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

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

Age Restriction
18 years and older.

Prescriber Restriction

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

Other Criteria

Drugs
FORTEO SUBCUTANEOUS PEN INJECTOR 20 MCG/DOSE (600MCG/2.4ML)

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
FOTIVDA

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

Exclusion Criteria

Required Medical Information
Diagnosis of Renal cell carcinoma, Advanced, relapsed or refractory following 2 or more prior systemic therapies

Age Restriction
18 years or older

Prescriber Restriction
Oncologist

Coverage Duration
End of Benefit Year

Other Criteria
1) Must have tried and failed or have a contraindication to other NCCN recommended therapies 2) Must have an Eastern Cooperative Oncology Group (ECOG) performance status of 0 or 1

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
GAVRETO

Covered Uses

Exclusion Criteria

Required Medical Information
Patient has a diagnosis of metastatic non-small cell lung cancer (NSCLC) AND Patient's disease is RET fusion-positive detected by an FDA approved test.

Age Restriction

Prescriber Restriction

Coverage Duration
3 months

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 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-UVEITS-ADOL HS**, **HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML**, **HUMIRA(CF) PEDI CROHNS STARTER SUBCUTANEOUS SYRINGE KIT 80 MG/0.8 ML, 80 MG/0.8 ML-40 MG/0.4 ML**, **HUMIRA(CF) PEN CROHNS-UC-HS**, **HUMIRA(CF) PEN PEDIATRIC UC**, **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 from Part D. All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria
Using in combination with other TNF antagonists,IL-1R antagonists, janus kinase inhibitor, anti-cd20 monoclonalantibodies or selective co-stimulation modulators.

Required Medical Information
Diagnosis of 1 of the following: A) Mod-severe rheumatoid arthritis and trial of 1 or more non-biologic disease modifying anti-rheumatic drugs (DMARD) (e.g., hydroxychloroquine [HCQ], sulfasalazine, methotrexate [MTX], leflunomide, azathioprine, cyclosporine) for at least 3 months, or B) Mod-severe polyarticular juvenile idiopathic arthritis (JIA) and trial of 1 or more non-biologic DMARDs (e.g., HCQ, sulfasalazine, MTX, leflunomide, azathioprine, cyclosporine) for at least 3 months, or C) Psoriatic arthritis and trial of MTX, or D) Ankylosing spondylitis and trial of 1 or more NSAIDs, or E) Mod-severe chronic plaque psoriasis (affecting more than 5% of body surface area or crucial body areas such as the hands, feet, face, or genitals) and trial of at least 1 of the following: phototherapy (including but not limited to Ultraviolet A with a psoralen [PUVA] and/or retinoids [RePUVA] for at least 1 continuous month or 1 or more oral systemic treatments (e.g., MTX, cyclosporine, acitretin, sulfasalazine) for at least 3 months, or F) Mod-severe Crohn's disease and trial of 2 or more of the following: corticosteroids (e.g., prednisone, methylprednisolone) or non-biologic DMARDs (e.g., azathioprine, MTX, mercaptopurine), or G) Mod-severe ulcerative colitis trial of 2 or more of the following: corticosteroids (e.g., prednisone, methylprednisolone), 5-ASA (i.e. mesalamine, sulfasalazine, balsalazide, olsalazine) or non-biologic DMARDs (azathioprine, MTX, mercaptopurine), or H) Hidradenitis suppurativa, or I) Non-infectious intermediate, posterior, and panuveitis and trial of 1 or more of the following: periocular, intraocular, or systemic corticosteroids, immunosuppressants (azathioprine, MTX, mycophenolate mofetil, cyclophosphamide, cyclosporine). A trial is defined as an inadequate response, intolerance or contraindication to the therapy.

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria

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

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 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

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
INLYTA ORAL TABLET 1 MG, 5 MG

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

Exclusion Criteria

Required Medical Information

Age Restriction
18 years or older

Prescriber Restriction

Coverage Duration
3 months

Other Criteria

Drugs
INQOVI

Covered Uses

Exclusion Criteria

Required Medical Information
Patient has a diagnosis of myelodysplastic syndromes (MDS), including previously treated and untreated, de novo and secondary MDS with the following French-American-British subtypes (refractory anemia, refractory anemia with ringed sideroblasts, refractory anemia with excess blasts, and chronic myelomonocytic leukemia [CMML]) and intermediate-1, intermediate-2, and high-risk International Prognostic Scoring System groups AND patient is not receiving Inqovi concomitantly with intravenous decitabine AND patient has tried and failed or has a contraindication to SQ azacitadine.

