Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

ACTIQ

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

Member is already taking and is tolerant to around-the-clock opioid therapy. Member is considered opioid tolerant when taking another opioid daily for a week or longer (for example, at least 60 mg of oral morphine per day or an equianalgesic dose of another opioid).

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

ACYCLOVIR

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

ADAKVEO

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

SICKLE CELL DISEASE (initial authorization only): Disease is associated with one of the following genotypes: Homozygous hemoglobin S, Hemoglobin S beta 0-thalassemia, Hemoglobin S beta+ thalassemia, Hemoglobin SC. Member has a hemoglobin level of at least 4 g/dL. Member meets one of the following (a or b): a) Member experienced at least 1 vaso-occlusive crisis (VOC) within the past 6 months while on hydroxyurea, OR b) Member has intolerance or contraindication to hydroxyurea and has experienced at least 2 VOC within the past 12 months. Confirmation of baseline incidence of VOC over the last 12 months. Failure of L-glutamine, unless contraindicated or clinically significant adverse effects are experienced. SICKLE CELL DISEASE (continuation of therapy): Member is responding positively to therapy as evidenced by an improvement in the incidence of VOC from baseline prior to initiating therapy.

Age Restrictions:

Prescriber Restrictions:

SICKLE CELL DISEASE: Prescribed by or in consultation with a hematologist.

Coverage Duration:

6 months.

Other Criteria:

SICKLE CELL DISEASE: Adakveo is prescribed concurrently with hydroxyurea, unless contraindicated or clinically significant adverse effects are experienced. Adakveo is not prescribed concurrently with Oxbryta.

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

ADEMPAS

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Members on concomitant phosphodiesterase (PDE) inhibitors (e.g., sildenafil, tadalafil, vardenafil, dipyridamole or theophylline) or nitrates (e.g., Nitrodur, Nitrobid, Nitrostat, Isordil, Ismo).

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

AFINITOR

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist. TUBEROUS SCLEROSIS COMPLEX ASSOCIATED PARTIAL ONSET SEIZURES: Prescribed by or in consultation with an oncologist or neurologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

AIMOVIG

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

MIGRAINE PROPHYLAXIS (new starts only): One of the following (a or b): a) Member experiences 4 or more migraine days per month for at least 3 months, or b) Diagnosis of chronic migraine and Aimovig is prescribed for prophylaxis. MIGRAINE PROPHYLAXIS (continuation of therapy): Member has experienced and maintained positive response to therapy as evidenced by a reduction in migraine days per month from baseline prior to initiating therapy.

Age Restrictions:

Prescriber Restrictions:

MIGRAINE PROPHYLAXIS: Prescribed by or in consultation with a neurologist, headache, or pain specialist.

Coverage Duration:

Initial authorization: 3 months. Continuation of therapy: 6 months.

Other Criteria:

MIGRAINE PROPHYLAXIS (new starts only): Failure of two of the following oral migraine preventative therapies, each from different therapeutic classes, unless contraindicated or clinically significant adverse effects are experienced: antiepileptic drugs (e.g., divalproex sodium, sodium valproate, topiramate), beta-blockers (e.g., metoprolol, propranolol, timolol), antidepressants (e.g., amitriptyline, venlafaxine).

Prior Authorization Group Description:

ALECENSA

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

ALPHA1-PROTEINASE INHIBITOR

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

ALPHA-1 ANTITRYPSIN (AAT) DEFICIENCY (initial authorization only): Member meets one of the following (a, b, or c): a) Diagnosis of necrotizing panniculitis, b) Confirmation of plasma AAT level less than 11 micromol/L (50 mg/dL using nephelometry or 80 mg/dL by radial immunodiffusion), OR c) If member has an AAT level greater than 11 micromol/L, then the member must have one of the high-risk phenotypes (i.e. PiZZ, PiZnull, Pi(null, null), or one of a few rare phenotypes [e.g. Pi(Malton, Malton)]). For members without necrotizing panniculitis, member demonstrates clinical evidence of emphysema by one of the following (a or b): a) Pre-treatment post-bronchodilator forced expiratory volume in one second (FEV1) from 30% or greater to 65% or less of predicted, OR b) Pre-treatment post-bronchodilator FEV1 from greater than 65% to less than 80% of predicted and a rapid decline in lung function showing a change in FEV1 greater than 100 mL/year.

Age Restrictions:

Prescriber Restrictions:

AAT DEFICIENCY: Prescribed by or in consultation with a pulmonologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

ALUNBRIG

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

AMBRISENTAN

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

PULMONARY ARTERIAL HYPERTENSION: Prescribed by or in consultation with a cardiologist or pulmonologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

AMITRIPTYLINE

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

DEPRESSION: Failure of one of the following generic antidepressants, unless contraindicated or clinically significant adverse effects are experienced: bupropion, bupropion SR, bupropion XL, citalopram, desvenlafaxine succinate, duloxetine, escitalopram, fluoxetine, mirtazapine, sertraline, venlafaxine, or venlafaxine XR.

Prior Authorization Group Description:

AMITRIPTYLINE/CHLORDIAZEPOXIDE

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

DEPRESSION ASSOCIATED WITH ANXIETY: Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: duloxetine, escitalopram, or venlafaxine XR.

Prior Authorization Group Description:

AMITRIPTYLINE/PERPHENAZINE

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

DEPRESSION WITH ANXIETY: Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: duloxetine, escitalopram, or venlafaxine XR.

Prior Authorization Group Description:

AMPHOTERICIN B

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

ABELCET (initial authorization only): Failure of conventional amphotericin B therapy unless contraindicated or clinically significant adverse effects are experienced. AMBISOME (initial authorization only): For requests when treating patients with Aspergillus species, Candida species and/or Cryptococcus species infections, failure of conventional amphotericin B therapy unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

AMPYRA

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

MULTIPLE SCLEROSIS (MS): Prescribed by or in consultation with a neurologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

ANTIHISTAMINES

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

ALL INDICATIONS (continuation of therapy): Prescriber has documented all of the following (a, b, and c): a) Medical justification outlining the specific benefit for continued therapy that outweighs the potential risk, b) Patient counseling has occurred outlining the potential risks of the medication, c) Ongoing monitoring plan.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

ALLERGIC RHINITIS (new starts only): Failure to two of the following, unless contraindicated or clinically significant adverse effects are experienced: levocetirizine, desloratadine, fluticasone propionate nasal suspension, flunisolide nasal solution or triamcinolone acetonide nasal inhaler.

Prior Authorization Group Description:

ANTIHISTAMINE COMBINATIONS

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

ALL INDICATIONS (continuation of therapy): Prescriber has documented all of the following (a, b, and c): a) Medical justification outlining the specific benefit for continued therapy that outweighs the potential risk, b) Patient counseling has occurred outlining the potential risks of the medication, c) Ongoing monitoring plan.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

ALLERGIC RHINITIS (new starts only): Failure to two of the following, unless contraindicated or clinically significant adverse effects are experienced: levocetirizine, desloratadine, fluticasone propionate nasal suspension, flunisolide nasal solution or triamcinolone acetonide nasal inhaler.

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

APOKYN

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

ARIKAYCE

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

MYCOBACTERIUM AVIUM COMPLEX (new starts only): Positive sputum culture after at least 6 consecutive months of a multidrug background regimen therapy (e.g., clarithromycin or azithromycin, ethambutol, and a rifamycin). MYCOBACTERIUM AVIUM COMPLEX (continuation of therapy): Confirmation of at least 3 consecutive negative monthly sputum cultures in the first 6 months of therapy or at least 2 consecutive negative monthly sputum cultures in the last 2 months of therapy. Member has not received Arikayce treatment for more than 12 months after converting to negative sputum status.

Age Restrictions:

Prescriber Restrictions:

MYCOBACTERIUM AVIUM COMPLEX: Prescribed by or in consultation with an infectious disease specialist or pulmonologist.

Coverage Duration:

Initial authorization: 6 months. Continuation of therapy: End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

AUBAGIO

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

MULTIPLE SCLEROSIS: Prescribed by or in consultation with a neurologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

AUSTEDO

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

TARDIVE DYSKINESIA: Development of tardive dyskinesia is secondary to a centrally acting dopamine receptor blocking agent (neuroleptic) (e.g., first- or second-generation antipsychotics such as chlorpromazine or aripiprazole, antiemetics such as promethazine or metoclopramide, the tri-cyclic antidepressant amoxapine).

Age Restrictions:

Prescriber Restrictions:

HUNTINGTON'S DISEASE: Prescribed by or in consultation with a neurologist. TARDIVE DYSKINESIA: Prescribed by or in consultation with a psychiatrist or neurologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

HUNTINGTON'S DISEASE (initial authorization only): Failure of tetrabenazine, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

AYVAKIT

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

GASTROINTESTINAL STROMAL TUMOR: If disease is positive for a PDGFRA exon 18 mutation other than D842V, failure of imatinib, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

BALVERSA

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

BAXDELA

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

ACUTE BACTERIAL SKIN AND SKIN STRUCTURE INFECTION (ABSSSI), COMMUNITY-ACQUIRED BACTERIAL PNEUMONIA (CABP): Request is for continuation of therapy initiated in an acute care hospital from which member was discharged OR Both of the following (1 and 2): 1) Current culture and sensitivity (C&S) report shows isolated pathogen is susceptible to delafloxacin, unless provider confirms that obtaining a C&S report is not feasible AND 2) Failure of one fluoroquinolone, unless all are contraindicated or clinically significant adverse effects are experienced, or C&S report shows resistance or lack of susceptibility of the isolated pathogen to all fluoroquinolones.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

ABSSSI: 14 days. CABP: 10 days.

Other Criteria:

Prior Authorization Group Description:

BELEODAQ

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

BELSOMRA

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

INSOMNIA (initial authorization only): For patients 65 years of age and older: Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: ramelteon, doxepin 6 mg/day or less, or trazodone. For patients under 65 years of age: Failure of zolpidem or zolpidem CR, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

BENLYSTA

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

LUPUS NEPHRITIS (initial authorization only): confirmation that member is positive for an SLE autoantibody (e.g., anti-nuclear antibody (ANA), anti-double-stranded DNA (anti-ds-DNA), anti-Smith (anti-Sm), anti-ribonucleoprotein (anti-RNP), anti-Ro/SSA, anti-La/SSB, antiphospholipid antibody).

Age Restrictions:

Prescriber Restrictions:

SYSTEMIC LUPUS ERYTHEMATOSUS: Prescribed by or in consultation with a rheumatologist. LUPUS NEPHRITIS: Prescribed by or in consultation with a nephrologist or rheumatologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

BENZTROPINE

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

PARKINSONS DISEASE/PARKINSONISM (continuation of therapy): Prescriber has documented all of the following (a, b, and c): a) Medical justification outlining the specific benefit for continued therapy that outweighs the potential risk, b) Patient counseling has occurred outlining the potential risks of the medication, c) Ongoing monitoring plan.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

PARKINSONS DISEASE/PARKINSONISM (new starts only): Failure of two of the following, unless contraindicated or clinically significant adverse effects are experienced: amantadine, levodopa/carbidopa, entacapone, pramipexole, ropinirole, selegiline.

Prior Authorization Group Description:

BEOVU

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

NEOVASCULAR (WET) AGE-RELATED MACULAR DEGENERATION (AMD) (continuation of therapy): Member is responding positively to therapy as evidenced by one of the following (a, b, c, or d): a) detained neovascularization, b) improvement/stabilization in visual acuity, c) maintenance of corrected visual acuity from prior treatment, or d) supportive findings from optical coherence tomography or fluorescein angiography.

Age Restrictions:

Prescriber Restrictions:

NEOVASCULAR (WET) AMD: Prescribed by or in consultation with an ophthalmologist.

Coverage Duration:

NEOVASCULAR (WET) AMD: Initial authorization: 4 months. Continuation of therapy: 6 months.

Other Criteria:

NEOVASCULAR (WET) AMD (new starts only): member must use bevacizumab intravitreal solution, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

BLEOMYCIN

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

BOSENTAN

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

PULMONARY ARTERIAL HYPERTENSION: Prescribed by or in consultation with a cardiologist or pulmonologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

BOSULIF

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

BOTOX

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

CHRONIC MIGRAINE HEADACHE (new starts only): Persistent history of chronic, debilitating migraine headaches with frequent attacks on more than 15 days per month.

Age Restrictions:

Prescriber Restrictions:

CHRONIC MIGRAINE HEADACHE: Prescribed by or in consultation with a neurologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

CHRONIC MIGRAINE HEADACHE (new starts only): Failure of prophylactic treatment with ONE of the following, unless contraindicated or clinically significant adverse effects are experienced: divalproex, topiramate, timolol or propranolol AND Failure of abortive therapy with ONE of the following, unless contraindicated or clinically significant adverse effects are experienced: sumatriptan, rizatriptan, zolmitriptan, naratriptan, almotriptan, frovatriptan, Relpax, ergotamine/caffeine or dihydroergotamine. BLEPHAROSPASM, CERVICAL DYSTONIA, UPPER LIMB SPASTICITY (new starts only): For members age 18 or older, failure of Xeomin unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

BRAFTOVI

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

BRIVIACT

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

PARTIAL-ONSET SEIZURES: Failure of two of the following generic antiepileptic drugs, unless contraindicated or clinically significant adverse effects are experienced: lamotrigine, topiramate, oxcarbazepine, carbamazepine, phenytoin, valproic acid or divalproex sodium.

Prior Authorization Group Description:

BRUKINSA

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

C1 ESTERASE INHIBITOR

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Member is not using the requested product in combination with another FDA-approved product for the same indication (e.g., using both Cinryze and Haegarda for long-term prophylaxis of HAE attacks).

Age Restrictions:

Prescriber Restrictions:

HEREDITARY ANGIOEDEMA: Prescribed by or in consultation with an immunologist, allergist, or hematologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

CABLIVI

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

ACQUIRED THROMBOTIC THROMBOCYTOPENIC PURPURA (aTTP) (continuation of therapy): Member has received no more than 58 days of Cablivi therapy after completion of plasma exchange therapy AND member meets one of the following (a or b): a) If request is for a new treatment cycle, member has experienced no more than two recurrences while taking Cablivi and Cablivi is prescribed in combination with plasma exchange and immunosuppressive therapy (i.e., glucocorticoids, rituximab) OR b) If request is for treatment extension, member is responding positively to therapy as evidenced by, including but not limited to, improvement in any of the following parameters: increase in platelet counts, reduction in neurological symptoms, or improvements in organ-damage markers (lactate dehydrogenase, cardiac troponin I, and serum creatinine).

Age Restrictions:

Prescriber Restrictions:

aTTP: Prescribed by or in consultation with a hematologist.

Coverage Duration:

Initial authorization: 60 days. Continuation of therapy: 58 days post plasma-exchange.

Other Criteria:

Prior Authorization Group Description:

CABOMETYX

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

CALQUENCE

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

CAPLYTA

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

SCHIZOPHRENIA: Failure of two of the following atypical antipsychotics, unless contraindicated or clinically significant adverse effects are experienced: risperidone, olanzapine, quetiapine, ziprasidone, aripiprazole.

Prior Authorization Group Description:

CAPRELSA

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

DIFFERENTIATED THYROID CARCINOMA: Failure of Lenvima or Nexavar, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

CAYSTON

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

CERDELGA

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

CEREZYME

Prior Authorization Indication:

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

Off Label Uses:

Type 3 Gaucher disease.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

CHLORPROMAZINE

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

Medical justification supports inability to use generic chlorpromazine tablet (e.g., contraindications to excipients). SCHIZOPHRENIA, BIPOLAR DISORDER: Failure of one of the following generic atypical antipsychotics, unless contraindicated or clinically significant adverse effects are experienced: risperidone, olanzapine, quetiapine, ziprasidone, aripiprazole.