Age Restriction

Prescriber Restriction

Coverage Duration
3 months

Other Criteria

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 RECON SOLN

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

Exclusion Criteria

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

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

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
INVEGA HAFYERA, **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
IRESSA

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

Exclusion Criteria

Required Medical Information
Diagnosis

Age Restriction

Prescriber Restriction
Must be prescribed by Oncologist

Coverage Duration
3 mos initial, renewable in 6 month increments

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
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 x 109/L and dose must be less than 50 mg per day. No dose increases will be approved within 4 weeks of therapy and not more frequently than every 2 weeks. If no spleen reduction or symptom improvement after 6 months then discontinue the drug.

Age Restriction
18 years or older

Prescriber Restriction
Myelofibrosis: Prescribed by a Hematologist/Oncologist

Coverage Duration
3 months

Other Criteria

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

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

Exclusion Criteria

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

Age Restriction
Patient is 18 years of age or older

Prescriber Restriction

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

Other Criteria

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

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

Exclusion Criteria

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

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

Prescriber Restriction
Endocrinologist or Pulmonologist

Coverage Duration
Plan year

Other Criteria

Drugs
KESIMPTA PEN

Covered Uses

Exclusion Criteria

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

Age Restriction

Prescriber Restriction

Coverage Duration
Through end of benefit year

Other Criteria

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

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction

Coverage Duration
Through end of benefit year

Other Criteria

Drugs
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
LATUDA ORAL TABLET 120 MG, 20 MG, 40 MG, 60 MG, 80 MG

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

Exclusion Criteria

Required Medical Information
Trial of at least two other drugs: lurasidone, risperidone, questiapine, or cariprazine.

Age Restriction

Prescriber Restriction

Coverage Duration
Through the end of benefit year

Other Criteria

Drugs
ledipasvir-sofosbuvir

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

Exclusion Criteria

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

Age Restriction
Patient must be 12 years of age or older

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

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

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

Drugs
LENVIMA 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

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

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

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

Age Restriction
18 years and older

Prescriber Restriction

Coverage Duration
3 months

Other Criteria

Drugs
LEUKINE INJECTION RECON SOLN

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

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

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

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

Prescriber Restriction
Oncologist or Hematologist

Coverage Duration
Plan year

Other Criteria

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

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

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
linezolid

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

Exclusion Criteria
Patients that are currently myelosuppressed due to any cause

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

Age Restriction

Prescriber Restriction
Presribing physician must be an infectious disease specialist

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

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

Drugs
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
LUMAKRAS

Covered Uses

Exclusion Criteria

Required Medical Information
Diagnosis of Non-small cell lung cancer, Locally advanced or metastatic with a KRAS G12C-mutation in patients who have received at least 1 prior systemic therapy

Age Restriction
18 years of age or older

Prescriber Restriction
Oncologist

Coverage Duration
Through benefit year

Other Criteria

Drugs
LUPANETA PACK (1 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
LUPKYNIS

Covered Uses

Exclusion Criteria

Required Medical Information
Diagnosis of Lupus nephritis, Active, in combination with mycophenolate mofetil and corticosteroids

Age Restriction
18 years of age and older

Prescriber Restriction

Coverage Duration
1 year

Other Criteria
Establish an accurate baseline estimated GFR (eGFR) and blood pressure (BP) prior to initiation. Do not initiate treatment in patient with BP greater than 165/105 mm Hg or with hypertensive emergency. Use not recommended with baseline eGFR of 45 mL/min/1.73m(2)

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

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

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

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

Age Restriction

Prescriber Restriction
Oncologist, Endocrinologist, or Gynecologist to prescribe

Coverage Duration
Plan year

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

Drugs
LYNPARZA

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction

Coverage Duration
Through end of benefit year

Other Criteria

Drugs
MAKENA INTRAMUSCULAR OIL 250 MG/ML (1 ML)

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

Exclusion Criteria

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

Age Restriction
16 years of age or older

Prescriber Restriction

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

Other Criteria

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

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

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

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

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria
Will only be approved for 2 treatment cycles.

Drugs
MAVYRET ORAL TABLET

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

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

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

Age Restriction

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

Coverage Duration
based on the AASLD treatment guidelines

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

Drugs
MAYZENT ORAL TABLET 0.25 MG, 2 MG, MAYZENT STARTER PACK

Covered Uses
All FDA-approved indications not otherwise excluded from Part D. Diagnosis of relapsing forms of multiple sclerosis and must have tried and failed one generic alternative agent such as dimethyl fumarate or glatiramer acetate.

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

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 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

Drugs
MENEST

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

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

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

Age Restriction
18 years and older

Prescriber Restriction

Coverage Duration
Plan year

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

Drugs
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

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
MONJUVI

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

Exclusion Criteria

Required Medical Information
Patient has a diagnosis of diffuse large B-cell lymphoma (DLBCL) not otherwise specified, including DLBCL arising from low grade lymphoma (excluding primary refractory AND 'double or triple hit' disease) AND Patient has at least one measurable lesion AND Patient's disease is relapsed or refractory AND Therapy will be initiated in combination with lenalidomide AND Patient is NOT eligible for autologous stem cell transplant AND Patient is ineligible for intensive therapy (i.e., high-dose chemotherapy (HDC) and autologous stem cell transplantation (ASCT))

Age Restriction
Patient is 18 years or older

Prescriber Restriction
Prescribed by oncologist

Coverage Duration
3 months

Other Criteria

Drugs
MOVANTIK

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

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

Required Medical Information
Documentation of diagnosis and treatment history.

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

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

Drugs
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.

Drugs
MULPLETA

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction

Coverage Duration
3 Months

Other Criteria

Drugs
NAGLAZYME

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
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

Drugs
NEULASTA, **NEULASTA ONPRO**

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
NEXLIZET

Covered Uses

Exclusion Criteria

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

Age Restriction
18 years and older.

Prescriber Restriction

Coverage Duration
Through end of benefit year

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

Drugs
NORPACE CR

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
droxidopa, **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
Documenation of non-metastatic castration resistant prostate cancer (nmCRPC).

Age Restriction

Prescriber Restriction
Oncologist

Coverage Duration
3 months

Other Criteria

Drugs
NUCALA SUBCUTANEOUS AUTO-INJECTOR, **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/µL within previous 12 months or greater than or equal to 150 cells/µL within 6 weeks of dosing AND medication will be used in combination with a corticosteroid inhaler and long acting beta2-agonist AND Patient must have experienced two or more exacerbations in the previous year OR require daily oral corticosteroids OR B)patient has eosinophilic granulomatosis with polyangiitis (EGPA)AND documented trial and failure of or contraindication to treatment with at least one immunosuppressants (azathioprine, cyclophosphamide, or methotrexate).

Age Restriction

Prescriber Restriction

Coverage Duration
6 months

Other Criteria

Drugs
NUCYNTA, **NUCYNTA ER**

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

Exclusion Criteria

Required Medical Information
Documentation of diagnosis and treatment history.

Age Restriction
18 years and older.

Prescriber Restriction

Coverage Duration
Plan year

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

Drugs
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
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 member has tried and failed two triptan therapies OR Documentation that the medication will be used for the prevention of migraine with or without aura in adults AND member has tried and failed two preventative medication alternatives

Age Restriction

Prescriber Restriction

Coverage Duration
Through end of benefit year

Other Criteria
Reauthorization requires documentation of medication efficacy.

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 or call at 877-825-7722.

Drugs
ONFI

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
ONUREG

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

Exclusion Criteria

Required Medical Information
Documented diagnosis of Acute myeloid leukemia AND achieved first complete remission (CR) or complete remission with incomplete blood count recovery (CRi) following intensive induction chemotherapy AND are not able to complete intensive curative therapy AND Have tried and failed or has contraindication to all other NCCN recommended therapies (Azacitadine SQ or IV, Decitabine, Low-dose cytarabine, Venclexta) AND Baseline CBC tests be performed prior to initiation.

Age Restriction

Prescriber Restriction
Oncologist or hematologist

Coverage Duration
3 months

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 catherization. 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
ORGOVYX

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

Exclusion Criteria

Required Medical Information
Patient has a diagnosis of advanced prostate cancer

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria

Drugs
ORIAHNN

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

Exclusion Criteria
Presence of any contraindications as defined by the FDA.

Required Medical Information
Documentation that the medication will be used for an FDA approved indication and Trial of two previous therapies (estrogen/progestin contraceptives, Progestin IUD, tranexamic acid).

Age Restriction
18 years of age or older

Prescriber Restriction
physician specializing in patient's diagnosis or is in consultation with a gynecologist

Coverage Duration
12 months

Other Criteria
Max duration of therapy for 2 years

Drugs
ORILISSA ORAL TABLET 150 MG, 200 MG

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

Exclusion Criteria
presence of medication contraindication as defined by the FDA.