Prior Authorization Group Description:

CHLORZOXAZONE

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

ALL INDICATIONS (continuation of therapy): Prescriber has documented all of the following (a, b, and c): a) Medical justification outlining the specific benefit for continued therapy that outweighs the potential risk, b) Patient counseling has occurred outlining the potential risks of the medication, c) Ongoing monitoring plan.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

CHORIONIC GONADOTROPIN

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Induction of ovulation and pregnancy in the anovulatory, infertile woman in whom the cause of anovulation is secondary and not due to primary ovarian failure. Treatment of obesity.

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

CINQAIR

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

ASTHMA (initial authorization only): Blood eosinophil count of greater than or equal to 400 cells/mcL within the past 3 months. ASTHMA (continuation of therapy): member is responding positively to therapy (examples may include but are not limited to a reduction in exacerbations or corticosteroid dose, improvement in forced expiratory volume over one second since baseline prior to initiating therapy, reduction in the use of rescue therapy since baseline prior to initiating therapy).

Age Restrictions:

Prescriber Restrictions:

ASTHMA: Prescribed by or in consultation with an allergist, pulmonologist, or immunologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

ASTHMA (initial authorization only): Failure of an inhaled corticosteroid used in combination with a long-acting beta-agonist (e.g., fluticasone/salmeterol), unless clinically significant adverse effects are experienced or all are contraindicated. Prescribed in combination with ONE inhaled corticosteroid (e.g., beclomethasone, budesonide, flunisolide, fluticasone, mometasone, ciclesonide), unless contraindicated or clinically significant adverse effects are experienced. AND Prescribed in combination with ONE long-acting beta-agonist (e.g., salmeterol, formoterol, vilanterol), unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

CLADRIBINE

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

CLOMIPRAMINE

Prior Authorization Indication:

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

Off Label Uses:

Autistic disorder.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

OBSESSIVE-COMPULSIVE DISORDER, AUTISTIC DISORDER: Failure of one selective serotonin reuptake inhibitor (e.g., fluoxetine, fluvoxamine, sertraline), unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

COMETRIQ

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

DIFFERENTIATED THYROID CARCINOMA: Failure of Lenvima or Nexavar unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

COPIKTRA

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

COTELLIC

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

CRYSVITA

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

X-LINKED HYPOPHOSPHATEMIA (new starts only): DNA testing results confirm the presence of mutations in the PHEX gene or documentation of elevated serum fibroblast growth factor 23 (FGF23) levels. Current (within the last 30 days) serum phosphorus level is below the reference range for age and gender and member has not received oral phosphate or vitamin D replacement therapy, OR serum phosphorus level is in normal range and member is receiving oral phosphate and/or vitamin D replacement therapy. X-LINKED HYPOPHOSPHATEMIA (continuation of therapy): Member has had an increase in serum phosphorus level from baseline prior to initiating therapy and/or maintenance within the normal range for age and gender, while on Crysvita therapy. TUMOR-INDUCED OSTEOMALACIA (new starts only): Confirmation of elevated serum FGF23 levels. Current (within the last 30 days) serum phosphorus level is below the reference range for age and gender and member has not received oral phosphate or vitamin D replacement therapy, OR serum phosphorus level is in normal range and member is receiving oral phosphate and/or vitamin D replacement therapy. TUMOR-INDUCED OSTEOMALACIA (continuation of therapy): Member has had an increase in serum phosphorus level from baseline prior to initiating therapy and/or maintenance within the normal range for age and gender, while on Crysvita therapy.

Age Restrictions:

Prescriber Restrictions:

TUMOR-INDUCED OSTEOMALACIA and X-LINKED HYPOPHOSPHATEMIA: Prescribed by or in consultation with an endocrinologist or metabolic disease specialist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

CYCLOBENZAPRINE HCL

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

ALL INDICATIONS (continuation of therapy): Prescriber has documented all of the following (a, b, and c): a) Medical justification outlining the specific benefit for continued therapy that outweighs the potential risk, b) Patient counseling has occurred outlining the potential risks of the medication, c) Ongoing monitoring plan.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

CYTARABINE

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

DAURISMO

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

DIACOMIT

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

DRAVET SYNDROME: Prescribed by or in consultation with a neurologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

DRAVET SYNDROME: Will be prescribed as adjunctive therapy with at least one other antiepileptic drug (e.g., clobazam).

Prior Authorization Group Description:

DICLOFENAC GEL

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

ACTINIC KERATOSES: 3 months.

Other Criteria:

Prior Authorization Group Description:

DIPYRIDAMOLE

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

ALL INDICATIONS (continuation of therapy): Prescriber has documented all of the following (a, b, and c): a) Medical justification outlining the specific benefit for continued therapy that outweighs the potential risk, b) Patient counseling has occurred outlining the potential risks of the medication, c) Ongoing monitoring plan.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

DISOPYRAMIDE

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

ALL INDICATIONS (continuation of therapy): Prescriber has documented all of the following (a, b, and c): a) Medical justification outlining the specific benefit for continued therapy that outweighs the potential risk, b) Patient counseling has occurred outlining the potential risks of the medication, c) Ongoing monitoring plan.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

DOPTELET

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

THROMBOCYTOPENIA WITH CHRONIC LIVER DISEASE: Recent (within the past 14 days) platelet count is less than 50 x 10^9/L. Member is scheduled to undergo a medical or dental procedure within the next 30 days. CHRONIC IMMUNE THROMBOCYTOPENIA (ITP) (new starts only): Recent (within the last 30 days) platelet count is less than 30 x 10^9/L or member has an active bleed. CHRONIC ITP (continuation of therapy): Member is responding positively to therapy (examples may include but are not limited to an increase in platelet count from baseline, reduction in bleeding events).

Age Restrictions:

Prescriber Restrictions:

THROMBOCYTOPENIA WITH CHRONIC LIVER DISEASE: Prescribed by or in consultation with a hematologist, hepatologist, or gastroenterologist. CHRONIC ITP: Prescribed by or in consultation with a hematologist.

Coverage Duration:

THROMBOCYTOPENIA WITH CHRONIC LIVER DISEASE: 4 weeks. CHRONIC ITP: End of Plan Year.

Other Criteria:

THROMBOCYTOPENIA WITH CHRONIC LIVER DISEASE (new starts only): For members with platelet count less than 40 x 10^9/L, failure of Mulpleta unless contraindicated or clinically significant adverse effects are experienced. CHRONIC ITP (new starts only): Failure of a corticosteroid (e.g., prednisone, methylprednisolone, or dexamethasone), unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

DOXEPIN

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

DOXEPIN CREAM

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

4 weeks.

Other Criteria:

PRURITUS (initial authorization only): Failure of two topical corticosteroids (e.g., amcinonide, fluticasone propionate, triamcinolone acetonide, betamethasone valerate, fluocinolone acetonide, hydrocortisone butyrate, mometasone furoate, desoximetasone, fluocinonide or betamethasone dipropionate), unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

DRIZALMA SPRINKLE

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

ALL INDICATIONS: Medical justification supports inability to use generic duloxetine capsules (e.g., contraindications to excipients).

Prior Authorization Group Description:

ELIDEL

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

ATOPIC DERMATITIS (initial authorization only): Failure of two medium to high potency topical corticosteroids (e.g., amcinonide, fluticasone propionate, triamcinolone acetonide, betamethasone valerate, fluocinolone acetonide, hydrocortisone butyrate, mometasone furoate, desoximetasone, fluocinonide or betamethasone dipropionate), unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

EMEND 40 MG

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

4 weeks.

Other Criteria:

Prior Authorization Group Description:

EMFLAZA

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

DUCHENNE MUSCULAR DYSTROPHY (initial authorization only): Diagnosis of Duchenne muscular dystrophy (DMD) confirmed by one of the following: Genetic testing (e.g., dystrophin deletion or duplication mutation found) OR if genetic studies are negative (i.e., no mutation identified), positive muscle biopsy (e.g., absence of dystrophin protein).

Age Restrictions:

Prescriber Restrictions:

DUCHENNE MUSCULAR DYSTROPHY: Prescribed by or in consultation with a neurologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

DUCHENNE MUSCULAR DYSTROPHY (initial authorization only): Failure of prednisone, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

EMGALITY

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

MIGRAINE PROPHYLAXIS (new starts only): One of the following (a or b): a) Member experiences 4 or more migraine days per month for at least 3 months, or b) Diagnosis of chronic migraine and Emgality is prescribed for prophylaxis. MIGRAINE PROPHYLAXIS (continuation of therapy): Member has experienced and maintained positive response to therapy as evidenced by a reduction in migraine days per month from baseline prior to initiating therapy. EPISODIC CLUSTER HEADACHE (new starts only): Member has a history of at least 2 cluster headache attack periods which lasted from 7 days to 1 year each and were separated by at least 3 months. EPISODIC CLUSTER HEADACHE (continuation of therapy): Member has experienced and maintained positive response to therapy as evidenced by a reduction in cluster headache attack frequency. Member has not received more than 12 months of consecutive treatment OR it has been at least 3 months since the member last received Emgality.

Age Restrictions:

Prescriber Restrictions:

MIGRAINE PROPHYLAXIS, EPISODIC CLUSTER HEADACHE: Prescribed by or in consultation with a neurologist, headache or pain specialist.

Coverage Duration:

Initial authorization: 3 months. Continuation of therapy: 6 months.

Other Criteria:

MIGRAINE PROPHYLAXIS (new starts only): Failure of two of the following oral migraine preventative therapies, each from different therapeutic classes, unless contraindicated or clinically significant adverse effects are experienced: antiepileptic drugs (e.g., divalproex sodium, sodium valproate, topiramate), beta-blockers (e.g., metoprolol, propranolol, timolol), antidepressants (e.g., amitriptyline, venlafaxine).

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

ENBREL

Prior Authorization Indication:

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

Off Label Uses:

Hidradenitis suppurativa.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

PSORIATIC ARTHRITIS, PLAQUE PSORIASIS: Prescribed by or in consultation with a rheumatologist or dermatologist. RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS: Prescribed by or in consultation with a rheumatologist. HIDRADENITIS SUPPURATIVA: Prescribed by or in consultation with a rheumatologist, dermatologist or gastroenterologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

RHEUMATOID ARTHRITIS (new starts only): Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: methotrexate, sulfasalazine, hydroxychloroquine, d-penicillamine, azathioprine or auranofin. PLAQUE PSORIASIS (new starts only): Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: methotrexate, cyclosporine or acitretin.

Prior Authorization Group Description:

ENDARI

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

SICKLE CELL DISEASE (initial authorization only): Failure of hydroxyurea, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

ENTYVIO

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ULCERATIVE COLITIS, CROHN'S DISEASE: Prescribed by or in consultation with a gastroenterologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

CROHN'S DISEASE (new starts only): Failure of Humira and infliximab/infliximab biosimilar, unless contraindicated or clinically significant adverse effects are experienced. ULCERATIVE COLITIS (new starts only): Failure of two of the following, unless contraindicated or clinically significant adverse effects are experienced: Humira, Xeljanz/Xeljanz XR, infliximab/infliximab biosimilar.

Prior Authorization Group Description:

EPCLUSA

Prior Authorization Indication:

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

Off Label Uses:

Criteria will be applied consistent with current AASLD-IDSA guidance.

Exclusion Criteria:

Required Medical Information:

CHRONIC HEPATITIS C INFECTION: Refer to the document, "Recommendations for Testing, Managing, and Treating Hepatitis C," by AASLD-IDSA available at http://www.hcvguidelines.org for drug regimen and duration of treatment based on genotype, treatment status, previous drug regimens used, past medical history and comorbidities.

Age Restrictions:

Prescriber Restrictions:

CHRONIC HEPATITIS C INFECTION: Prescribed by or in consultation with a gastroenterologist, hepatologist, infectious disease specialist, or provider who has expertise in treating HCV based on a certified training program.

Coverage Duration:

12 to 24 weeks based on cirrhosis status, genotype, prior treatment, or ribavirin eligibility.

Other Criteria:

Prior Authorization Group Description:

EPIDIOLEX

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

DRAVET SYNDROME, LENNOX-GASTAUT SYNDROME, SEIZURES ASSOCIATED WITH TUBEROUS SCLEROSIS COMPLEX (TSC): will be used as adjunctive therapy with other antiepileptic drugs.

Age Restrictions:

Prescriber Restrictions:

DRAVET SYNDROME, LENNOX-GASTAUT SYNDROME, SEIZURES ASSOCIATED WITH TSC: Prescribed by or in consultation with a neurologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

LENNOX-GASTAUT SYNDROME: Failure of two of the following, unless contraindicated or clinically significant adverse effects are experienced: Banzel, clobazam, clonazepam, felbamate, lamotrigine, topiramate.

Prior Authorization Group Description:

EPOETIN

Prior Authorization Indication:

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

Off Label Uses:

Anemia due to myelodyspastic syndrome. Anemia associated with myelofibrosis. Anemia secondary to combination ribavirin and interferon-alfa therapy in patients infected with hepatitis C virus.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

ERGOLOID MESYLATES

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

ALL INDICATIONS (continuation of therapy): Prescriber has documented all of the following (a, b, and c): a) Medical justification outlining the specific benefit for continued therapy that outweighs the potential risk, b) Patient counseling has occurred outlining the potential risks of the medication, c) Ongoing monitoring plan.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

ALZHEIMER'S DISEASE (new starts only): Failure of two of the following, unless contraindicated or clinically significant adverse effects are experienced: donepezil, memantine, rivastigmine or galantamine.

Prior Authorization Group Description:

ERLEADA

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

PROSTATE CANCER: Concurrent use of a gonadotropin-releasing hormone (GnRH) analog or past bilateral orchiectomy.

Age Restrictions:

Prescriber Restrictions:

PROSTATE CANCER: Prescribed by or in consultation with an oncologist or urologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

ESBRIET

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

IDIOPATHIC PULMONARY FIBROSIS (initial authorization only): Pulmonary fibrosis on high resolution computed tomography (HRCT). Known causes of pulmonary fibrosis have been ruled out (examples may include but are not limited to domestic and occupational environmental exposures, connective tissue disease, drug toxicity).

Age Restrictions:

Prescriber Restrictions:

IDIOPATHIC PULMONARY FIBROSIS: Prescribed by or in consultation with pulmonologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

ESTROGENS(Femhrt , Prempro , Estrace , Activella , Divigel , Climara , Premarin , Premphase , Fyavolv)

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

ALL INDICATIONS (continuation of therapy): Prescriber has documented all of the following (a, b, and c): a) Medical justification outlining the specific benefit for continued therapy that outweighs the potential risk, b) Patient counseling has occurred outlining the potential risks of the medication, c) Ongoing monitoring plan.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

ATROPHIC VAGINITIS AND KRAUROSIS VULVAE (new starts only): Failure to one of the following, unless contraindicated or clinically significant adverse effects are experienced: Estradiol vaginal tablet, Femring or Premarin vaginal cream.

Prior Authorization Group Description:

EVENITY

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

POSTMENOPAUSAL OSTEOPOROSIS (PMO): Total duration of Evenity therapy has not exceeded 12 months of cumulative use.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

PMO (initial authorization only): Member meets one of the following (a, b, or c): a) Failure of bisphosphonate therapy (e.g., alendronate) unless contraindicated or clinically significant adverse effects are experienced to both intravenous and oral formulations. OR b) Bone mineral density T-score at hip or spine is -3.5 or less. OR c) Bone mineral density T-score at hip or spine is -2.5 or less with a history of major osteoporotic fracture of the hip, spine, forearm, wrist, or humerus.