Required Medical Information
Documentation that the medication will be used for an FDA approved indication AND trial of NSAIDs, estrogen/progestin unless contraindicated ANDtrial of Eligard unless contraindication.

Age Restriction
18 years of age or older

Prescriber Restriction
physician specializing in patient's diagnosis or is in consultation with a gynecologist

Coverage Duration
12 months

Other Criteria
Treatment not to exceed two years in duration

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
OSPHENA

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 patient is free of any clinically important active infections.

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria

Drugs
oxandrolone oral tablet 10 mg, 2.5 mg

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

Exclusion Criteria
Pregnancy Category X

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

Age Restriction

Prescriber Restriction

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

Other Criteria

Drugs
OXERVATE

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

Exclusion Criteria

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

Age Restriction
Member is 2 years of age or older

Prescriber Restriction
The medication is prescribed by an ophthalmologist

Coverage Duration
8 weeks

Other Criteria

Drugs
OXLUMO

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

Exclusion Criteria

Required Medical Information
Documented diagnosis of PH1 by, or in consultation with, a specialist (e.g., geneticist, nephrologist, urologist) with expertise in thediagnosis of PH1) AND confirmation of the PH1 diagnosis based on both metabolic (Increased urinary oxalate excretion greater than 1 mmol/1.73 m2 per day [90 mg/1.73 m2 per day OR increased urinary oxalate: creatinine ratio relative to normative values for age) OR increased plasma oxalate and glyoxylate concentrations) AND Genetic testing confirming a mutation in the alanine:glyoxylate aminotransferase (AGT or AGXT) gene AND patient has not received a liver transplant AND Oxlumo dosing is in accordance with the United States Food and Drug Administration approved labeling

Age Restriction

Prescriber Restriction
Oxlumo is prescribed by, or in consultation with, a specialist (e.g., geneticist, nephrologist, urologist) with expertise in the treatment of PH1

Coverage Duration
6 months

Other Criteria

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 additional 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 treament of bone metastases, diagnosis of breast cancer or multiple myeloma. For Paget's disease, must have symptomatic form of disease.

Age Restriction
18 years and older

Prescriber Restriction

Coverage Duration
Plan year

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

Drugs
PANRETIN

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

Exclusion Criteria

Required Medical Information

Age Restriction
18 years and older

Prescriber Restriction
Oncologist or HIV specialist

Coverage Duration
Plan year

Other Criteria

Drugs
paricalcitol oral

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

Exclusion Criteria

Required Medical Information
Documentation of diagnosis and treatment history.

Age Restriction
18 years and older.

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria
Documented failure or intolerance to calcitriol.

Drugs
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 recomended 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**

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
penicillamine oral capsule, **PENICILLAMINE ORAL TABLET**

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
3 months

Other Criteria

Drugs
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.

Drugs
PERSERIS

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction

Coverage Duration
Through the benefit year

Other Criteria

Drugs
PICATO

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

Exclusion Criteria

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

Age Restriction
18 years or older

Prescriber Restriction

Coverage Duration
Per treatment

Other Criteria
Must have failed 5-FU cream

Drugs
PIQRAY

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 SUBCUTANEOUS

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

Drugs
POMALYST

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction

Coverage Duration
3 Months

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

Drugs
POTELIGEO

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

Exclusion Criteria

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

Age Restriction
18 years or older

Prescriber Restriction

Coverage Duration
3 Months

Other Criteria

Drugs
pramipexole oral tablet extended release 24 hr

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
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 immunosupressive therapy.

Age Restriction

Prescriber Restriction

Coverage Duration
3 Months

Other Criteria

Drugs
tacrolimus topical

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

Exclusion Criteria

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

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

Prescriber Restriction

Coverage Duration
8 weeks

Other Criteria

Drugs
PULMOZYME

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

Exclusion Criteria

Required Medical Information
Clinical documentation of Cystic Fibrosis diagnosis

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

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

Drugs
REGRANEX

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

Exclusion Criteria

Required Medical Information
Documentation of diagnosis

Age Restriction
16 years and older

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
RELENZA DISKHALER

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction

Coverage Duration
Per treatment (up to 28 days)

Other Criteria

Drugs
REMODULIN

Covered Uses
All FDA-approved indications not otherwise excluded 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
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
RIABNI

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria

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

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction

Coverage Duration
Per treatment (up to 48 weeks)

Other Criteria

Drugs
RINVOQ

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

Exclusion Criteria

Required Medical Information
Diagnosis of Mod-severe rheumatoid arthritis and trial of 1 or more non-biologic disease modifying anti-rheumatic drugs (DMARD) (e.g., hydroxychloroquine [HCQ], sulfasalazine, methotrexate [MTX], leflunomide, azathioprine, cyclosporine)

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria

Drugs
RISPERDAL CONSTA

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

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

Drugs
vigabatrin oral powder in packet

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

Exclusion Criteria

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

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

Prescriber Restriction
Neurologist registered with the Sabril REMS program

Coverage Duration
Plan year

Other Criteria

Drugs
SAMSCA

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

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

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

Age Restriction

Prescriber Restriction

Coverage Duration
1 month

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

Drugs
asenapine maleate, **SAPHRIS SUBLINGUAL TABLET 10 MG, 2.5 MG, 5 MG**, **SECUADO**

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

Exclusion Criteria

Required Medical Information
Documentation of diagnosis and treatment history

Age Restriction
18 years and older

Prescriber Restriction

Coverage Duration
Plan year

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

Drugs
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
SKYRIZI SUBCUTANEOUS SYRINGE 75 MG/0.83 ML, **SKYRIZI SUBCUTANEOUS SYRINGE KIT**

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

Exclusion Criteria

Required Medical Information
Diagnosis of Mod-severe chronic plaque psoriasis (affecting more than 5% of body surface area or crucial body areas such as the hands, feet, face, or genitals) and trial of at least one oral systemic treatment (e.g., MTX, cyclosporine, acitretin, sulfasalazine)

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria

Drugs
sofosbuvir-velpatasvir

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

Exclusion Criteria

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

Age Restriction
18 years of age and older

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

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

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

Drugs
SOMATULINE DEPOT

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

Exclusion Criteria

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

Age Restriction
18 years of age and older

Prescriber Restriction

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

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

Drugs
SOMAVERT

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 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

Drugs
sunitinib, **SUTENT**

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

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

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

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

Prescriber Restriction
Must be prescribed by oncologist

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

Other Criteria

Drugs
SYNERA

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
TABLOID

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction

Coverage Duration
Through chemotherapy remission inducation and consolidation treatment

Other Criteria

Drugs
TAFINLAR

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

Exclusion Criteria

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

Age Restriction
18 years or older

Prescriber Restriction
Oncologist

Coverage Duration
3 Months

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

Drugs
TAKHZYRO

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

Exclusion Criteria

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

Age Restriction
12 years of age or older

Prescriber Restriction

Coverage Duration
3 Months

Other Criteria

Drugs
TALZENNA ORAL CAPSULE 0.25 MG, 1 MG

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction
Oncology

Coverage Duration
3 months

Other Criteria

Drugs
erlotinib

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

Exclusion Criteria

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

Age Restriction
18 years or older

Prescriber Restriction
Prescriber must be an oncologist.

Coverage Duration
Plan year

Other Criteria

Drugs
bexarotene, **TARGRETIN TOPICAL**

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

Exclusion Criteria

Required Medical Information
Documentation of diagnosis and treatment history.

Age Restriction
18 years and older.

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
TASIGNA ORAL CAPSULE 150 MG, 200 MG

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

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

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

Age Restriction
18 years and older

Prescriber Restriction
Must be prescribed by Oncologist

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

Other Criteria

Drugs
TAVALISSE

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

Exclusion Criteria

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

Age Restriction
18 years or older

Prescriber Restriction
Hematologist

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

Other Criteria

Drugs
TAZVERIK

Covered Uses

Exclusion Criteria

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

Age Restriction

Prescriber Restriction
Oncology

Coverage Duration
3 months

Other Criteria

Drugs
dimethyl fumarate oral capsule,delayed release(DR/EC) 120 mg, 120 mg (14)- 240 mg (46), 240 mg

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

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

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

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
temozolomide

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

Exclusion Criteria

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

Age Restriction
18 years and older

Prescriber Restriction

Coverage Duration
3 Months

Other Criteria

Drugs
TEPMETKO

Covered Uses

Exclusion Criteria

Required Medical Information
Diagnosis of Non-small cell lung cancer, metastatic (with mesenchymal-epithelial transition [MET] exon 14 skipping mutation).

Age Restriction
18 years of age and older

Prescriber Restriction
Oncology

Coverage Duration
Through end of benefit year

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.