Prior Authorization Group Description:

EXKIVITY

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

EXONDYS 51

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

DUCHENNE MUSCULAR DYSTROPHY: Duchenne muscular dystrophy with mutation amenable to exon 51 skipping confirmed by genetic testing.

Age Restrictions:

Prescriber Restrictions:

DUCHENNE MUSCULAR DYSTROPHY: Prescribed by or in consultation with a neurologist.

Coverage Duration:

6 months.

Other Criteria:

DUCHENNE MUSCULAR DYSTROPHY: Currently stable on an oral corticosteroid regimen (e.g., prednisone), unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

EYLEA

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

NEOVASCULAR (WET) AGE-RELATED MACULAR DEGENERATION (AMD), RETINAL VEIN OCCLUSION (RVO), DIABETIC MACULAR EDEMA (DME), DIABETIC RETINOPATHY (DR): Prescribed by or in consultation with an ophthalmologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

NEOVASCULAR (WET) AMD, RVO, DME, DR (new starts only): For all indications, except for DME in members with baseline visual acuity worse than 20/50: member must use bevacizumab intravitreal solution, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

FARYDAK

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with a hematologist or oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

FASENRA

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

ASTHMA (initial authorization only): Blood eosinophil count of greater than or equal to 150 cells/mcL within the past 3 months. ASTHMA (continuation of therapy): member is responding positively to therapy (examples may include but are not limited to a reduction in exacerbations or corticosteroid dose, improvement in forced expiratory volume over one second since baseline prior to initiating therapy, reduction in the use of rescue therapy since baseline prior to initiating therapy).

Age Restrictions:

Prescriber Restrictions:

ASTHMA: Prescribed by or in consultation with an allergist, pulmonologist, or immunologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

ASTHMA (initial authorization only): Prescribed in combination with ONE inhaled corticosteroid (e.g., beclomethasone, budesonide, flunisolide, fluticasone, mometasone, ciclesonide), unless contraindicated or clinically significant adverse effects are experienced AND Prescribed in combination with ONE long-acting beta-agonist (e.g., salmeterol, formoterol, vilanterol), unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

FERRIPROX

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

TRANSFUSIONAL IRON OVERLOAD (initial authorization only): Failure of Exjade or Jadenu, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

FINTEPLA

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

DRAVET SYNDROME: Will be prescribed as adjunctive therapy with at least one other antiepileptic drug (e.g., Diacomit, clobazam, valproic acid, Epidiolex, topiramate, levetiracetam, clonazepam, zonisamide, ethosuximide, phenobarbital).

Age Restrictions:

Prescriber Restrictions:

DRAVET SYNDROME: Prescribed by or in consultation with a neurologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

FIORINAL WITH CODEINE

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

TENSION HEADACHE (continuation of therapy): Prescriber has documented all of the following (a, b, and c): a) Medical justification outlining the specific benefit for continued therapy that outweighs the potential risk, b) Patient counseling has occurred outlining the potential risks of the medication, c) Ongoing monitoring plan.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

TENSION HEADACHE (new starts only): Failure of naproxen and ibuprofen, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

FIRAZYR

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

HEREDITARY ANGIOEDEMA: Member is not using icatibant in combination with another FDA-approved product for treatment of acute HAE attacks [e.g., C1 esterase inhibitor (Berinert, Ruconest), ecallantide (Kalbitor)].

Age Restrictions:

Prescriber Restrictions:

HEREDITARY ANGIOEDEMA: Prescribed by or in consultation with an immunologist, allergist, or hematologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

FIRDAPSE

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

LAMBERT-EATON MYASTHENIC SYNDROME (LEMS) (initial authorization only): Confirmation of a baseline clinical muscle strength assessment (examples may include but are not limited to the Quantitative Myasthenia Gravis (QMG) score, triple-timed up-and-go test (3TUG), Timed 25-foot Walk test (T25FW)). LEMS (continuation of therapy): Member is responding positively to therapy as evidenced by clinical muscle strength assessments.

Age Restrictions:

Prescriber Restrictions:

LEMS: Prescribed by or in consultation with a neurologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

LEMS (initial authorization only): Medical justification supports inability to use Ruzurgi (e.g., contraindications to excipients).

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

FLECTOR

Prior Authorization Indication:

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

Off Label Uses:

Cancer pain.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Acute Pain: 4 weeks. Cancer pain: End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

FLUOROURACIL

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

FORTEO

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

OSTEOPOROSIS: For requests to continue therapy after having had a total of 2 years duration with any parathyroid hormone (PTH) analog (e.g., abaloparatide, teriparatide), confirmation that member remains at or has returned to having a high risk for fracture.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

OSTEOPOROSIS (initial authorization only): Member meets one of the following (a, b, or c): a) Failure of bisphosphonate therapy (e.g., alendronate) unless contraindicated or clinically significant adverse effects are experienced to both intravenous and oral formulations. OR b) Bone mineral density T-score at hip or spine is -3.5 or less. OR c) Bone mineral density T-score at hip or spine is -2.5 or less with a history of major osteoporotic fracture of the hip, spine, forearm, wrist, or humerus.

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

FOTIVDA

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

GALAFOLD

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

FABRY DISEASE: Amenable GLA variants (mutations) associated with benign phenotypes (i.e., phenotypes known not to cause Fabry disease), including the following GLA mutation: c.937G to T, (p.(D313Y)).

Required Medical Information:

FABRY DISEASE (initial authorization only): Presence of at least one amenable GLA variant (mutation) as confirmed by one of the following resources: Galafold Prescribing Information brochure (package insert - Section 12, Table 2), Amicus Fabry GLA Gene Variant Search Tool: http://www.fabrygenevariantsearch.com/hcp, or Amicus Medical Information at 1-877-4AMICUS or medinfousa@amicusrx.com.

Age Restrictions:

Prescriber Restrictions:

FABRY DISEASE: Prescribed by or in consultation with a clinical geneticist or nephrologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

GANCICLOVIR

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

GATTEX

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

SHORT BOWEL SYNDROME (SBS) (initial authorization only): Member has been dependent on parenteral nutrition or other intravenous support for at least 12 months. SBS (continuation of therapy): Requirement for parenteral nutrition or other intravenous support has decreased since initiation of Gattex therapy.

Age Restrictions:

Prescriber Restrictions:

SBS: Prescribed by or in consultation with a gastroenterologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

GAVRETO

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

ALL ONCOLOGY INDICATIONS: Gavreto is not prescribed concurrently with Retevmo. Member has not received prior RET targeted therapy (e.g., Retevmo).

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

GILENYA

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Baseline QTc interval greater than or equal to 500 msec.

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

MULTIPLE SCLEROSIS: Prescribed by or in consultation with a neurologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

GILOTRIF

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

GIVLAARI

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

ACUTE HEPATIC PORPHYRIA (AHP): Diagnosis of one of the following AHP subtypes and corresponding gene mutation (a, b, c, or d): a. ALA dehydratase-deficiency (ALAD) porphyria: ALAD mutation. b. Acute intermittent porphyria (AIP): HMBS or PBGD mutation. c. Hereditary coproporphyria (HCP): CPOX mutation. d. Variegate porphyria (VP): PPOX mutation. Panhematin, as a prophylactic treatment, is not prescribed concurrently with Givlaari (note: use of Panhematin for treatment of acute porphyria attacks while taking Givlaari is appropriate). AHP (new starts only): History of at least a four-fold increase of 5-aminolevulinic acid (ALA) or porphobilinogen (PBG) using a random urine sample. History of two or more porphyria attacks in a 6-month period requiring hospitalization, urgent healthcare visit, or intravenous Panhematin (hemin for injection) administration at home, and one of the following (a or b): a. The porphyria attacks occurred within the last 6 months, b. The porphyria attacks occurred in any 6-month period and member is currently receiving prophylactic Panhematin therapy (e.g., once or twice a week on a regular basis). AHP (continuation of therapy): Member is responding positively to therapy as evidenced by one of the following (a or b): a. Decreased number of porphyria attacks requiring hospitalization, urgent healthcare visit, or intravenous Panhematin administration at home, OR b. No increase in porphyria attacks requiring hospitalization, urgent healthcare visit, or intravenous Panhematin administration at home if member was receiving prophylactic Panhematin prior to Givlaari initiation.

Age Restrictions:

Prescriber Restrictions:

AHP: Prescribed by or in consultation with a gastroenterologist, hematologist, or neurologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

GLATIRAMER

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

MULTIPLE SCLEROSIS: Prescribed by or in consultation with a neurologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

GLIMEPIRIDE

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

TYPE 2 DIABETES MELLITUS (continuation of therapy): Prescriber has documented all of the following (a, b, and c): a) Medical justification outlining the specific benefit for continued therapy that outweighs the potential risk, b) Patient counseling has occurred outlining the potential risks of the medication, c) Ongoing monitoring plan.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

TYPE 2 DIABETES MELLITUS (new starts only): Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: glipizide or glipizide/metformin combination product.

Prior Authorization Group Description:

GLYBURIDE

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

TYPE 2 DIABETES MELLITUS (continuation of therapy): Prescriber has documented all of the following (a, b, and c): a) Medical justification outlining the specific benefit for continued therapy that outweighs the potential risk, b) Patient counseling has occurred outlining the potential risks of the medication, c) Ongoing monitoring plan.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

TYPE 2 DIABETES MELLITUS (new starts only): Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: glipizide or glipizide/metformin combination product.

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

GLYBURIDE/METFORMIN

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

TYPE 2 DIABETES MELLITUS (continuation of therapy): Prescriber has documented all of the following (a, b, and c): a) Medical justification outlining the specific benefit for continued therapy that outweighs the potential risk, b) Patient counseling has occurred outlining the potential risks of the medication, c) Ongoing monitoring plan.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

TYPE 2 DIABETES MELLITUS (new starts only): Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: glipizide or glipizide/metformin combination product.

Prior Authorization Group Description:

GUANFACINE

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

HYPERTENSION (continuation of therapy): Prescriber has documented all of the following (a, b, and c): a) Medical justification outlining the specific benefit for continued therapy that outweighs the potential risk, b) Patient counseling has occurred outlining the potential risks of the medication, c) Ongoing monitoring plan.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

HYPERTENSION (new starts only): Failure of two of the following, unless contraindicated or clinically significant adverse effects are experienced: amlodipine/benazepril, benazepril, benazepril/hydrochlorothiazide, captopril, captopril/hydrochlorothiazide, fosinopril, fosinopril/hydrochlorothiazide, lisinopril, lisinopril/hydrochlorothiazide, quinapril, quinapril/hydrochlorothiazide, losartan, losartan/hydrochlorothiazide, valsartan, valsartan/hydrochlorothiazide, irbesartan, irbesartan/hydrochlorothiazide, candesartan, candesartan/hydrochlorothiazide, carvedilol, labetalol, acebutolol, atenolol, bisoprolol, bisoprolol/hydrochlorothiazide, timolol, nadolol, propranolol, metoprolol, metoprolol/hydrochlorothiazide, pindolol, nifedipine SR, amlodipine, nicardipine.

Prior Authorization Group Description:

HARVONI

Prior Authorization Indication:

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

Off Label Uses:

Criteria will be applied consistent with current AASLD-IDSA guidance.

Exclusion Criteria:

Required Medical Information:

CHRONIC HEPATITIS C INFECTION: Refer to the document, "Recommendations for Testing, Managing, and Treating Hepatitis C," by AASLD-IDSA available at http://www.hcvguidelines.org for drug regimen and duration of treatment based on genotype, treatment status, previous drug regimens used, past medical history and comorbidities.

Age Restrictions:

Prescriber Restrictions:

CHRONIC HEPATITIS C INFECTION: Prescribed by or in consultation with a gastroenterologist, hepatologist, infectious disease specialist, or provider who has expertise in treating HCV based on a certified training program.

Coverage Duration:

8 to 24 weeks based on cirrhosis status, genotype, prior treatment, or ribavirin eligibility.

Other Criteria:

Prior Authorization Group Description:

HERCEPTIN

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

ALL INDICATIONS: Medical justification supports inability to use Ogivri or Trazimera (e.g., contraindications to excipients).

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

HETLIOZ

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

HUMAN GROWTH HORMONE

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

CHILDREN AND ADOLESCENTS WITH GROWTH HORMONE DEFICIENCY, SHOX DEFICIENCY IN CHILDREN (initial authorization only): Baseline height prior to initiating therapy must be greater than 2 standard deviations below the mean for gender and age. Growth rate is such that the member is unlikely to attain an adult height in the normal range - 59 inches for girls and 63 inches for boys. TURNER SYNDROME (initial authorization only): Confirmed by karyotype. PRADER-WILLI or NOONAN SYNDROME (initial authorization only): Baseline height prior to initiating therapy must be less than the 5th percentile for gender and age OR 2 or more standard deviations below the mean measured paternal height. Growth rate is such that the member is unlikely to attain an adult height in the normal range - 59 inches for girls and 63 inches for boys.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

ADULT GROWTH HORMONE DEFICIENCY: End of Plan Year. HIV WASTING OR CACHEXIA, CHILDREN: 6 months.

Other Criteria:

HIV WASTING OR CACHEXIA: Member is being treated with concomitant antiretroviral therapy.

Prior Authorization Group Description:

HUMIRA

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

For the following indications, prescribed by or in consultation with: PSORIATIC ARTHRITIS, PLAQUE PSORIASIS - rheumatologist or dermatologist. CROHN'S DISEASE, ULCERATIVE COLITIS - gastroenterologist. RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS - rheumatologist. HIDRADENITIS SUPPURATIVA - rheumatologist, dermatologist or gastroenterologist. UVEITIS - ophthalmologist or rheumatologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

RHEUMATOID ARTHRITIS (new starts only): Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: methotrexate, sulfasalazine, hydroxychloroquine, d-penicillamine, azathioprine or auranofin. PLAQUE PSORIASIS (new starts only): Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: methotrexate, cyclosporine or acitretin.

Prior Authorization Group Description:

HYDROCODONE

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

CANCER PAIN: Plan Year. NON-MALIGNANT PAIN: Initial auth: 3 months, cont. of therapy: Plan Year.

Other Criteria:

CANCER PAIN, NON-MALIGNANT PAIN (initial authorization only): Failure of two of the following, unless contraindicated or clinically significant adverse effects are experienced: MS Contin, Kadian, Duragesic, Opana ER, Avinza or Oxycontin.

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

HYDROXYZINE HCL INJECTION

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

HYDROXYZINE HCL ORAL

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

ALL INDICATIONS (continuation of therapy): Prescriber has documented all of the following (a, b, and c): a) Medical justification outlining the specific benefit for continued therapy that outweighs the potential risk, b) Patient counseling has occurred outlining the potential risks of the medication, c) Ongoing monitoring plan.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

PRURITUS (new starts only): Failure of one of the following topical agents, unless contraindicated or clinically significant adverse effects are experienced: betamethasone, hydrocortisone, triamcinolone, fluticasone, clobetasol, fluocinonide or fluocinolone. ANXIETY (new starts only): Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: venlafaxine, buspirone, duloxetine or escitalopram.

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

HYDROXYZINE PAMOATE

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

ALL INDICATIONS (continuation of therapy): Prescriber has documented all of the following (a, b, and c): a) Medical justification outlining the specific benefit for continued therapy that outweighs the potential risk, b) Patient counseling has occurred outlining the potential risks of the medication, c) Ongoing monitoring plan.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

PRURITUS (new starts only): Failure of one of the following topical agents, unless contraindicated or clinically significant adverse effects are experienced: betamethasone, hydrocortisone, triamcinolone, fluticasone, clobetasol, fluocinonide or fluocinolone. ANXIETY (new starts only): Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: venlafaxine, buspirone, duloxetine or escitalopram.

Prior Authorization Group Description:

ICLUSIG

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

IDHIFA

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

ILARIS

Prior Authorization Indication:

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

Off Label Uses:

Acute gouty arthritis.