Drugs
THALOMID

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

Exclusion Criteria
Pregnancy (category X)

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

Age Restriction
12 years of age and older

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

Coverage Duration
3 months

Other Criteria

Drugs
THYMOGLOBULIN

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

Exclusion Criteria

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

Age Restriction
18 years and older

Prescriber Restriction

Coverage Duration
Up to 14 days.

Other Criteria

Drugs
TIBSOVO

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction
Oncology

Coverage Duration
3 months

Other Criteria

Drugs
TIGAN INTRAMUSCULAR

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

Exclusion Criteria

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

Age Restriction
Use not recommended in children

Prescriber Restriction

Coverage Duration
Per treatment

Other Criteria

Drugs
tobramycin in 0.225 % NaCl

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

Exclusion Criteria

Required Medical Information
Documented diagnosis of cystic fibrosis with Pseudomonas

Age Restriction

Prescriber Restriction

Coverage Duration
Plan yer

Other Criteria

Drugs
bosentan, **TRACLEER ORAL TABLET FOR SUSPENSION**

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

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

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

Age Restriction
Greater than 12 years of age

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

Coverage Duration
3 Months

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

Drugs
tranexamic acid intravenous

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

Exclusion Criteria

Required Medical Information
Documentation of hemophilia diagnosis as appropriate

Age Restriction

Prescriber Restriction

Coverage Duration
8 days

Other Criteria

Drugs
ALTRENO, *tretinoin (antineoplastic)*

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction

Coverage Duration
3 months

Other Criteria

Drugs
TRIKAFTA ORAL TABLETS, SEQUENTIAL 100-50-75 MG(D) /150 MG (N)

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
TRINTELLIX

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

Exclusion Criteria

Required Medical Information
Diagnosis of major depressive disorder and treatment failure of at least two other formulary medications used in the treatment of major depressive disorder

Age Restriction

Prescriber Restriction

Coverage Duration
Through end of benefit year.

Other Criteria

Drugs
TRUSELTIQ

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

Exclusion Criteria

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

Age Restriction
18 years of age or older

Prescriber Restriction
Oncologist

Coverage Duration
12 months

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
lapatinib, **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

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 two triptans, unless contraindicated.

Age Restriction

Prescriber Restriction

Coverage Duration
Through end of benefit year

Other Criteria
Reauthorization requires documentation of medication efficacy.

Drugs
VALCYTE ORAL RECON SOLN, *valganciclovir*

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

Exclusion Criteria

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

Age Restriction
4 months and older.

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria

Drugs
vancomycin oral capsule

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction

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

Other Criteria

Drugs
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 or call at 877-825-7722.

Drugs
calcitriol topical

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

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

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

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

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

Drugs
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

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
VERQUVO

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

Exclusion Criteria

Required Medical Information
Heart failure, chronic, To reduce the risk of cardiovascular death and heart failure hospitalization in symptomatic patients with reduced ejection fraction

Age Restriction
18 years or older

Prescriber Restriction
Cardiologist

Coverage Duration
1 year

Other Criteria
All the below must be met. 1) Diagnosis of chronic heart failure of NYHA class II-IV 2)Must have LVEF less than 45% 3)Concomitant or prior treatment with Ace inhibitor/Angiotensin receptor blocker/Entresto and a beta blocker 4) Dose does not exceed 10mg/day 5)Must have had a previous hospitalization due to heart failure within the past 6 months, or an outpatient intravenous diuretic treatment for heart failure within the past 3 months.

Drugs
VERZENIO

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction
Oncologist

Coverage Duration
3 Months

Other Criteria

Drugs
VIBERZI

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction

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

Other Criteria

Drugs
VIIBRYD ORAL TABLET, **VIIBRYD ORAL TABLETS,DOSE PACK 10 MG (7)- 20 MG (23)**

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

Exclusion Criteria

Required Medical Information
Documented trial of at least two generic antidepressants (e.g. bupropion, citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine, paroxetine CR, sertraline, duloxetine, venlafaxine).