Exclusion Criteria:

Required Medical Information:

ALL INDICATIONS: Confirmation of current weight.

Age Restrictions:

Prescriber Restrictions:

SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS: Prescribed by or in consultation with a dermatologist, rheumatologist, or gastroenterologist. ADULT ONSET STILL'S DISEASE: Prescribed by or in consultation with a rheumatologist or hematologist. ALL OTHER COVERED INDICATIONS: Prescribed by or in consultation with a rheumatologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

IMATINIB

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

IMBRUVICA

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

CHRONIC GRAFT-VERSUS-HOST DISEASE: Prescribed by or in consultation with an oncologist, hematologist, or bone marrow transplant specialist. ALL OTHER INDICATIONS: Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

IMIPRAMINE

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

DEPRESSION: Failure of one of the following generic antidepressants, unless contraindicated or clinically significant adverse effects are experienced: bupropion, bupropion SR, bupropion XL, citalopram, desvenlafaxine succinate, duloxetine, escitalopram, fluoxetine, mirtazapine, sertraline, venlafaxine or venlafaxine XR.

Prior Authorization Group Description:

INDOMETHACIN

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

ALL INDICATIONS (continuation of therapy): Prescriber has documented all of the following (a, b, and c): a) Medical justification outlining the specific benefit for continued therapy that outweighs the potential risk, b) Patient counseling has occurred outlining the potential risks of the medication, c) Ongoing monitoring plan.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

ALL INDICATIONS (new starts only): Failure of naproxen and sulindac, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

INFLECTRA

Prior Authorization Indication:

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

Off Label Uses:

Granulomatosis with polyangiitis (Wegener's granulomatosis).

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

PSORIATIC ARTHRITIS/PLAQUE PSORIASIS: Prescribed by or in consultation with a rheumatologist or dermatologist. CROHN'S DISEASE/ULCERATIVE COLITIS: Prescribed by or in consultation with a gastroenterologist. RHEUMATOID ARTHRITIS/ANKYLOSING SPONDYLITIS: Prescribed by or in consultation with a rheumatologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

RHEUMATOID ARTHRITIS (new starts only): Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: methotrexate, sulfasalazine, hydroxychloroquine, d-penicillamine, azathioprine or auranofin. PLAQUE PSORIASIS (new starts only): Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: methotrexate, cyclosporine or acitretin.

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

INGREZZA

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

TARDIVE DYSKINESIA: Development of tardive dyskinesia is secondary to a centrally acting dopamine receptor blocking agent (neuroleptic) (e.g., first- or second-generation antipsychotics such as chlorpromazine or aripiprazole, antiemetics such as promethazine or metoclopramide, the tri-cyclic antidepressant amoxapine).

Age Restrictions:

Prescriber Restrictions:

TARDIVE DYSKINESIA: Prescribed by or in consultation with a psychiatrist or neurologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

INLYTA

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

DIFFERENTIATED THYROID CARCINOMA: Failure of Lenvima or Nexavar unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

INQOVI

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

MYELODYSPLASTIC SYNDROMES: Medical justification supports inability to use decitabine (e.g., contraindications or clinically significant adverse effects to excipients).

Prior Authorization Group Description:

INREBIC

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

MYELOFIBROSIS: Confirmation of a recent (within the last 30 days) thiamine level of 70 nmol/L (3 mcg/dL) or greater. Confirmation of a recent (within the last 30 days) platelet count of 50,000/mcL or greater.

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

MYELOFIBROSIS: Failure of Jakafi, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

INTERFERON BETA-1B

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

MULTIPLE SCLEROSIS: Prescribed by or in consultation with a neurologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

INTUNIV

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

ATTENTION DEFICIT HYPERACTIVITY DISORDER (continuation of therapy): Prescriber has documented all of the following (a, b, and c): a) Medical justification outlining the specific benefit for continued therapy that outweighs the potential risk, b) Patient counseling has occurred outlining the potential risks of the medication, c) Ongoing monitoring plan.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

ATTENTION DEFICIT HYPERACTIVITY DISORDER (new starts only): Failure of both of the following, unless contraindicated or clinically significant adverse effects are experienced: amphetamine-based stimulant and methylphenidate based-stimulant.

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

JAKAFI

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

STEROID REFRACTORY GRAFT-VERSUS-HOST DISEASE: Member has history of bone marrow or stem cell transplant.

Age Restrictions:

Prescriber Restrictions:

STEROID REFRACTORY GRAFT-VERSUS-HOST DISEASE: Prescribed by or in consultation with an oncologist, hematologist, or bone marrow transplant specialist. ALL OTHER INDICATIONS: Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

JUXTAPID

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (new starts only): Failure of Repatha 420 mg, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

JYNARQUE

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

AUTOSOMAL DOMINANT POLYCYSTIC KIDNEY DISEASE: Prescribed by or in consultation with a nephrologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

KADCYLA

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

KALYDECO

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

CYSTIC FIBROSIS (new starts only): Diagnosis of CF confirmed by all of the following (a, b, c, and d): a) Clinical symptoms consistent with CF in at least one organ system, or positive newborn screen or genetic testing for siblings of patients with CF, AND b) Evidence of cystic fibrosis transmembrane conductance regulator (CFTR) dysfunction confirmed by one of the following (i or ii): i) Elevated sweat chloride that is 60 mmol/L or greater, OR ii) Genetic testing confirming the presence of two disease-causing mutations in the CFTR gene, one from each parental allele, AND c) Presence of one mutation in the CFTR gene that is responsive to Kalydeco based on clinical and/or in vitro assay data, AND d) Confirmation that a homozygous F508del mutation in the CFTR gene is not present. Confirmation that pulmonary function tests, performed within the last 90 days, show a percent predicted forced expiratory volume in 1 second (ppFEV1) that is between 40-90%. CYSTIC FIBROSIS (continuation of therapy): Member is responding positively to therapy as evidenced by a stabilization in ppFEV1 if baseline prior to initiating therapy was 70% or greater or increase in ppFEV1 if baseline prior to initiating therapy was less than 70%.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

Kalydeco is not prescribed concurrently with other CFTR modulators (e.g., Orkambi, Symdeko, Trikafta).

Prior Authorization Group Description:

KANJINTI

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

ALL INDICATIONS: Medical justification supports inability to use Ogivri or Trazimera (e.g., contraindications to excipients).

Prior Authorization Group Description:

KETOROLAC TROMETHAMINE

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Patients with active peptic ulcer disease. Advanced renal impairment or at risk for renal failure due to volume depletion. Suspected or confirmed cerebrovascular bleeding, hemorrhagic diathesis, incomplete hemostasis and those at high risk for bleeding. Patient currently receiving aspirin or NSAIDs (non-steroidal anti-inflammatory drugs). Patient currently receiving probenecid or pentoxifylline.

Required Medical Information:

ACUTE PAIN (continuation of therapy): Prescriber has documented all of the following (a, b, and c): a) Medical justification outlining the specific benefit for continued therapy that outweighs the potential risk, b) Patient counseling has occurred outlining the potential risks of the medication, c) Ongoing monitoring plan.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

5 days.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

KISQALI(Kisqali , Kisqali Femara Co-Pack)

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

KORLYM

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

CUSHING'S SYNDROME: Prescribed by or in consultation with an endocrinologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

KOSELUGO

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

NEUROFIBROMATOSIS TYPE 1 (NF1): Diagnosis is confirmed by positive genetic testing for NF1 or member has at least one diagnostic criteria for NF1 based on the National Institutes of Health Neurofibromatosis 1 Diagnostic Criterion. Presence of at least one plexiform neurofibroma (PN) with lesion measuring 3 cm or greater in one dimension. Complete resection of PN is not considered to be feasible without substantial risk or morbidity (e.g., due to encasement of, or close proximity to, vital structures, invasiveness, or high vascularity of the PN).

Age Restrictions:

Prescriber Restrictions:

NF1: Prescribed by or in consultation with an oncologist or neurologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

KUVAN

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

PHENYLKETONURIA (PKU) (new starts only): Recent (within 90 days) phenylalanine (Phe) blood level is greater than 360 micromol/L. PKU (continuation of therapy): Confirmation of a reduction in Phe blood levels since initiation of therapy.

Age Restrictions:

Prescriber Restrictions:

PKU: Prescribed by or in consultation with a metabolic or genetic disease specialist.

Coverage Duration:

Initial authorization: 3 months. Continuation of therapy: End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

LATUDA

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

BIPOLAR I DISORDER, SCHIZOPHRENIA: Failure of two of the following atypical antipsychotics, unless contraindicated or clinically significant adverse effects are experienced: risperidone, olanzapine, quetiapine, ziprasidone, aripiprazole.

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

LAZANDA

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

Member is already taking and is tolerant to around-the-clock opioid therapy. Member is considered opioid tolerant when taking another opioid daily for a week or longer (for example, at least 60 mg of oral morphine per day or an equianalgesic dose of another opioid).

Prior Authorization Group Description:

LEMTRADA

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

MULTIPLE SCLEROSIS (MS): Prescribed by or in consultation with a neurologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

MS (initial authorization only): Failure of TWO of the following, unless clinically significant adverse effects are experienced or all are contraindicated: Aubagio, Tecfidera, Gilenya, Avonex, Betaseron, Plegridy, glatiramer, Copaxone, Glatopa, Extavia, Rebif.

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

LENVIMA

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

LIDODERM

Prior Authorization Indication:

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

Off Label Uses:

Diabetic neuropathy. Cancer-related neuropathic pain.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

LONSURF

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

LORBRENA

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

LOTRONEX

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Male patients.

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

LUCEMYRA

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

OPIOID WITHDRAWAL: Diagnosis of opioid dependence (may be limited to physiologic dependence/tolerance) or opioid use disorder. Member is currently or will be undergoing abrupt opioid discontinuation within the next seven days, and meets one of the following: member has taken one or more opioids for at least the last three weeks OR an opioid antagonist (e.g., naltrexone) has been or will be administered after a period of opioid use. Medical justification supports why an opioid taper (e.g., with buprenorphine, methadone, or other opioid) cannot be used. Lucemyra has not been prescribed for a prior opioid withdrawal event within the last 30 days or medical justification supports retreatment.

Age Restrictions:

Prescriber Restrictions:

OPIOID WITHDRAWAL: Prescribed by or in consultation with a physician specializing in one of the following areas: emergency medicine/inpatient care, pain management, addiction psychiatry.

Coverage Duration:

OPIOID WITHDRAWAL: 14 days per course of treatment.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

LUMAKRAS

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

LYNPARZA TABLET

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

METASTATIC CASTRATION-RESISTANT PROSTATE CANCER: Member does not have a PPP2R2A gene mutation.

Age Restrictions:

Prescriber Restrictions:

PROSTATE CANCER: Prescribed by or in consultation with an oncologist or urologist. ALL OTHER ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

MAVENCLAD

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Member has not yet received 2 courses (4 cycles) lifetime total.

Age Restrictions:

Prescriber Restrictions:

MULTIPLE SCLEROSIS (MS): Prescribed by or in consultation with a neurologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

RELAPSING-REMITTING MS (initial authorization only): Failure of one of the following, unless clinically significant adverse effects are experienced or all are contraindicated: Aubagio, Tecfidera, Gilenya, Avonex, Betaseron, Plegridy, glatiramer, Copaxone, Glatopa, Extavia, Rebif.

Prior Authorization Group Description:

MAVYRET

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Treatment-experienced patients with both NS3/4A protease inhibitor and NS5A inhibitor.

Required Medical Information:

CHRONIC HEPATITIS C INFECTION: Refer to the document, "Recommendations for Testing, Managing, and Treating Hepatitis C," by AASLD-IDSA available at http://www.hcvguidelines.org for drug regimen and duration of treatment based on genotype, treatment status, previous drug regimens used, past medical history and comorbidities.

Age Restrictions:

Prescriber Restrictions:

CHRONIC HEPATITIS C INFECTION: Prescribed by or in consultation with a gastroenterologist, hepatologist, infectious disease specialist, or provider who has expertise in treating HCV based on a certified training program.

Coverage Duration:

8 to 16 weeks based on genotype, cirrhosis status, prior treatment regimen.

Other Criteria:

Prior Authorization Group Description:

MAYZENT

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

CYP2C9*3/*3 genotype.

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

MULTIPLE SCLEROSIS (MS): Prescribed by or in consultation with a neurologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

RELAPSING-REMITTING MS (new starts only): Failure of one of the following, unless clinically significant adverse effects are experienced or all are contraindicated: Aubagio, Tecfidera, Gilenya, Avonex, Betaseron, Plegridy, glatiramer, Copaxone, Glatopa, Extavia, Rebif.

Prior Authorization Group Description:

MEGACE

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

ANOREXIA AND CACHEXIA ASSOCIATED WITH AIDS (new starts only): Failure of dronabinol and oxandrolone, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

MEGACE ES

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

ANOREXIA AND CACHEXIA ASSOCIATED WITH AIDS (new starts only): Failure of dronabinol and oxandrolone, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

MEKINIST

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

MEKTOVI

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

METAXALONE

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

ALL INDICATIONS (continuation of therapy): Prescriber has documented all of the following (a, b, and c): a) Medical justification outlining the specific benefit for continued therapy that outweighs the potential risk, b) Patient counseling has occurred outlining the potential risks of the medication, c) Ongoing monitoring plan.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

METHAMPHETAMINE

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Treatment of obesity.

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

METHOCARBAMOL

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

ALL INDICATIONS (continuation of therapy): Prescriber has documented all of the following (a, b, and c): a) Medical justification outlining the specific benefit for continued therapy that outweighs the potential risk, b) Patient counseling has occurred outlining the potential risks of the medication, c) Ongoing monitoring plan.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

METHOTREXATE INJ

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS, RHEUMATOID ARTHRITIS: Prescribed by or in consultation with a rheumatologist. PSORIASIS: Prescribed by or in consultation with a rheumatologist or a dermatologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

ALL INDICATIONS (initial authorization only): Failure of generic methotrexate injection, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

MIRVASO

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

ERYTHEMA OF ROSACEA WITH PAPULES OR PUSTULES (initial authorization only): Failure of topical metronidazole, oral doxycycline or Finacea, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

MOZOBIL

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

MOBILIZATION OF HEMATOPOIETIC STEM CELLS: Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

MULPLETA

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

THROMBOCYTOPENIA: Recent (within the past 14 days) platelet count is less than 50 x 10^9/L. Member is scheduled to undergo a medical or dental procedure within the next 30 days.

Age Restrictions:

Prescriber Restrictions:

THROMBOCYTOPENIA: Prescribed by or in consultation with a hematologist, hepatologist, or gastroenterologist.

Coverage Duration:

4 weeks.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

NAMENDA

Prior Authorization Indication:

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

Off Label Uses:

Vascular dementia.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 59 years and younger. Prior authorization is not required for patients 60 years and older.

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

NATPARA

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

HYPOPARATHYROIDISM (new starts only): Recent (dated within the last 30 days) serum calcium level is greater than 7.5 mg/dL. Recent (dated within the last 30 days) lab result shows sufficient 25-hydroxyvitamin D stores (at least 50 nmol/L or 20 ng/mL). HYPOPARATHYROIDISM (continuation of therapy): Maintained on therapy with positive response as evidenced by a recent (dated within the last 90 days) serum calcium level within 8-9 mg/dL.

Age Restrictions:

Prescriber Restrictions:

HYPOPARATHYROIDISM: Prescribed by or in consultation with an endocrinologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

HYPOPARATHYROIDISM (new starts only): Failure of an active form of vitamin D (e.g., calcitriol) unless contraindicated or clinically significant adverse events are experienced.