Age Restriction

Prescriber Restriction

Coverage Duration
Through end of benefit year

Other Criteria

Drugs
VILTEPSO

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

Exclusion Criteria

Required Medical Information
Diagnosis of Duchenne muscular dystrophy by, or in consultation with, a neurologist with expertise in the diagnosis of DMD AND Submission of medical records (e.g., chart notes, laboratory values) confirming the mutation of the DMD gene amenable to exon 53 skipping AND One of the following 1) patient has a 6-Minute OR Walk Time (6MWT) greater than 300 meters while walking independently (e.g., without side-by-side assist, cane, walker, wheelchair, etc.) prior to beginning Viltepso therapy OR 2) the patient is ambulatory without needing an assistive device AND has achieved a score of greater than 17 on the North Star Ambulatory Assessment (NSAA) AND dosing for DMD is in accordance with the United States Food and Drug Administration approved labeling

Age Restriction

Prescriber Restriction
Prescribed by, or in consultation with, a neurologist with expertise in the treatment of DMD

Coverage Duration
6 months

Other Criteria
Reauthorization: Documentation of an increase in the physical function from baseline

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

Drugs
voriconazole oral

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

Exclusion Criteria

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

Age Restriction
12 years or older

Prescriber Restriction

Coverage Duration
6 months

Other Criteria

Drugs
VOTRIENT

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

Exclusion Criteria

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

Age Restriction
18 years of age and older

Prescriber Restriction
Oncologist

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

Other Criteria

Drugs
VRAYLAR

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

Exclusion Criteria
ADocumentation 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

Drugs
XCOPRI, **XCOPRI MAINTENANCE PACK ORAL TABLET 250MG/DAY(150 MG X1-100MG X1), 350 MG/DAY (200 MG X1-150MG X1)**, **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 from the following list: Briviact, clobazam, felbamate, lamotrigine, levetiracetam, Fycompa, rufinamide, topiramate, valproate, zonisamide, carbamazepine, Aptiom, gabapentin, Vimpat, oxcarbazepine, phenobarbital, phenytoin, pregabalin, primidone, tiagabine, vigabatrin.

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
Diagnosis of one of the following: A) Psoriatic arthritis and trial of MTX OR B) Mod-severe rheumatoid arthritis and trial of 1 or more non-biologic disease modifying anti-rheumatic drugs (DMARD) (e.g., hydroxychloroquine [HCQ], sulfasalazine, methotrexate [MTX], leflunomide, azathioprine, cyclosporine) for at least 3 months, C) Ulcerative Colitis AND trial of 2 or more of the following: corticosteroids (e.g., prednisone, methylprednisolone), 5-ASA (i.e. mesalamine, sulfasalazine, balsalazide, olsalazine) or non-biologic DMARDs (azathioprine, MTX, mercaptopurine) OR D) Moderate to severe polyarticular juvenile idiopathic arthritis and patient had an inadequate response, intolerance or contraindication to at least one DMARD and one NSAID for at least 3 months

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria

Drugs
XELJANZ ORAL SOLUTION, **XELJANZ ORAL TABLET 5 MG**, **XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HR 11 MG, 22 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
Diagnosis of one of the following: A) Psoriatic arthritis and trial of MTX OR B) Mod-severe rheumatoid arthritis and trial of 1 or more non-biologic disease modifying anti-rheumatic drugs (DMARD) (e.g., hydroxychloroquine [HCQ], sulfasalazine, methotrexate [MTX], leflunomide, azathioprine, cyclosporine) for at least 3 months, C) Ulcerative Colitis AND trial of 2 or more of the following: corticosteroids (e.g., prednisone, methylprednisolone), 5-ASA (i.e. mesalamine, sulfasalazine, balsalazide, olsalazine) or non-biologic DMARDs (azathioprine, MTX, mercaptopurine) OR D) Moderate to severe polyarticular juvenile idiopathic arthritis and patient had an inadequate response, intolerance or contraindication to at least one DMARD and one NSAID for at least 3 months

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 anitdiarrheals (e.g. loperamide, diphenoxylate-atropine), antispasmodics (e.g. dicyclomine), bile acid sequestrants (e.g. cholestryramine, colestipol).

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

Prescriber Restriction

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

Other Criteria

Drugs
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

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 60MG TWICE WEEK (120 MG/WEEK), 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 ORAL CAPSULE

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

Exclusion Criteria

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

Age Restriction

Prescriber Restriction
Oncologist or urologist

Coverage Duration
3 months

Other Criteria
Must try and fail Zytiga first.

Drugs
XYREM

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

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

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

Age Restriction
18 years of age and older

Prescriber Restriction
Neurologist

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

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

Drugs
YONSA

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

Exclusion Criteria

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

Age Restriction
18 years of age or older

Prescriber Restriction

Coverage Duration
3 Months

Other Criteria

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

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

Exclusion Criteria

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

Age Restriction
18 years and older

Prescriber Restriction

Coverage Duration
Per treatment

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

Drugs
ZOLINZA

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

Exclusion Criteria

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

Age Restriction
18 years and older.