Prior Authorization Group Description:

NAYZILAM

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

EPILEPSY: Member is currently on a stable regimen of antiepileptic drugs.

Age Restrictions:

Prescriber Restrictions:

EPILEPSY: Prescribed by or in consultation with neurologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

NERLYNX

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

NINLARO

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

NORTHERA

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

NUBEQA

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

PROSTATE CANCER: Concurrent use of a gonadotropin-releasing hormone (GnRH) analog or past bilateral orchiectomy.

Age Restrictions:

Prescriber Restrictions:

PROSTATE CANCER: Prescribed by or in consultation with an oncologist or urologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

NUCALA

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

ASTHMA OR EOSINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS (initial authorization only): Blood eosinophil count of greater than or equal to 150 cells/mcL within the past 3 months. ASTHMA (continuation of therapy): member is responding positively to therapy (examples may include but are not limited to a reduction in exacerbations or corticosteroid dose, improvement in forced expiratory volume over one second since baseline prior to initiating therapy, reduction in the use of rescue therapy since baseline prior to initiating therapy). EOSINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS (continuation of therapy): Member is responding positively to therapy (examples may include but are not limited to: reduction of relapses or reduction in glucocorticoid dose). HYPEREOSINOPHILIC SYNDROME (HES) (initial authorization only): Diagnosis of FIP1L1-PDGFR-alpha negative HES without a non-hematologic secondary cause. HES is uncontrolled, defined as a history of at least 2 flares within the past 12 months. Blood eosinophil count of greater than or equal to 1,000 cells/mcL within the past 3 months. Failure of a corticosteroid, unless contraindicated or clinically significant adverse events are experienced. HYPEREOSINOPHILIC SYNDROME (continuation of therapy): Member is responding positively to therapy with reduction in flares from baseline or reduction in maintenance HES therapy dose from baseline.

Age Restrictions:

Prescriber Restrictions:

ASTHMA: Prescribed by or in consultation with an allergist, pulmonologist, or immunologist. EOSINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS: Prescribed by or in consultation with a pulmonologist, immunologist, rheumatologist, or nephrologist. HYPEREOSINOPHILIC SYNDROME: Prescribed by or in consultation with hematologist, dermatologist, or immunologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

ASTHMA (initial authorization only): Prescribed in combination with ONE inhaled corticosteroid (e.g., beclomethasone, budesonide, flunisolide, fluticasone, mometasone, ciclesonide), unless contraindicated or clinically significant adverse effects are experienced AND Prescribed in combination with ONE long-acting beta-agonist (e.g., salmeterol, formoterol, vilanterol), unless contraindicated or clinically significant adverse effects are experienced. EOSINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS (initial authorization only): Failure of ONE glucocorticoid, unless contraindicated or clinically significant adverse events are experienced. HYPEREOSINOPHILIC SYNDROME: Prescribed concurrently with baseline HES maintenance therapy (e.g., oral corticosteroids, immunosuppressive therapy).

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

NUEDEXTA

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

PSEUDOBULBAR AFFECT: Prescribed by or in consultation with a neurologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

NUPLAZID

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

NUZYRA

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

ACUTE BACTERIAL SKIN AND SKIN STRUCTURE INFECTION (ABSSSI), COMMUNITY-ACQUIRED BACTERIAL PNEUMONIA (CABP): Request is for continuation of therapy initiated in an acute care hospital from which member was discharged OR Culture and sensitivity (C&S) report for the current infection shows isolated pathogen is an organism susceptible to omadacycline, unless provider confirms that obtaining a C&S report is not feasible.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

14 days.

Other Criteria:

ABSSSI, CABP: For members initiating Nuzyra therapy outside of an acute care hospital, one of the following (a, b, or c): a) If a C&S report is available: Failure of 2 antibiotics to which the isolated pathogen is susceptible (if available) per C&S report, unless all are contraindicated or clinically significant adverse effects are experienced. b) C&S report shows resistance or lack of susceptibility of the isolated pathogen to all antibiotics FDA-approved for member's diagnosis. c) If provider confirms that obtaining a C&S report is not feasible: Failure of 2 antibiotics indicated for member's diagnosis (if available), unless all are contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

OCALIVA

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

PRIMARY BILIARY CHOLANGITIS (continuation of therapy): Member is responding positively to therapy as evidenced by a reduction in alkaline phosphatase (ALP) level from pretreatment level or maintenance of initial reduction in ALP level.

Age Restrictions:

Prescriber Restrictions:

PRIMARY BILIARY CHOLANGITIS: Prescribed by or in consultation with a hepatologist or gastroenterologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

OCREVUS

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

MULTIPLE SCLEROSIS (MS): Prescribed by or in consultation with a neurologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

RELAPSING-REMITTING MS (new starts only): Failure of one of the following, unless clinically significant adverse effects are experienced or all are contraindicated: Aubagio, Tecfidera, Gilenya, Avonex, Betaseron, Plegridy, glatiramer, Copaxone, Glatopa, Extavia, Rebif.

Prior Authorization Group Description:

ODOMZO

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

OFEV

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

SYSTEMIC SCLEROSIS (SSc) ASSOCIATED INTERSTITIAL LUNG DISEASE (initial authorization only): Pulmonary fibrosis on high resolution computed tomography (HRCT). Additional signs of SSc are identified (examples may include but are not limited to skin thickening of the fingers, fingertip lesions, telangiectasia, abnormal nailfold capillaries, Raynaud's phenomenon, pulmonary arterial hypertension, SSc-related autoantibodies - anticentromere, anti-topoisomerase I [anti-Scl-70], anti-RNA polymerase III). IDIOPATHIC PULMONARY FIBROSIS (initial authorization only): Pulmonary fibrosis on HRCT. Known causes of pulmonary fibrosis have been ruled out (examples may include but are not limited to domestic and occupational environmental exposures, connective tissue disease, drug toxicity). CHRONIC FIBROSING INTERSTITIAL LUNG DISEASE WITH A PROGRESSIVE PHENOTYPE (new starts only): Confirmation of both of the following within the past 24 months (a and b): a) pulmonary fibrosis affecting more than 10% of lung volume on HRCT and b) confirmation of one of the following (i or ii): i) a relative decline in the forced vital capacity (FVC) of 10% or more of the predicted value, or ii) a relative decline in the FVC of 5% to less than 10% of the predicted value plus either worsening of respiratory symptoms or an increased extent of fibrosis on HRCT.

Age Restrictions:

Prescriber Restrictions:

IDIOPATHIC PULMONARY FIBROSIS, SYSTEMIC SCLEROSIS ASSOCIATED INTERSTITIAL LUNG DISEASE, CHRONIC FIBROSING INTERSTITIAL LUNG DISEASE WITH A PROGRESSIVE PHENOTYPE: Prescribed by or in consultation with pulmonologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

ONUREG

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ACUTE MYELOID LEUKEMIA (AML): Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

OPSUMIT

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

PULMONARY ARTERIAL HYPERTENSION: Prescribed by or in consultation with a cardiologist or pulmonologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

ORENITRAM

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

ORGOVYX

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

PROSTATE CANCER: Prescribed by or in consultation with an oncologist or urologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

ORILISSA

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

For 200 mg twice daily requests, members with osteoporosis.

Required Medical Information:

ENDOMETRIOSIS PAIN (continuation of therapy): Improvement in dysmenorrhea, dyspareunia, pelvic pain/induration/tenderness, or size of endometrial lesions. Total duration of therapy has not exceeded 6 months for 200 mg twice daily or 24 months for 150 mg once daily dosing.

Age Restrictions:

Prescriber Restrictions:

ENDOMETRIOSIS PAIN: Prescribed by or in consultation with a gynecologist.

Coverage Duration:

200 mg twice daily: 6 months. 150 mg once daily: End of Plan Year.

Other Criteria:

ENDOMETRIOSIS PAIN (initial authorization only): Failure of ONE non-steroidal anti-inflammatory drug (e.g., ibuprofen, naproxen, ketoprofen, mefenamic acid, meclofenamate, tolmetin, diclofenac, etodolac, diflunisal, meloxicam, piroxicam) or ONE progestin-containing agent (e.g., norethindrone, ethinyl estradiol with (desogestrel, ethynodiol diacetate, drospirenone, etonogestrel, levonorgestrel, norelgestromin, norethindrone, norgestimate, or norgestrel), estradiol valerate/dienogest, mestranol/norethindrone, depot injectable medroxyprogesterone acetate), unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

ORKAMBI

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

CYSTIC FIBROSIS: (new starts only): Diagnosis of CF confirmed by all of the following (a, b, and c): a) Clinical symptoms consistent with CF in at least one organ system, or positive newborn screen or genetic testing for siblings of patients with CF, AND b) Evidence of cystic fibrosis transmembrane conductance regulator (CFTR) dysfunction confirmed by one of the following (i or ii): i) Elevated sweat chloride that is 60 mmol/L or greater, OR ii) Genetic testing confirming the presence of two disease-causing mutations in the CFTR gene, one from each parental allele, AND c) Confirmation that member is homozygous for the F508del mutation in the CFTR gene. Confirmation that pulmonary function tests, performed within the last 90 days, show a percent predicted forced expiratory volume in 1 second (ppFEV1) that is between 40-90%. CYSTIC FIBROSIS (continuation of therapy): Member is responding positively to therapy as evidenced by a stabilization in ppFEV1 if baseline prior to initiating therapy was 70% or greater or increase in ppFEV1 if baseline prior to initiating therapy was less than 70%.

Age Restrictions:

Prescriber Restrictions:

CYSTIC FIBROSIS: Prescribed by or in consultation with a pulmonologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Orkambi is not prescribed concurrently with other CFTR modulators (e.g., Kalydeco, Symdeko, Trikafta).

Prior Authorization Group Description:

OXBRYTA

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

SICKLE CELL DISEASE (initial authorization only): Disease is associated with one of the following genotypes: Homozygous hemoglobin S, Hemoglobin S beta 0-thalassemia, Hemoglobin S beta+ thalassemia, Hemoglobin SC, or other genotypic variants of sickle cell disease. Member has a hemoglobin level between 5.5 and 10.5 g/dL. Member meets one of the following (a or b): a) Member experienced at least 1 vaso-occlusive crisis (VOC) within the past 6 months while on hydroxyurea, OR b) Member has intolerance or contraindication to hydroxyurea and has experienced at least 1 VOC within the past 12 months. Failure of L-glutamine, unless contraindicated or clinically significant adverse effects are experienced. SICKLE CELL DISEASE (continuation of therapy): Member is responding positively to therapy as evidenced by an increase in Hb level from baseline prior to initiating therapy.

Age Restrictions:

Prescriber Restrictions:

SICKLE CELL DISEASE: Prescribed by or in consultation with a hematologist.

Coverage Duration:

6 months.

Other Criteria:

SICKLE CELL DISEASE: Oxbryta is not prescribed concurrently with Adakveo.

Prior Authorization Group Description:

OXERVATE

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

NEUROTROPHIC KERATITIS: Prescribed by or in consultation with an ophthalmologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

PALYNZIQ

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

PHENYLKETONURIA (new starts only): Recent (within 90 days) phenylalanine (Phe) blood level is greater than 600 micromol/L. PHENYLKETONURIA (continuation of therapy): Positive response as evidenced by one of the following (a, b, or c): a) Blood Phe level has decreased by at least 20% from pre-treatment baseline, b) Blood Phe level is less than or equal to 600 micromol/L, c) Member has been using 20 mg per day for at least 6 months, but a dose titration to 40 mg per day is being requested after failure to meet therapeutic targets (a or b above).

Age Restrictions:

Prescriber Restrictions:

PHENYLKETONURIA: Prescribed by or in consultation with an endocrinologist, metabolic disease specialist, or genetic disease specialist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

PEMAZYRE

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

PENNSAID

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

OSTEOARTHRITIS PAIN (initial authorization only): Failure of diclofenac 1.5% topical solution and diclofenac 1% topical gel, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

PERSERIS

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

SCHIZOPHRENIA: Member meets one of the following (a or b): a) therapy was initiated in an inpatient setting during a recent (within 60 days) hospital admission, OR b) Confirmation of established tolerability to oral risperidone AND failure of TWO of the following atypical antipsychotics, unless contraindicated or clinically significant adverse effects are experienced: aripiprazole, ziprasidone, quetiapine, olanzapine, risperidone, asenapine, iloperidone, paliperidone.

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

PHENOBARBITAL

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

PARTIAL SEIZURES: Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: carbamazepine, phenytoin, topiramate, tiagabine, levetiracetam, gabapentin, lamotrigine, oxcarbazepine, primidone or divalproex. GENERALIZED SEIZURES: Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: carbamazepine, phenytoin, topiramate, levetiracetam, primidone or lamotrigine.

Prior Authorization Group Description:

PIQRAY

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

PRALUENT

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

GENETICALLY MEDIATED PRIMARY HYPERLIPIDEMIA (INCLUDING HETEROZYGOUS OR HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA) (initial authorization only): Confirmation (e.g., medical records, chart notes, laboratory values) of LDL level suggestive of a diagnosis of familial hypercholesterolemia (e.g., adults: LDL of 190 mg/dL or greater). NON-GENETICALLY MEDIATED PRIMARY HYPERLIPIDEMIA (initial authorization only): Request meets both of the following (a and b): a) Confirmation of a LDL of 100 mg/dL or greater AND b) a diagnosis of secondary hyperlipidemia has been ruled out with confirmation of absence of all of the following potential causes of elevated cholesterol (a-e): a) hypothyroidism, b) obstructive liver disease, c) renal disease, d) nephrosis, e) medications that have had a clinically relevant contributory effect on the current degree of this member's elevated lipid levels including, but not limited to: glucocorticoids, sex hormones, antipsychotics, antiretrovirals, immunosuppressive agents, retinoic acid derivatives. HYPERCHOLESTEROLEMIA WITH HISTORY OF CLINICAL ATHEROSCLEROTIC CARDIOVASCULAR DISEASE (ASCVD) (initial authorization only): Confirmation of an LDL of 70 mg/dL or greater AND history of clinical ASCVD defined as one of the following: Acute coronary syndromes, Myocardial infarction, Stable or unstable angina, Coronary or other arterial revascularization, Stroke, Peripheral arterial disease presumed to be of atherosclerotic origin, Transient ischemic attack (TIA), Clinically significant coronary heart disease (CHD) diagnosed by invasive or noninvasive testing (such as coronary angiography, stress test using treadmill, stress echocardiography, or nuclear imaging. ALL HYPERLIPIDEMIA AND HYPERCHOLESTEROLEMIA INDICATIONS (continuation of therapy): Confirmation of LDL reduction while on Praluent therapy AND, if tolerated, confirmation of continued statin therapy at the maximally tolerated dose.

Age Restrictions:

Prescriber Restrictions:

ALL HYPERLIPIDEMIA AND HYPERCHOLESTEROLEMIA INDICATIONS: Prescribed by or in consultation with a cardiologist, endocrinologist, or lipid specialist.

Coverage Duration:

6 months.

Other Criteria:

ALL HYPERLIPIDEMIA AND HYPERCHOLESTEROLEMIA INDICATIONS (initial authorization only): One of the following (a, b, or c): a) Member has a contraindication to statins. OR b) For members currently on statin therapy, inadequate response to two of the following at maximally tolerated doses, unless clinically significant adverse effects are experienced: atorvastatin, rosuvastatin, simvastatin, ezetimibe/simvastatin, pitavastatin, pravastatin, fluvastatin, or lovastatin. OR c) For members not on statin therapy, member is statin intolerant as

demonstrated by both of the following (1 and 2): 1) member has tried at least two statins, 1 of which must be hydrophilic statin (pravastatin, fluvastatin, or rosuvastatin), AND 2) One of the following (i or ii): i) member has a statin risk factor that increases the likelihood of experiencing an adverse effect to statin therapy (i.e., multiple or serious comorbidities, including impaired renal or hepatic function, unexplained alanine transaminase (ALT) elevations greater than 3 times upper limit of normal or active liver disease, concomitant use of drugs adversely affecting statin metabolism, age greater than 75 years or history of hemorrhagic stroke, Asian ancestry) OR ii) confirmation that member has experienced intolerable statin-associated muscle symptoms persisting for at least two weeks, which disappeared with discontinuing the statin therapy and recurred with a statin re-challenge (statin re-challenge may be initiated with titration from lowest possible dose and/or intermittent dosing frequency (e.g., 1 to 3 times weekly)).