Prescriber Restriction

Coverage Duration
Plan year

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

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

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

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

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

Age Restriction
18 years and older.

Prescriber Restriction

Coverage Duration
6 months.

Other Criteria

Drugs
ZYDELIG ORAL TABLET 100 MG, 150 MG

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

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan year

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

Drugs
ZYFLO

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

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

Required Medical Information
Documentation of diagnosis and treatment history.

Age Restriction
12 years and older.

Prescriber Restriction

Coverage Duration
Plan year

Other Criteria
Must have failed montelukast and zafirlukast.

Drugs
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 or call at 877-825-7722.

Drugs
abiraterone oral tablet 250 mg, 500 mg, **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

Index

This formulary was updated on 03/01/2019. For more recent information or other questions, please call Customer Service toll-free at 1.855.443.4735 (TTY/TDD relay: 1.800.955.8771) Monday through Friday from 8 a.m. to 6 p.m.

You must generally use network pharmacies to use your prescription drug benefit. The Formulary or pharmacy network may change at any time. You will receive notice when necessary.

Health First Commercial Plans, Inc. is doing business under the name of Health First Health Plans. Health First Health Plans does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.

Health First Health Plans

6450 U.S. Highway 1
Rockledge, FL 32955
myHFHP.org

Nondiscrimination Notice

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

Health First Health Plans:

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

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

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

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

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

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

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36194_MPINFO324 (05/2019)

Health First
Health Plans

6450 U.S. Highway 1
Rockledge, FL 32955
myHFHP.org

English:
If you, or someone you're helping, has questions about Health First Health Plans, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-443-4735.

Spanish:
En caso que usted, o alguien a quien usted ayude, tenga cualquier duda o pregunta acerca de Health First Health Plans, usted tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-443-4735.

Haitian Creole:
Si oumenm oswa yon moun w ap ede gen kesyon konsènan Health First Health Plans, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 855-443-4735.

Vietnamese:
Nếu Quý vị, hay người mà Quý vị đang giúp đỡ, có câu hỏi về Health First Health Plans thì Quý vị có quyền được trợ giúp và được biết thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với thông dịch viên, xin gọi số 855-443-4735.

Portuguese:
Você ou alguém que você estiver ajudando tem o direito de tirar dúvidas e obter informações sobre os Health First Health Plans no seu idioma e sem custos. Para falar com um tradutor, ligue para 855-443-4735.

Chinese:
如果您，或是您正在協助的對象，有與 Health First Health Plans 相關的問題，您有權以您的母語免費取得幫助和資訊。請致電 855-443-4735 與翻譯員洽談。

French:
Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Health First Health Plans, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-443-4735.

Tagalog:
Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Health First Health Plans, may karapatan ka na humingi ng tulong at impormasyon sa iyong wika nang libre. Upang makausap ang isang tagasalin, tumawag sa 855-443-4735.

Russian:
Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Health First Health Plans, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 855-443-4735.

Arabic:

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Health First Health Plans، فلديك الحق في الحصول على المساعدةوالمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بالرقم 855-443-4735.

Italian:
Se lei o qualcuno che sta aiutando avete domande su Health First Health Plans, ha il diritto di ottenere aiuto e informazioni nella sua lingua gratuitamente. Per parlare con un interprete, può chiamare il numero 855-443-4735.

German:
Falls Sie oder jemand, dem Sie helfen, Fragen zum Health First Health Plans haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-443-4735 an.

Korean:
만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Health First Health Plans 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 855-443-4735 로 전화하십시오.

Polish:
Jeśli Ty lub osoba, której pomagasz, macie pytania na temat Health First Health Plans, macie Państwo prawo do bezpłatnego uzyskania informacji i pomocy w języku ojczystym. Aby porozmawiać z tłumaczem, prosimy zadzwonić pod numer 855-443-4735.

Gujarati:
જો તમે અથવા તમે કોઇને મદદ કરી રહ્યા હો તેમાંથી કોઇને હેલ્થ ફર્સ્ટ હેલ્થ પ્લાન્સ વિશે પ્રશ્નો હોય તો તમને તમારી ભાષામાં વિના મૂલ્યે મદદ અને માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે **855-443-4735** પર કોલ કરો.

Thai:
หากคุณหรือคนที่คุณกำลังช่วยเหลือมีคำถามเกี่ยวกับ Health First Health Plansคุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย หากต้องการพูดคุยกับล่าม โปรดโทร 855-443- 4735.

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36194-77150_MPINFO109 (08/2016)