Prior Authorization Group Description:

PRETOMANID

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

TUBERCULOSIS (new starts only): Confirmed resistance to fluoroquinolones, unless contraindicated or clinically significant adverse effects are experienced. Prescribed in combination with bedaquiline and linezolid. TUBERCULOSIS (continuation of therapy): Confirmation of delayed culture conversion and total duration of pretomanid therapy has not exceeded 9 months. Member meets one of the following (a or b): a) Prescribed in combination with bedaquiline and linezolid OR b) If member has completed at least 4 weeks of linezolid therapy, member continues to receive pretomanid in combination with bedaquiline.

Age Restrictions:

Prescriber Restrictions:

TUBERCULOSIS: Prescribed by or in consultation with an expert in the treatment of tuberculosis.

Coverage Duration:

Initial authorization: 6 months. Continuation of therapy: 3 months.

Other Criteria:

Prior Authorization Group Description:

PREVYMIS

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Member is receiving pimozide or ergot alkaloids. Member is receiving cyclosporine co-administered with pitavastatin or simvastatin.

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

PROPHYLAXIS OF CMV INFECTION: Prescribed by or in consultation with an oncology, hematology, infectious disease, or transplant specialist.

Coverage Duration:

Through day 100 post-transplantation.

Other Criteria:

PROPHYLAXIS OF CMV INFECTION (new starts only): Failure of generic valacyclovir, unless contraindicated, clinically significant adverse effects are experienced, or member is at high risk for CMV.

Prior Authorization Group Description:

PROCYSBI

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

NEPHROPATHIC CYSTINOSIS (initial authorization only): Diagnosis is confirmed by one of the following (a, b, or c): a) Increased leukocyte cystine concentration (normal concentration: less than 0.2 nmol half-cystine/mg protein). b) Cystinosin, lysosomal cystine transporter gene mutation. c) Corneal crystals on slit lamp examination. NEPHROPATHIC CYSTINOSIS (continuation of therapy): Member is responding positively to therapy as evidenced by improvement in the leukocyte cystine concentration.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

NEPHROPATHIC CYSTINOSIS (initial authorization only): Medical justification supports inability to use Cystagon (e.g., contraindication to excipients in Cystagon).

Prior Authorization Group Description:

PROLIA

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

OSTEOPOROSIS (initial authorization only): Member meets one of the following (a, b, or c): a) Failure of bisphosphonate therapy (e.g., alendronate) unless contraindicated or clinically significant adverse effects are experienced to both intravenous and oral formulations. OR b) Bone mineral density T-score at hip or spine is -3.5 or less. OR c) Bone mineral density T-score at hip or spine is -2.5 or less with a history of major osteoporotic fracture of the hip, spine, forearm, wrist, or humerus.

Prior Authorization Group Description:

PROMACTA

Prior Authorization Indication:

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

Off Label Uses:

Myelodysplastic Syndromes.

Exclusion Criteria:

Required Medical Information:

THROMBOCYTOPENIA IN CHRONIC HEPATITIS C: Confirmation of current or planned interferon-based treatment of chronic hepatitis C. MYELODYSPLASTIC SYNDROMES (new starts only): Member has lower-risk MDS (IPSS-R (Very Low, Low, Intermediate), IPSS (Low/Intermediate-1), WPSS (Very Low, Low, Intermediate). Member has severe or refractory thrombocytopenia following disease progression or no response to hypomethylating agents (e.g., azacitadine, decitabine), immunosuppressive therapy (e.g., Atgam, cyclosporine), or clinical trial.

Age Restrictions:

Prescriber Restrictions:

PERSISTENT/CHRONIC IMMUNE THROMBOCYTOPENIA, SEVERE APLASTIC ANEMIA: Prescribed by or in consultation with a hematologist. THROMBOCYTOPENIA IN CHRONIC HEPATITIS C: Prescribed by or in consultation with a hematologist, gastroenterologist, or an infectious disease specialist. MYELODYSPLASTIC SYNDROMES: Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

PROTOPIC

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Tacrolimus 0.1%: 16 years and older.

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

ATOPIC DERMATITIS (initial authorization only): Failure of two medium to high potency topical corticosteroids (e.g., amcinonide, fluticasone propionate, triamcinolone acetonide, betamethasone valerate, fluocinolone acetonide, hydrocortisone butyrate, mometasone furoate, desoximetasone, fluocinonide or betamethasone dipropionate), unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

PROVIGIL

Prior Authorization Indication:

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

Off Label Uses:

Multiple sclerosis-related fatigue.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

NARCOLEPSY: Prescribed by or in consultation with a neurologist or sleep medicine specialist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

PURIXAN

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with oncologist or hematologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

One of the following: Failure of mercaptopurine tablets, unless contraindicated or clinically significant adverse effects are experienced OR member has a swallowing disorder or an inability to swallow tablets or capsules..

Prior Authorization Group Description:

QINLOCK

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

GASTROINTESTINAL STROMAL TUMOR: For members with PDGFRA exon 18 mutation, failure of Ayvakit, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

QUALAQUIN

Prior Authorization Indication:

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

Off Label Uses:

Babesiosis. Plasmodium vivax malaria.

Exclusion Criteria:

For the treatment or prevention of nocturnal leg cramps.

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

Malaria: 7 days. Babesiosis: 7-10 days.

Other Criteria:

PLASMODIUM VIVAX MALARIA: Infection is chloroquine-resistant.

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

RADICAVA

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

AMYOTROPHIC LATERAL SCLEROSIS (ALS): Confirmation of definite or probable ALS diagnosis based on El Escorial revised criteria. Forced vital capacity greater than or equal to 80%. Functionally retains most activities of daily living (defined as a baseline revised ALS Functional Rating Scale (ALSFRS-R) score with greater than or equal to 2 points in each of the 12 items. Prescribed in combination with riluzole unless contraindicated or clinically significant adverse effects are experienced.

Age Restrictions:

Prescriber Restrictions:

ALS: Prescribed by or in consultation with a neurologist.

Coverage Duration:

6 months.

Other Criteria:

ALS (new starts only): Disease duration of less than or equal to 2 years.

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

RAYALDEE

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

REBLOZYL

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

TRANSFUSION DEPENDENT BETA-THALASSEMIA (new starts only): Total volume of transfusions exceeds 6 red blood cell units within the last 6 months. No transfusion free period for greater than or equal to 35 days within the last 6 months. TRANSFUSION DEPENDENT BETA THALASSEMIA (continuation of therapy): Member meets one of the following (a or b): a) Member is responding positively to therapy as evidenced by at least a 33% reduction in transfusion burden from baseline, b) Request is for a dose increase. MYELODYSPLASTIC SYNDROMES (MDS) (new starts only): Member requires 2 or more RBC units per 8 weeks confirmed for at least the last 16 weeks. Member has either a ring sideroblast of at least 15% of erythroid precursors in bone marrow or ring sideroblast of at least 5% if SF3B1 mutation is present. Member does not have del(5q) cytogenetic abnormality. MDS (continuation of therapy): Member meets one of the following (a or b): a) Member is responding positively to therapy as evidenced by a decreased transfusion burden, b) Request is for a dose increase.

Age Restrictions:

Prescriber Restrictions:

TRANSFUSION DEPENDENT BETA-THALASSEMIA: Prescribed by or in consultation with a hematologist. MDS: Prescribed by or in consultation with a hematologist or oncologist.

Coverage Duration:

TD BETA-THALASSEMIA, MDS: Initial: 2 months. Continuation of therapy: 6 months.

Other Criteria:

MDS (new starts only): Failure of an erythropoiesis-stimulating agent used in combination with a granulocyte colony stimulating factor, unless clinically significant adverse effects are experienced, all are contraindicated, or confirmation of current serum erythropoietin greater than 500 mU/mL.

Prior Authorization Group Description:

REMICADE

Prior Authorization Indication:

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

Off Label Uses:

Granulomatosis with polyangiitis (Wegener's granulomatosis).

Exclusion Criteria:

Required Medical Information:

ALL INDICATIONS (initial authorization only): Medical justification supports inability to use Inflectra and Renflexis (e.g., contraindications to the excipients).

Age Restrictions:

Prescriber Restrictions:

PSORIATIC ARTHRITIS/PLAQUE PSORIASIS: Prescribed by or in consultation with a rheumatologist or dermatologist. CROHN'S DISEASE/ULCERATIVE COLITIS: Prescribed by or in consultation with a gastroenterologist. RHEUMATOID ARTHRITIS/ANKYLOSING SPONDYLITIS: Prescribed by or in consultation with a rheumatologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

RHEUMATOID ARTHRITIS (new starts only): Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: methotrexate, sulfasalazine, hydroxychloroquine, d-penicillamine, azathioprine or auranofin. PLAQUE PSORIASIS (new starts only): Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: methotrexate, cyclosporine or acitretin.

Prior Authorization Group Description:

RENFLEXIS

Prior Authorization Indication:

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

Off Label Uses:

Granulomatosis with polyangiitis (Wegener's granulomatosis).

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

PSORIATIC ARTHRITIS/PLAQUE PSORIASIS: Prescribed by or in consultation with a rheumatologist or dermatologist. CROHN'S DISEASE/ULCERATIVE COLITIS: Prescribed by or in consultation with a gastroenterologist. RHEUMATOID ARTHRITIS/ANKYLOSING SPONDYLITIS: Prescribed by or in consultation with a rheumatologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

RHEUMATOID ARTHRITIS (new starts only): Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: methotrexate, sulfasalazine, hydroxychloroquine, d-penicillamine, azathioprine or auranofin. PLAQUE PSORIASIS (new starts only): Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: methotrexate, cyclosporine or acitretin.

Prior Authorization Group Description:

REPATHA

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

GENETICALLY MEDIATED PRIMARY HYPERLIPIDEMIA (INCLUDING HETEROZYGOUS OR HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA) (initial authorization only): Confirmation (e.g., medical records, chart notes, laboratory values) of LDL level suggestive of a diagnosis of familial hypercholesterolemia (e.g., adults: LDL 190 mg/dL or greater). NON-GENETICALLY MEDIATED PRIMARY HYPERLIPIDEMIA (initial authorization only): Request meets both of the following (a and b): a) Confirmation of a LDL of 100 mg/dL or greater AND b) a diagnosis of secondary hyperlipidemia has been ruled out with confirmation of absence of all of the following potential causes of elevated cholesterol (a-e): a) hypothyroidism, b) obstructive liver disease, c) renal disease, d) nephrosis, e) medications that have had a clinically relevant contributory effect on the current degree of this member's elevated lipid levels including, but not limited to: glucocorticoids, sex hormones, antipsychotics, antiretrovirals, immunosuppressive agents, retinoic acid derivatives. HYPERCHOLESTEROLEMIA WITH HISTORY OF CLINICAL ATHEROSCLEROTIC CARDIOVASCULAR DISEASE (ASCVD) (initial authorization only): Confirmation of an LDL of 70 mg/dL or greater AND history of clinical ASCVD defined as one of the following: Acute coronary syndromes, Myocardial infarction, Stable or unstable angina, Coronary or other arterial revascularization, Stroke, Peripheral artery disease presumed to be of atherosclerotic origin, Transient ischemic attack (TIA), Clinically significant coronary heart disease (CHD) diagnosed by invasive or noninvasive testing (such as coronary angiography, stress test using treadmill, stress echocardiography, or nuclear imaging). ALL HYPERLIPIDEMIA AND HYPERCHOLESTEROLEMIA INDICATIONS (continuation of therapy): Confirmation of LDL reduction while on Repatha therapy AND, if tolerated, confirmation of continued statin therapy at the maximally tolerated dose.

Age Restrictions:

Prescriber Restrictions:

ALL HYPERLIPIDEMIA AND HYPERCHOLESTEROLEMIA INDICATIONS: Prescribed by or in consultation with a cardiologist, endocrinologist, or lipid specialist.

Coverage Duration:

6 months.

Other Criteria:

ALL HYPERLIPIDEMIA AND HYPERCHOLESTEROLEMIA INDICATIONS (initial authorization only): One of the following (a, b, or c): a) Member has a contraindication to statins. OR b) For members currently on statin therapy, inadequate response to two of the following at maximally tolerated doses, unless clinically significant adverse effects are experienced: atorvastatin, rosuvastatin, simvastatin, ezetimibe/simvastatin, pitavastatin, pravastatin, fluvastatin, or lovastatin. OR c) For members not on statin therapy, member is statin intolerant as

demonstrated by both of the following (1 and 2): 1) member has tried at least two statins, 1 of which must be hydrophilic statin (pravastatin, fluvastatin, or rosuvastatin), AND 2) One of the following (i or ii): i) member has a statin risk factor that increases the likelihood of experiencing an adverse effect to statin therapy (i.e., multiple or serious comorbidities, including impaired renal or hepatic function, unexplained alanine transaminase (ALT) elevations greater than 3 times upper limit of normal or active liver disease, concomitant use of drugs adversely affecting statin metabolism, age greater than 75 years or history of hemorrhagic stroke, Asian ancestry) OR ii) confirmation that member has experienced intolerable statin-associated muscle symptoms persisting for at least two weeks, which disappeared with discontinuing the statin therapy and recurred with a statin re-challenge (statin re-challenge may be initiated with titration from lowest possible dose and/or intermittent dosing frequency (e.g., 1 to 3 times weekly)).

Prior Authorization Group Description:

RETEVMO

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

REVATIO

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Members on concomitant nitrates (e.g., Nitrodur, Nitrobid, Nitrostat, Isordil, Ismo). Members on concomitant guanylate cyclase stimulator, such as riociguat (Adempas).

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

REVCOVI

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ADENOSINE DEAMINASE SEVERE COMBINED IMMUNODEFICIENCY DISEASE (ADA-SCID): Prescribed by or in consultation with an immunologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

REVLIMID

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

REXULTI

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

SCHIZOPHRENIA, MAJOR DEPRESSIVE DISORDER: Failure of aripiprazole and one of the following generic atypical antipsychotics, unless contraindicated or clinically significant adverse effects are experienced: risperidone, olanzapine, quetiapine, ziprasidone.

Prior Authorization Group Description:

RINVOQ

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

RHEUMATOID ARTHRITIS: Prescribed by or in consultation with a rheumatologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

RHEUMATOID ARTHRITIS (new starts only): Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: methotrexate, sulfasalazine, hydroxychloroquine, d-penicillamine, azathioprine or auranofin.

Prior Authorization Group Description:

ROZLYTREK

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

ROS1-POSITIVE NON-SMALL CELL LUNG CANCER: Member has not received prior ROS1 targeted therapy (e.g., Xalkori, Zykadia, Lorbrena). NTRK FUSION-POSITIVE SOLID TUMOR: Member has not received prior NTRK targeted therapy (e.g., Vitrakvi).

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

RUBRACA

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

PROSTATE CANCER: Prescribed by or in consultation with an oncologist or urologist. ALL OTHER ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

RUZURGI

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

LAMBERT-EATON MYASTHENIC SYNDROME (LEMS) (initial authorization only): Confirmation of a baseline clinical muscle strength assessment (examples may include but are not limited to the Quantitative Myasthenia Gravis (QMG) score, triple-timed up-and-go test (3TUG), Timed 25-foot Walk test (T25FW)). LEMS (continuation of therapy): Member is responding positively to therapy as evidenced by clinical muscle strength assessments.

Age Restrictions:

Prescriber Restrictions:

LEMS: Prescribed by or in consultation with a neurologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

RYDAPT

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

ACUTE MYELOID LEUKEMIA (AML): Positive for the FLT3 mutation.

Age Restrictions:

Prescriber Restrictions:

ADVANCED SYSTEMIC MASTOCYTOSIS: Prescribed by or in consultation with an oncologist, allergist, or immunologist. ALL OTHER ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

SECUADO

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

Medical justification supports inability to use Saphris (asenapine sublingual tablets) (e.g., contraindications to excipients).

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

SIMPONI(auto-injector, prefilled syringe)

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

PSORIATIC ARTHRITIS: Prescribed by or in consultation with a rheumatologist or dermatologist. ULCERATIVE COLITIS: Prescribed by or in consultation with a gastroenterologist. RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS: Prescribed by or in consultation with a rheumatologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

RHEUMATOID ARTHRITIS (new starts only): Failure of two of the following, unless contraindicated or clinically significant adverse effects are experienced: Enbrel, Humira, Rinvoq, Xeljanz/Xeljanz XR. PSORIATIC ARTHRITIS (new starts only): Failure of two of the following, unless contraindicated or clinically significant adverse effects are experienced: Enbrel, Humira, Xeljanz/Xeljanz XR. ANKYLOSING SPONDYLITIS (new starts only): Failure of Humira and Enbrel, unless contraindicated or clinically significant adverse effects are experienced. ULCERATIVE COLITIS (new starts only): Failure of Humira and Xeljanz/Xeljanz XR, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

SKYRIZI

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

PLAQUE PSORIASIS: Prescribed by or in consultation with a dermatologist or rheumatologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

PLAQUE PSORIASIS (new starts only): Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: methotrexate, cyclosporine, or acitretin.

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

SOMA

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

ALL INDICATIONS (continuation of therapy): Prescriber has documented all of the following (a, b, and c): a) Medical justification outlining the specific benefit for continued therapy that outweighs the potential risk, b) Patient counseling has occurred outlining the potential risks of the medication, c) Ongoing monitoring plan.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

SOMAVERT

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ACROMEGALY: Prescribed by or in consultation with an endocrinologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

SPRAVATO

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

TREATMENT-RESISTANT DEPRESSION (TRD): Currently on an oral antidepressant (must not be an agent previously tried and failed). Spravato is prescribed in combination with an oral antidepressant. MAJOR DEPRESSIVE DISORDER WITH SUICIDAL IDEATION OR BEHAVIOR: Prescribed in combination with another oral antidepressant.

Age Restrictions:

TRD: Age is 18 to 64 years.

Prescriber Restrictions:

Coverage Duration:

TRD: 6 months. MAJOR DEPRESSIVE DISORDER WITH SUICIDAL IDEATION OR BEHAVIOR: 4 weeks.

Other Criteria:

TRD: Failure of two antidepressants (e.g., selective serotonin reuptake inhibitor [SSRI], serotonin-norepinephrine reuptake inhibitor [SNRI], tricyclic antidepressant [TCA], bupropion, mirtazapine) from two different classes, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

SPRITAM

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

Medical justification must be provided why patient cannot take generic levetiracetam tablets or liquid.

Prior Authorization Group Description:

SPRYCEL

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

CHRONIC MYELOGENOUS LEUKEMIA, ACUTE LYMPHOBLASTIC LEUKEMIA: Prescribed by or in consultation with an oncologist or hematologist. ALL OTHER COVERED ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

STELARA IV

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

CROHN'S DISEASE, ULCERATIVE COLITIS: Prescribed by or in consultation with a gastroenterologist.

Coverage Duration:

4 weeks.

Other Criteria:

CROHN'S DISEASE (new starts only): Failure of Humira, unless contraindicated or clinically significant adverse effects are experienced. ULCERATIVE COLITIS(new starts only): Failure of Humira and Xeljanz/Xeljanz XR, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

STELARA SC

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

PSORIATIC ARTHRITIS, PLAQUE PSORIASIS: Prescribed by or in consultation with a rheumatologist or dermatologist. CROHN'S DISEASE, ULCERATIVE COLITIS: Prescribed by or in consultation with a gastroenterologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

PLAQUE PSORIASIS (new starts only): Failure of two of the following, unless contraindicated or clinically significant adverse effects are experienced: Enbrel, Humira, Skyrizi. PSORIATIC ARTHRITIS (new starts only): Failure of two of the following, unless contraindicated or clinically significant adverse effects are experienced: Enbrel, Humira, Xeljanz/Xeljanz XR. CROHN'S DISEASE (new starts only): Failure of Humira, unless contraindicated or clinically significant adverse effects are experienced. ULCERATIVE COLITIS (new starts only): Failure of Humira and Xeljanz/Xeljanz XR, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

STIVARGA

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

STRENSIQ

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

HYPOPHOSPHATASIA: Prescribed by or in consultation with an endocrinologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

SUBSYS

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

Member is already taking and is tolerant to around-the-clock opioid therapy. Member is considered opioid tolerant when taking another opioid daily for a week or longer (for example, at least 60 mg of oral morphine per day or an equianalgesic dose of another opioid).

Prior Authorization Group Description:

SUNOSI

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

NARCOLEPSY: Prescribed by or in consultation with a neurologist or sleep medicine specialist.

Coverage Duration:

End of Plan Year.

Other Criteria:

NARCOLEPSY, OBSTRUCTIVE SLEEP APNEA (initial authorization only): Failure of armodafinil (Nuvigil) or modafinil (Provigil), unless contraindicated or clinically significant side effects are experienced.

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

SURMONTIL

Prior Authorization Indication:

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

Off Label Uses:

Irritable bowel syndrome.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

DEPRESSION: Failure of one of the following generic antidepressants, unless contraindicated or clinically significant adverse effects are experienced: bupropion, bupropion SR, bupropion XL, citalopram, desvenlafaxine succinate, duloxetine, escitalopram, fluoxetine, mirtazapine, sertraline, venlafaxine, or venlafaxine XR.

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

SYMDEKO

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

CYSTIC FIBROSIS (new starts only): Diagnosis of CF confirmed by all of the following (a, b, and c): a) Clinical symptoms consistent with CF in at least one organ system, or positive newborn screen or genetic testing for siblings of patients with CF, AND b) Evidence of cystic fibrosis transmembrane conductance regulator (CFTR) dysfunction confirmed by one of the following (i or ii): i) Elevated sweat chloride that is 60 mmol/L or greater, ii) Genetic testing confirming the presence of two disease-causing mutations in CFTR gene, one from each parental allele, AND c) One of the following (i or ii): i) Member is homozygous for the F508del mutation in the CFTR gene, OR ii) Presence of at least one mutation in the CFTR gene that is responsive to Symdeko. Confirmation that pulmonary function tests, performed within the last 90 days, show a percent predicted forced expiratory volume in 1 second (ppFEV1) that is between 40-90%. CYSTIC FIBROSIS (continuation of therapy): Member is responding positively to therapy as evidenced by a stabilization in ppFEV1 if baseline prior to initiating therapy was 70% or greater or increase in ppFEV1 if baseline prior to initiating therapy was less than 70%.

Age Restrictions:

Prescriber Restrictions:

CYSTIC FIBROSIS: Prescribed by or in consultation with a pulmonologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Symdeko is not prescribed concurrently with other CFTR modulators (e.g., Kalydeco, Orkambi, Trikafta).

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

SYMLINPEN

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

TYPE I OR TYPE 2 DIABETES MELLITUS (initial authorization only): Previous use of mealtime insulin therapy or an insulin pump.

Prior Authorization Group Description:

SYMPAZAN

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

LENNOX-GASTAUT SYNDROME: Prescribed by or in consultation with a neurologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

LENNOX-GASTAUT SYNDROME: Medical justification supports inability to use clobazam tablets and oral suspension (e.g., contraindications to excipients).

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

TABRECTA

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

NON-SMALL CELL LUNG CANCER: Disease is epidermal growth factor receptor (EGFR) wild-type and anaplastic lymphoma kinase (ALK) negative.

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

TADALAFIL

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Members on concomitant nitrates (e.g., Nitrodur, Nitrobid, Nitrostat, Isordil, Ismo). Members on concomitant guanylate cyclase stimulator, such as riociguat (Adempas).

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

TAFAMIDIS

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

TRANSTHYRETIN AMYLOID CARDIOMYOPATHY (ATTR-CM) (initial authorization only): Diagnosis is supported by one of the following (a or b): a) Tissue biopsy amyloid protein is identified as transthyretin via mass spectrometry or immunohistochemistry, AND (i or ii): i) Tissue biopsy is of endomyocardial origin OR ii) Tissue biopsy is of extra-cardiac origin and echocardiography (Echo), cardiac magnetic resonance imaging (CMR), or positron emission tomography (PET) findings are consistent with cardiac amyloidosis. OR b) Member meets all of the following (i, ii, and iii): i) Echo, CMR, or PET findings are consistent with cardiac amyloidosis, AND ii) Cardiac uptake is Grade 2 or 3 on a radionuclide scan utilizing one of the following radiotracers (a, b, or c): a) 99m technetium (Tc)-labeled 3,3-diphosphono-1,2-propanodicarboxylic acid (DPD), b) 99mTc-labeled pyrophosphate (PYP), or c) 99mTc-labeled hydroxymethylene diphosphonate (HMDP), AND iii) Each of the following laboratory tests is negative for monoclonal protein (a, b, and c): a) Serum kappa/lambda free light chain ratio analysis, b) Serum protein immunofixation, c) Urine protein immunofixation. ATTR-CM (continuation of therapy): Maintained on therapy with positive response, including but not limited to, improvement or stabilization in any of the following parameters: 1) walking ability, 2) nutrition (e.g., body mass index), 3) cardiac related hospitalization, 4) cardiac procedures or laboratory tests (e.g., Holter monitoring, echocardiography, electrocardiogram, plasma BNP or NT-proBNP, serum troponin).

Age Restrictions:

Prescriber Restrictions:

ATTR-CM: Prescribed by or in consultation with a cardiologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

TAGRISSO

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

TAKHZYRO

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

HEREDITARY ANGIOEDEMA: Prescribed by or in consultation with an immunologist, allergist, or hematologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

TALTZ

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

PLAQUE PSORIASIS, PSORIATIC ARTHRITIS: Prescribed by or in consultation with a rheumatologist or dermatologist. ANKYLOSING SPONDYLITIS, NONRADIOGRAPHIC AXIAL SPONDYLOARTHRITIS: Prescribed by or in consultation with a rheumatologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

PLAQUE PSORIASIS (new starts only): Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: Enbrel, Humira, Skyrizi. PSORIATIC ARTHRITIS (new starts only): Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: Enbrel, Humira, Xeljanz/Xeljanz XR. ANKYLOSING SPONDYLITIS (new starts only): Failure of Humira or Enbrel, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

TALZENNA

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

TARCEVA

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

TARGRETIN GEL

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

TASIGNA

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

CHRONIC MYELOGENOUS LEUKEMIA, ACUTE LYMPHOBLASTIC LEUKEMIA: Prescribed by or in consultation with an oncologist or hematologist. ALL OTHER ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

TAVALISSE

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

CHRONIC IMMUNE THROMBOCYTOPENIA (initial authorization only): Failure of a corticosteroid (e.g., prednisone, methylprednisolone, or dexamethasone), unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

TAZVERIK

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

EPITHELIOID SARCOMA: Tumor demonstrates loss of INI1 expression through inactivation, deletion, or mutation of the INI1 (SMARCB-1) gene.

Age Restrictions:

Prescriber Restrictions:

FOLLICULAR LYMPHOMA: Prescribed by or in consultation with an oncologist or hematologist. ALL OTHER ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

TECENTRIQ

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

TECFIDERA

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

MULTIPLE SCLEROSIS: Prescribed by or in consultation with a neurologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

TEGSEDI

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

HEREDITARY TRANSTHYRETIN-MEDIATED AMYLOIDOSIS (hATTR) (initial authorization only): Confirmation of transthyretin (TTR) mutation. Confirmation of amyloid deposition on biopsy or medical justification is provided as to why treatment should be initiated in the presence of a negative biopsy or no biopsy. hATTR (continuation of therapy): Maintained on therapy with positive response, including but not limited to improvement in any of the following parameters: 1) neuropathy (motor function, sensation, reflexes, walking ability), 2) nutrition (body mass index), 3) cardiac parameters (Holter monitoring, echocardiography, electrocardiogram, plasma BNP or NT-proBNP, serum troponin), 4) renal parameters (creatinine clearance, urine albumin), 5) ophthalmic parameters (eye exam).

Age Restrictions:

Prescriber Restrictions:

hATTR: Prescribed by or in consultation with a neurologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

TEPMETKO

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

NON-SMALL CELL LUNG CANCER: Disease is epidermal growth factor receptor (EGFR) wild-type and anaplastic lymphoma kinase (ALK) negative. Member does not have symptomatic CNS metastases.

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

TETRABENAZINE

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

HUNTINGTON'S DISEASE CHOREA: Prescribed by or in consultation with a neurologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

TIBSOVO

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

TOLSURA

Prior Authorization Indication:

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

Off Label Uses:

Hematologic malignancy for prophylaxis of aspergillosis.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

HISTOPLASMOSIS: 6 weeks. ASPERGILLOSIS: 3 months. BLASTOMYCOSIS, HEMATOLOGIC MALIGNANCY: 6 months.

Other Criteria:

ALL INDICATIONS (new starts only): Failure of generic itraconazole capsule, unless contraindicated or clinically significant adverse effects are experienced. ASPERGILLOSIS (new starts only): Failure of voriconazole, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

TRIHEXYPHENIDYL

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

ALL INDICATIONS (continuation of therapy): Prescriber has documented all of the following (a, b, and c): a) Medical justification outlining the specific benefit for continued therapy that outweighs the potential risk, b) Patient counseling has occurred outlining the potential risks of the medication, c) Ongoing monitoring plan.

Age Restrictions:

Prior authorization is required for patients 65 years and older. Prior authorization is not required for patients 64 years and younger.

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

PARKINSON'S DISEASE/PARKINSONISM (new starts only): Failure of two of the following, unless contraindicated or clinically significant adverse effects are experienced: amantadine, levodopa/carbidopa, entacapone, pramipexole, ropinirole, selegiline.

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

TRIKAFTA

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

CYSTIC FIBROSIS (new starts only): Diagnosis of cystic fibrosis (CF) confirmed by all of the following (a, b, and c): a) Clinical symptoms consistent with CF in at least one organ system, or positive newborn screen or genetic testing for siblings of patients with CF, AND b) Evidence of cystic fibrosis transmembrane conductance regulator (CFTR) dysfunction confirmed by one of the following (i or ii): i) Evidence of clinical severity as defined by an average sweat chloride greater than 60 mmol/L, OR ii) Genetic testing confirming the presence of two disease-causing mutations in CFTR gene, one from each parent allele. c) Confirmation of one of the following (i or ii): i) Member has at least one F508del mutation in the CFTR gene, OR ii) Member has a mutation in the CFTR gene that is responsive to Trikafta. Confirmation that pulmonary function tests, performed within the last 90 days, show a percent predicted forced expiratory volume in 1 second (ppFEV1) that is between 40-90%. CYSTIC FIBROSIS (continuation of therapy): For members that received at least 12 weeks of therapy, member is responding positively to therapy as evidenced by stabilization in ppFEV1 if baseline prior to initiating therapy was 70% or greater or increase in ppFEV1 if baseline prior to initiating therapy was less than 70%.

Age Restrictions:

Prescriber Restrictions:

CYSTIC FIBROSIS: Prescribed by or in consultation with a pulmonologist.

Coverage Duration:

Initial: 4 months. Continuation of therapy: End of Plan Year.

Other Criteria:

Trikafta is not prescribed concurrently with other CFTR modulators (e.g., Orkambi, Kalydeco, Symdeko).

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

TRUSELTIQ

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

TRUXIMA

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

RHEUMATOID ARTHRITIS (initial authorization only): Prescribed in combination with methotrexate, unless contraindicated or clinically significant adverse effects were experienced with prior methotrexate therapy.

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist or hematologist. RHEUMATOID ARTHRITIS, GRANULOMATOSIS WITH POLYANGIITIS, MICROSCOPIC POLYANGIITIS: Prescribed by or in consultation with a rheumatologist. PEMPHIGUS VULGARIS: Prescribed by or in consultation with a dermatologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

ALL INDICATIONS (initial authorization only): Medical justification supports inability to use Ruxience (e.g., contraindications to excipients in Ruxience). RHEUMATOID ARTHRITIS (new starts only): Failure of infliximab, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

TUKYSA

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

TURALIO

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

TYMLOS

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

POSTMENOPAUSAL OSTEOPOROSIS (PMO): Total duration of therapy on parathyroid hormone (PTH) analogs (e.g., Tymlos, Forteo) has not exceeded 2 years.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

PMO (initial authorization only): Member meets one of the following (a, b, or c): a) Failure of bisphosphonate therapy (e.g., alendronate) unless contraindicated or clinically significant adverse effects are experienced to both intravenous and oral formulations. OR b) Bone mineral density T-score at hip or spine is -3.5 or less. OR c) Bone mineral density T-score at hip or spine is -2.5 or less with a history of major osteoporotic fracture of the hip, spine, forearm, wrist, or humerus.

Prior Authorization Group Description:

TYSABRI

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

MULTIPLE SCLEROSIS (MS): Prescribed by or in consultation with a neurologist. CROHN'S DISEASE (CD): Prescribed by or in consultation with a gastroenterologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

RELAPSING-REMITTING MS (new starts only): Failure of one of the following, unless clinically significant adverse effects are experienced or all are contraindicated: Aubagio, Tecfidera, Gilenya, Avonex, Betaseron, Plegridy, glatiramer, Copaxone, Glatopa, Extavia, Rebif. CD (new starts only): Failure of Humira and infliximab/infliximab biosimilar, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

UKONIQ

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

UPTRAVI

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

PULMONARY ARTERIAL HYPERTENSION: Prescribed by or in consultation with a cardiologist or pulmonologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

VALCHLOR

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

VALTOCO

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

EPILEPSY: Diagnosis of partial or generalized epilepsy.

Age Restrictions:

Prescriber Restrictions:

EPILEPSY: Prescribed by or in consultation with a neurologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

EPILEPSY: Medical justification supports inability to use diazepam rectal gel (e.g., contraindications to excipients).

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

VANCOCIN

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

C. Diff diarrhea: 14 days. Staph enterocolitis: 10 days. Recurrent C. Diff: 12 weeks.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

VENCLEXTA

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

VERSACLOZ

Prior Authorization Indication:

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

Off Label Uses:

Psychotic disorder associated with Parkinson's disease.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

ALL INDICATIONS: Medical justification supports inability to use clozapine tablets (generic Clozaril or FazaClo) (e.g., contraindications to excipients).

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

VERZENIO

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

VINBLASTINE

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

VINCRISTINE

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Patients with the demyelinating form of Charcot-Marie-Tooth syndrome.

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

VITRAKVI

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Known acquired tropomyosin receptor kinase resistance mutation.

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

NTRK FUSION-POSITIVE SOLID TUMOR: Failure of Rozlytrek, unless contraindicated or clinically significant adverse effects are experienced

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

VIZIMPRO

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

VORICONAZOLE INJ

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

VOSEVI

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

CHRONIC HEPATITIS C INFECTION: Refer to the document, "Recommendations for Testing, Managing, and Treating Hepatitis C," by AASLD-IDSA available at http://www.hcvguidelines.org for drug regimen and duration of treatment based on genotype, treatment status, previous drug regimens used, past medical history and comorbidities.

Age Restrictions:

Prescriber Restrictions:

CHRONIC HEPATITIS C INFECTION: Prescribed by or in consultation with a gastroenterologist, hepatologist, infectious disease specialist, or provider who has expertise in treating HCV based on a certified training program.

Coverage Duration:

Criteria will be applied consistent with current AASLD-IDSA guidance.

Other Criteria:

CHRONIC HEPATITIS C INFECTION: Criteria will be applied consistent with current AASLD-IDSA guidance.

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

VOTRIENT

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

VRAYLAR

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

BIPOLAR I DISORDER, SCHIZOPHRENIA: Failure of TWO of the following atypical antipsychotics, unless contraindicated or clinically significant adverse effects are experienced: aripiprazole, ziprasidone, quetiapine, olanzapine, risperidone.

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

VUMERITY

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

MULTIPLE SCLEROSIS: Prescribed by or in consultation with a neurologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

VYONDYS 53

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

DUCHENNE MUSCULAR DYSTROPHY (DMD) (initial authorization only): DMD with mutation amenable to exon 53 skipping confirmed by genetic testing.

Age Restrictions:

Prescriber Restrictions:

DMD: Prescribed by or in consultation with a neurologist.

Coverage Duration:

6 months.

Other Criteria:

DMD: Currently stable on an oral corticosteroid regimen (e.g., prednisone), unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

WAKIX

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

NARCOLEPSY WITH CATAPLEXY OR NARCOLEPSY WITH EXCESSIVE DAYTIME SLEEPINESS: Prescribed by or in consultation with a neurologist or sleep medicine specialist.

Coverage Duration:

End of Plan Year.

Other Criteria:

NARCOLEPSY WITH EXCESSIVE DAYTIME SLEEPINESS (initial authorization only): Failure of Sunosi, unless contraindicated or clinically significant adverse effects are experienced. NARCOLEPSY WITH CATAPLEXY (initial authorizations only): Failure of two antidepressants from the following classes, unless clinically significant adverse effects are experienced or all are contraindicated: selective serotonin reuptake inhibitors (SSRI), serotonin-norepinephrine reuptake inhibitors (SNRI), tricyclic antidepressants (TCA).

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

WELIREG

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

XALKORI

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

XATMEP

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Less than 18 years of age.

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist or hematologist.
POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS: Prescribed by or in consultation with a rheumatologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

ALL INDICATIONS: Medical justification as to why member cannot use methotrexate tablets.

Prior Authorization Group Description:

XCOPRI

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

PARTIAL-ONSET SEIZURES: Prescribed by or in consultation with a neurologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

PARTIAL-ONSET SEIZURES: Failure of two of the following generic antiepileptic drugs, unless contraindicated or clinically significant adverse effects are experienced: lamotrigine, topiramate, oxcarbazepine, carbamazepine, phenytoin, valproic acid, divalproex sodium, felbamate, gabapentin, levetiracetam, pregabalin, tiagabine, zonisamide.

Prior Authorization Group Description:

XELJANZ

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

POLYARTICULAR COURSE JUVENILE IDIOPATHIC ARTHRITIS AND RHEUMATOID ARTHRITIS: Prescribed by or in consultation with a rheumatologist. PSORIATIC ARTHRITIS: Prescribed by or in consultation with a rheumatologist or dermatologist. ULCERATIVE COLITIS: Prescribed by or in consultation with a gastroenterologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

RHEUMATOID ARTHRITIS (new starts only): Failure of one of the following, unless contraindicated or clinically significant adverse effects are experienced: methotrexate, sulfasalazine, hydroxychloroquine, d-penicillamine, azathioprine or auranofin.

Prior Authorization Group Description:

XENICAL

Prior Authorization Indication:

For obesity management including weight loss and weight maintenance when used in conjunction with a reduced-calorie diet or to reduce the risk for weight regain after prior weight loss in obese patients with an initial body mass index (BMI) of 30 kg/m^2 or greater (obese) or 27 kg/m^2 or greater (overweight) in the presence of at least one weight-related comorbidity such as hypertension, type 2 diabetes mellitus, or dyslipidemia.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

BMI is greater than or equal to 30 kg/m^2 OR BMI is greater than or equal to 27 kg/m^2 with one or more of the following severe co-morbid conditions 1. Coronary artery/heart disease 2. Diabetes 3. Dyslipidemia 4. Hypertension 5. Obstructive sleep apnea. CONTINUATION OF THERAPY: for members that received at least 6 months of treatment, confirmation of a 5-10 pound weight loss from baseline prior to initiating therapy. Subsequent authorizations require confirmation of weight maintenance.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

6 months.

Other Criteria:

Prior Authorization Group Description:

XENLETA

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

COMMUNITY-ACQUIRED BACTERIAL PNEUMONIA (CABP): Request is for continuation of therapy initiated in an acute care hospital from which member was discharged OR culture and sensitivity (C&S) report for the current infection shows isolated pathogen is an organism susceptible to Xenleta, unless provider confirms that obtaining a C&S report is not feasible.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

CABP: 7 days.

Other Criteria:

CABP: For members initiating Xenleta therapy outside of an acute care hospital, one of the following (a, b, or c): a) If a C&S report is available: Failure of 2 antibiotics to which the isolated pathogen is susceptible (if available) per C&S report, unless all are contraindicated or clinically significant adverse effects are experienced. b) C&S report shows resistance or lack of susceptibility of the isolated pathogen to all formulary antibiotics FDA-approved for member's diagnosis. c) If provider confirms that obtaining a C&S report is not feasible: Failure of 2 antibiotics indicated for member's diagnosis (if available), unless all are contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

XEOMIN

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

XERMELO

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

XGEVA

Prior Authorization Indication:

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

Off Label Uses:

Systemic mastocytosis related osteopenia or osteoporosis.

Exclusion Criteria:

Required Medical Information:

HYPERCALCEMIA OF MALIGNANCY (new starts only): albumin-corrected calcium greater than 12.5 mg/dL despite intravenous (IV) bisphosphonate therapy in the last 30 days.

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

SYSTEMIC MASTOCYTOSIS (initial authorization only): failure of a bisphosphonate (e.g., zoledronic acid), unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

XOLAIR

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

ASTHMA (initial authorization only): Positive skin test or in vitro reactivity to a perennial aeroallergen AND immunoglobulin E (IgE) level greater than or equal to 30 IU/mL. ASTHMA (continuation of therapy): member is responding positively to therapy (examples may include but are not limited to a reduction in exacerbations or corticosteroid dose, improvement in forced expiratory volume over one second since baseline prior to initiating therapy, reduction in the use of rescue therapy since baseline prior to initiating therapy). CHRONIC IDIOPATHIC URTICARIA (continuation of therapy): member is responding positively to therapy (e.g., improved symptoms). NASAL POLYPS: Diagnosis of chronic rhinosinusitis with nasal polyps. Xolair is prescribed concurrently with an intranasal corticosteroid, unless contraindicated or clinically significant adverse effects are experienced. NASAL POLYPS (initial authorization only): Disease is bilateral, and member has experienced signs and symptoms (e.g., nasal congestion/blockage/obstruction, loss of smell, rhinorrhea) for at least 12 weeks. NASAL POLYPS (continuation of therapy): Member is responding positively to therapy (examples may include but are not limited to: reduced nasal polyp size, reduced need for systemic corticosteroids, improved sense of smell, improved quality of life).

Age Restrictions:

Prescriber Restrictions:

ASTHMA: Prescribed by or in consultation with a pulmonologist, immunologist, or allergist. CHRONIC IDIOPATHIC URTICARIA: Prescribed by or in consultation with an allergist, dermatologist, or immunologist. NASAL POLYPS: Prescribed by or in consultation with an allergist, immunologist, or otolaryngologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

ASTHMA (initial authorization only): Failure of one inhaled corticosteroid (e.g., beclomethasone, budesonide, flunisolide, fluticasone, mometasone, ciclesonide), unless contraindicated or clinically significant adverse effects are experienced. CHRONIC IDIOPATHIC URTICARIA (initial authorization only): Failure of one H1 Antihistamine (e.g., levocetirizine or desloratadine), unless contraindicated or clinically significant adverse effects are experienced. NASAL POLYPS (initial authorization only): Failure of maintenance therapy with an intranasal corticosteroid, unless contraindicated or clinically significant adverse effects are experienced.

Prior Authorization Group Description:

XOSPATA

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

XPOVIO

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist or hematologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

XTANDI

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

PROSTATE CANCER: Prescribed by or in consultation with an oncologist or urologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

YERVOY

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

HEPATOCELLULAR CARCINOMA: Member has not had previous treatment with a checkpoint inhibitor (e.g., Opdivo, Keytruda, Tecentriq, Imfinzi). NON-SMALL CELL LUNG CANCER: Member has not previously progressed on a PD-1/PD-L1 inhibitor (e.g., Opdivo, Keytruda, Tecentriq, Imfinzi).

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

YONSA

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

PROSTATE CANCER: Prescribed by or in consultation with an oncologist or urologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

PROSTATE CANCER: Medical justification supports inability to use Zytiga (e.g., contraindications to excipients). Member has not had disease progression after prior treatment with Zytiga.

Prior Authorization Group Description:

ZALTRAP

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

ZARXIO

Prior Authorization Indication:

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

Off Label Uses:

Myelodysplastic syndrome. Neutropenia in patients with HIV/AIDS. Hematopoietic syndrome of acute radiation syndrome.

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

ZEJULA

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Group Description:

ZELBORAF

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ERDHEIM-CHESTER DISEASE, HAIRY CELL LEUKEMIA: Prescribed by or in consultation with an oncologist or hematologist. ALL OTHER ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

ZINPLAVA

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

CLOSTRIDIUM DIFFICILE INFECTION (CDI): Confirmation of positive Clostridium difficile test.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

4 weeks.

Other Criteria:

CDI: Will receive or is currently receiving antibacterial drug treatment for Clostridium difficile infection (e.g., metronidazole, vancomycin, fidaxomicin) concomitantly with Zinplava. Has received appropriate treatment for past CDI recurrences, including a pulsed vancomycin regimen.

Prior Authorization Group Description:

ZULRESSO

Prior Authorization Indication:

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

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

POSTPARTUM DEPRESSION: No more than 6 months have passed since member has given birth.

Age Restrictions:

Prescriber Restrictions:

Coverage Duration:

POSTPARTUM DEPRESSION: 4 weeks.

Other Criteria:

POSTPARTUM DEPRESSION: Failure of one of the following oral antidepressants, unless contraindicated or clinically significant adverse effects are experienced: selective serotonin reuptake inhibitor (SSRI), serotonin-norepinephrine reuptake inhibitor (SNRI), tricyclic antidepressant (TCA), bupropion, mirtazapine.

Prior Authorization Group Description:

ZYDELIG

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with a hematologist or oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

ZYKADIA

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

ALL ONCOLOGY INDICATIONS: Prescribed by or in consultation with an oncologist.

Coverage Duration:

End of Plan Year.

Other Criteria:

Prior Authorization Protocol

Medicare Part D – 2021

Prior Authorization Group Description:

ZYTIGA

Prior Authorization Indication:

All medically accepted indications not otherwise excluded from Part D.

Off Label Uses:

Exclusion Criteria:

Required Medical Information:

Age Restrictions:

Prescriber Restrictions:

PROSTATE CANCER: Prescribed by or in consultation with an oncologist or urologist.

Coverage Duration:

End of Plan Year.

Other Criteria: