2019

Prior Authorization Criteria

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ACTIMMUNE

Products Affected

- ACTIMMUNE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from part D
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Diagnosis, Bone biopsy if osteopetrosis, Antibiotic failure if chronic granulomatous disease
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Infectious Disease/Hematology-oncology/Orthopedist/rheumatologist
Coverage Duration	12 months
Other Criteria	Sulfamethoxazole/Trimethoprim and/or itraconazole failure for infections secondary to chronic granulomatous disease. Osteopetrosis must be severe malignant

ADCIRCA TABS

Products Affected

- ADCIRCA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Right Heart catheterization, vasoreactivity test.
Age Restrictions	N/A
Prescriber Restrictions	Pulmonology, Cardiology
Coverage Duration	12 months
Other Criteria	Failure of Sildenafil for WHO group 1 PAH

ADEMPAS

Products Affected

- ADEMPAS

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	pulmonologist/cardiologist
Coverage Duration	12 months
Other Criteria	For PAH must have tried and failed bosentan and sildenafil, CTPH requires failure of bosentan (based on compendial support)

AFINITOR

Products Affected

- AFINITOR
- AFINITOR DISPERZ

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncology/neurology
Coverage Duration	12 months or until disease progression
Other Criteria	N/A

ALECENSA

Products Affected

- ALECENSA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematology/Oncology
Coverage Duration	12 months
Other Criteria	Approved for ALK+ Non Small Cell Lung Cancer after progression on crizotinib

ALUNBRIG

Products Affected

- ALUNBRIG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematology/Oncology
Coverage Duration	12 months or until progression
Other Criteria	N/A

AMPYRA

Products Affected

- AMPYRA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	History of seizure. Moderate or severe renal impairment (creatinine clearance less than or equal to 50 mL/minute).
Required Medical Information	Diagnosis of multiple sclerosis AND patient is ambulatory (able to walk at least 25 feet) AND patient has walking impairment
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial - 3 months. Renewal - 12 months
Other Criteria	For renewal, walking speed has improved from baseline.

APOKYN

Products Affected

- APOKYN SUBCUTANEOUS SOLUTION CARTRIDGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history
Age Restrictions	Ages approved in FDA labeling/compendia
Prescriber Restrictions	Neurologist
Coverage Duration	12 months
Other Criteria	Patient must have poorly controlled off time episodes and failed dopamine agonist and COMT inhibitor

APTIOM

Products Affected

- APTIOM

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded by Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurology
Coverage Duration	12 months
Other Criteria	Failure of carbamazepine and Oxcarbazepine

ARANESP

Products Affected

- ARANESP (ALBUMIN FREE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 25 MCG/ML, 300 MCG/ML, 40 MCG/ML, 60 MCG/ML
- ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from part D
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes and Scr and HGB and T-sat and Ferritin
Age Restrictions	Ages approved in FDA labeling
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	Failure of Procrit. Hemoglobin required to be within FDA approved ranges for initiation and maintenance. Patient must have adequate iron stores to initiate and continue treatment. ESRD would be covered under part B benefit

ARCALYST

Products Affected

- ARCALYST

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from part D
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Coverage will be based on a Diagnosis of CAPS, failure of 1 other treatment used for this condition such as cancakinumab, nsaids
Age Restrictions	N/A
Prescriber Restrictions	Immunologist,dermatologist,rheumatologist
Coverage Duration	12 months
Other Criteria	N/A

ARMODAFINIL/MODAFINIL

Products Affected

- *armodafinil*
- *modafinil*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

AUBAGIO

Products Affected

- AUBAGIO

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurology
Coverage Duration	12 months
Other Criteria	Failure of Glatopa, Gilenya

AVONEX

Products Affected

- AVONEX
- AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT
- AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurology
Coverage Duration	12 months
Other Criteria	Failure of glatiramer

AZILECT

Products Affected

- *rasagiline mesylate oral*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded by part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Failure of entacapone or a dopamine agonist

BANZEL

Products Affected

- BANZEL

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	Neurology
Coverage Duration	12 months
Other Criteria	N/A

BENLYSTA

Products Affected

- BENLYSTA SUBCUTANEOUS

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Member receiving other biologic therapy or intravenous cyclophosphamide.
Required Medical Information	Diagnosis of active, autoantibody-positive, systemic lupus erythematosus (SLE), and member currently receiving one or more of the following standard SLE therapies: Corticosteroids, Antimalarials, Non-steroidal anti-inflammatory drugs (NSAIDs), Immunosuppressants
Age Restrictions	Greater or equal to 18 years of age
Prescriber Restrictions	Rheumatologist or nephrologist
Coverage Duration	Lifetime
Other Criteria	None

BETASERON

Products Affected

- BETASERON SUBCUTANEOUS KIT

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurology
Coverage Duration	12 months
Other Criteria	Failure of glatiramer

BOSULIF

Products Affected

- BOSULIF

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months or until disease progression
Other Criteria	Requires failure of imatinib for low risk CML based on Sokal or Hasford scores. Can be used first line for Ph+ CML with an intermediate to high risk Sokal or Hasford score

BRIVIACT

Products Affected

- BRIVIACT ORAL

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	failed trial or contraindication or intolerance of Levetiracetam

BUDESONIDE EC

Products Affected

- *budesonide oral*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from part D
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history
Age Restrictions	Ages approved in FDA labeling
Prescriber Restrictions	Gastroenterologist
Coverage Duration	3 months
Other Criteria	Covered for Short term use in mild to moderate Crohn's

CABOMETYX

Products Affected

- CABOMETYX

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematology/Oncology
Coverage Duration	12 months
Other Criteria	Covered until disease progression.

CALQUENCE

Products Affected

- CALQUENCE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months or clinical progression
Other Criteria	N/A

CAPRELSA

Products Affected

- CAPRELSA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncology
Coverage Duration	12 months or until disease progression
Other Criteria	N/A

CARBAGLU

Products Affected

- CARBAGLU

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

CINRYZE

Products Affected

- CINRYZE

PA Criteria	Criteria Details
Covered Uses	All Medically acceptable indications not otherwise excluded by part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Patient must have two or more angioedema attacks per month and has failed danazol

COMETRIQ

Products Affected

- COMETRIQ (100 MG DAILY DOSE)
- COMETRIQ (140 MG DAILY DOSE)
- COMETRIQ (60 MG DAILY DOSE)

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded by part D
Exclusion Criteria	combination use with other tyrosine Kinase inhibitors.
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	oncology/hematology
Coverage Duration	6 months or until disease progression
Other Criteria	Covered for Metastatic Thyroid Medullary Cancer

CORLANOR

Products Affected

- CORLANOR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of the following: 1. Diagnosis of chronic heart failure with left ventricular ejection fraction less than or equal to 35% AND 2. Patient is in sinus rhythm with resting heart rate greater than or equal to 70 beats per minute AND 3. Patient is on maximally tolerated doses of beta-blockers or has a contraindication to beta-blocker use AND 4. Patient is receiving an ACE inhibitor or ARB or has a contraindication to these agents.
Age Restrictions	N/A
Prescriber Restrictions	Cardiologist
Coverage Duration	12 months
Other Criteria	N/A

COTELLIC

Products Affected

- COTELLIC

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematology/Oncology
Coverage Duration	12 months
Other Criteria	Covered for BRAF+ metastatic melanoma for combination use in with Zelboraf

CUBICIN

Products Affected

- *daptomycin intravenous solution reconstituted 500 mg*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D. *Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI) , and the Drug Package Insert).
Exclusion Criteria	daptomycin is contraindicated in patients with known hypersensitivity to daptomycin or any other component of the product.
Required Medical Information	Documentation of a consultation with an infectious disease specialist. If being used to treat a condition caused by end-stage renal disease(ESRD) and member is on dialysis, please bill to Medicare Part B.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	If all conditions are met, the request will be authorized until the end of the contract year.
Other Criteria	Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.

CUPRIMINE

Products Affected

- CUPRIMINE ORAL CAPSULE 250 MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	serum ceruloplasmin if used for wilson's disease
Age Restrictions	N/A
Prescriber Restrictions	rheumatology/hepatology/neurology/urology/nephrology
Coverage Duration	12 months
Other Criteria	Coverage for RA requires failure of a TNF-Agent and JAK inhibitor or abatacept.

CYCLOBENZAPRINE

Products Affected

- *cyclobenzaprine hcl oral tablet 10 mg*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Authorization is required for patients over 64 years of age
Prescriber Restrictions	N/A
Coverage Duration	3 weeks for skeletal muscle spasm, 12 months for fibromyalgia
Other Criteria	For patients over 64 years of age, Physician attests they have counseled patient on risk benefit of muscle relaxers as a high risk medication and patient has been evaluated for fall risk.

DALIRESP

Products Affected

- DALIRESP

PA Criteria	Criteria Details
Covered Uses	All medically acceptable indications not otherwise excluded by Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Failure or intolerance of combination inhaled corticosteroid/Long Acting Beta Agonist and long acting muscarinic antagonist.

DRONABINOL

Products Affected

- *dronabinol*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Previous Treatment History
Age Restrictions	Ages approved in FDA labeling
Prescriber Restrictions	Infectious disease/oncologist/gastroenterologist
Coverage Duration	12 months
Other Criteria	For HIV/Cancer related cachexia patient must fail megestrol, For Chemotherapy induced nausea, patient must fail Emend and Ondansetron.

EMEND

Products Affected

- *aprepitant*
- EMEND ORAL SUSPENSION RECONSTITUTED

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Previous treatment history
Age Restrictions	Ages approved in FDA labeling
Prescriber Restrictions	Hematologist/oncologist/Surgeon
Coverage Duration	12 months
Other Criteria	Patient must fail treatment with ondansetron (PA not applicable for PONV)

EMSAM

Products Affected

- EMSAM TRANSDERMAL PATCH 24 HOUR 6 MG/24HR, 9 MG/24HR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, prior medication failures
Age Restrictions	Ages approved in FDA labeling
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Patient must fail 6 week trial with two formulary anti-depressants

ENBREL

Products Affected

- ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- ENBREL SUBCUTANEOUS SOLUTION RECONSTITUTED
- ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	FDA labeled contraindications combination with other biologic
Required Medical Information	Medical notes
Age Restrictions	Ages approved in FDA labeling
Prescriber Restrictions	Rheumatology/Dermatology or Specialist trained in management of prescribed condition
Coverage Duration	12 months
Other Criteria	For RA Patient must fail adequate trial of MTX in combination with a DMARD If MTX contraindicated, must try combination of 2-nonbiologic DMARDS. For Ankylosing Spondylitis PT must fail 2 NSAIDS within past 6 months. For Plaque Psoriasis patient must fail MTX or Soriatane and Topical Therapy(ie. high potency steroids Vit D analogs). for Psoriatic Arthritis Patient must fail adequate trial of MTX or LEF in past 6 months.

ENTRESTO

Products Affected

- ENTRESTO

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of chronic heart failure (NYHA Class II-IV) and reduced ejection fraction (less than or equal to 40%).
Age Restrictions	N/A
Prescriber Restrictions	Cardiologist
Coverage Duration	12 months
Other Criteria	Entresto will be used in place of an ACE inhibitor or other ARB.

ERIVEDGE

Products Affected

- ERIVEDGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist/Oncologist
Coverage Duration	12 months or until progression
Other Criteria	Diagnosis of metastatic basal cell carcinoma OR Diagnosis of locally advanced basal cell carcinoma that has recurred following surgery or when the patient is not a candidate for surgery and radiation

ERLEADA

Products Affected

- ERLEADA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Urologist, Oncologist
Coverage Duration	12 months or until PSA progression
Other Criteria	Failure of abiraterone for metastatic disease. Failure of LHRH agonist and bicalutamide for non-metastatic disease

ESBRIET

Products Affected

- ESBRIET

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Confirmed Diagnosis of idiopathic pulmonary fibrosis (IPF) through exclusion of other fibrosing conditions/causes and definitive High resolution CT IPF pattern or Biopsy proven IPF. FVC of at least 50% of predicted value DLCO of at least 30%

EXELON

Products Affected

- *rivastigmine*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Failure of memantine and donepezil for Alzheimer's disease. no prequisite medications for dementia due to parkinson's disease

EXJADE

Products Affected

- EXJADE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history, iron indices
Age Restrictions	Ages approved in FDA labeling
Prescriber Restrictions	Hematologist/oncologist
Coverage Duration	12 months
Other Criteria	Patient must fail or have contraindication to deferoximine

FANAPT

Products Affected

- FANAPT
- FANAPT TITRATION PACK

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from part D
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Diagnosis
Age Restrictions	Ages approved in FDA labeling
Prescriber Restrictions	Neurology/Psychiatry
Coverage Duration	12 months
Other Criteria	N/A

FARYDAK

Products Affected

- FARYDAK

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist/oncologist
Coverage Duration	12months
Other Criteria	N/A

FENTANYL LOZENGE

Products Affected

- *fentanyl citrate buccal*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from part D
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Previous treatment history
Age Restrictions	Ages approved in FDA labeling
Prescriber Restrictions	Pain management physician/oncologist
Coverage Duration	12 months
Other Criteria	Covered for breakthrough pain in patients receiving long acting opioid treatment and are opioid tolerant. Patient must fail two immediate release C-II opioid such as hydromorphone, morphine, oxycodone.

FENTANYL PATCH

Products Affected

- *fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from part D
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history
Age Restrictions	Ages approved in FDA labeling
Prescriber Restrictions	Pain management physician/oncologist
Coverage Duration	12 months
Other Criteria	N/A

FERRIPROX

Products Affected

- FERRIPROX ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	oncologist/hematologist
Coverage Duration	12 months
Other Criteria	Failure of Exjade and Desferal

FETZIMA

Products Affected

- FETZIMA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded by part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Must fail two generically available anti-depressants in past12 months

FIRAZYR

Products Affected

- FIRAZYR

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded by part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

FLUCYTOSINE

Products Affected

- *flucytosine oral*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Infectious disease
Coverage Duration	up to 6 weeks
Other Criteria	N/A

FOSRENOL

Products Affected

- FOSRENOL ORAL PACKET
- *lanthanum carbonate*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from part D
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Previous treatment history, CA, PO4, IPTH
Age Restrictions	Ages approved in FDA labeling
Prescriber Restrictions	Nephrologist
Coverage Duration	12 months
Other Criteria	Patient must fail or not be a candidate for calcium based phosphate binders based on KDOQI guidelines for use

FYCOMPA

Products Affected

- FYCOMPA ORAL SUSPENSION
- FYCOMPA ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded by Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurology
Coverage Duration	12 months
Other Criteria	N/A

GATTEX

Products Affected

- GATTEX

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded by part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Gastroenterologist
Coverage Duration	6 months initially
Other Criteria	Diagnosis of Short Bowel Syndrome Dependent on Parenteral Support Baseline Records of parenteral hydration After 6 month trial of Gattex, patient must demonstrate clinical improvement and or reduction in weekly parenteral fluid volume for continuation.

GILENYA

Products Affected

- GILENYA ORAL CAPSULE 0.5 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurology
Coverage Duration	12 months
Other Criteria	N/A

GILOTRIF

Products Affected

- GILOTRIF

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncology/Hematology
Coverage Duration	12 months
Other Criteria	Off label use must be supported by NCCN criteria with evidence rating of 2a or 1

GLYBURIDE

Products Affected

- *glyburide micronized*
- *glyburide oral*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	failure or contraindication to preferred glipizide and glimeperide
Age Restrictions	Prior authorization required for members 65 years or older. Automatic approval for members less than 65 years of age.
Prescriber Restrictions	N/A
Coverage Duration	Through benefit year
Other Criteria	N/A

HETLIOZ

Products Affected

- HETLIOZ

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Confirmed Diagnosis of non-24 hour sleep-Wake disorder Sleep study to rule out Sleep/apnea or other contributory sleep disorders Patient must be totally Blind

HUMIRA

Products Affected

- HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT
- HUMIRA PEN SUBCUTANEOUS PEN-INJECTOR KIT
- HUMIRA PEN-CD/UC/HS STARTER
- HUMIRA PEN-PS/UV STARTER
- HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from part D
Exclusion Criteria	FDA labeled contraindications combination with other biologic
Required Medical Information	Medical notes
Age Restrictions	Ages approved in FDA labeling
Prescriber Restrictions	Dermatologist/rheumatologist/ Gastroenterologist/Ophthalmologist
Coverage Duration	12 months
Other Criteria	For RA or psoriatic arthritis patient must fail a preferred TNF (Enbrel/Simponi)and Xeljanz. For Ankylosing spondylitis Patient must fail Enbrel and Simponi. For ulcerative colitis s patient must fail Simponi and Xeljanz. For Crohn's disease patient must fail Remicade and 6-mp. For plaque psoriasis patients must fail Enbrel

IBRANCE

Products Affected

- IBRANCE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematology/Oncology
Coverage Duration	12 months
Other Criteria	N/A

ICLUSIG

Products Affected

- ICLUSIG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	Hematology/Oncology
Coverage Duration	12 months
Other Criteria	N/A

IDHIFA

Products Affected

- IDHIFA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Evidence of IDH-1 mutation
Age Restrictions	N/A
Prescriber Restrictions	Hematology/Oncology
Coverage Duration	12 months or until disease progression
Other Criteria	N/A

IMBRUVICA

Products Affected

- IMBRUVICA ORAL CAPSULE
- IMBRUVICA ORAL TABLET 420 MG, 560 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematology/Oncology/ transplant specialist
Coverage Duration	12 months
Other Criteria	Off Label and combination use must be supported by NCCN guidelines with evidence rating of 2a or 1

INCRELEX

Products Affected

- INCRELEX

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from part D
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history
Age Restrictions	Ages approved in FDA labeling
Prescriber Restrictions	Endocrinologist
Coverage Duration	12 months
Other Criteria	N/A

INLYTA

Products Affected

- INLYTA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncology
Coverage Duration	12 months or until disease progression
Other Criteria	N/A

IRESSA

Products Affected

- IRESSA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	Iressa is contraindicated in patients with severe hypersensitivity to gefitinib or other components.
Required Medical Information	Diagnosis
Age Restrictions	Patient must be at least 18 years old or older.
Prescriber Restrictions	Hematology/Oncology
Coverage Duration	12 months
Other Criteria	Approved for Non Small Cell Lung Cancer with Egfr exon 19 deletion or Exon 21 substitution.

ISOTRETINOIN

Products Affected

- *isotretinoin oral*

PA Criteria	Criteria Details
Covered Uses	All medically acceptable indications not otherwise excluded by part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	5 months
Other Criteria	For cystic, nodular or scarring acne, must be refractory to oral antibiotics and topical retinoids. Trial of combination oral teracycline and topical retinoid most have been tried in most recent 6 months.

ITRACONAZOLE

Products Affected

- *itraconazole oral*
- SPORANOX ORAL SOLUTION

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from part D
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history, fungal culture and sensitivity
Age Restrictions	Ages approved in FDA labeling
Prescriber Restrictions	N/A
Coverage Duration	minimum of 12 week up to 12 months
Other Criteria	Failure of terbinafine for onychomycosis

IVIG

Products Affected

- GAMMAGARD INJECTION SOLUTION 2.5 GM/25ML
- GAMUNEX-C INJECTION SOLUTION 1 GM/10ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, immunoglobulin studies
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For ITP Must fail corticosteroids and Anti-D immunoglobulin (if indicated).

JAKAFI

Products Affected

- JAKAFI

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from part D
Exclusion Criteria	FDA labeled contraindications, Low risk Disease
Required Medical Information	Diagnosis
Age Restrictions	Ages approved in FDA labeling
Prescriber Restrictions	Hematology-oncology
Coverage Duration	3 months
Other Criteria	Continuation will be based on reduction in spleen size from baseline or symptomatic improvement. Not covered when used in combination with antiproliferative drugs (i.e lenalidomide), or other JAK or Tyrosine Kinase inhibitors.

JANUVIA

Products Affected

- JANUVIA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	FDA labeled contraindications, Non FDA approved combinations
Required Medical Information	Medical notes, previous treatment history, HA1c BG
Age Restrictions	Ages approved in FDA labeling
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Failure of Onglyza

JUXTAPID

Products Affected

- JUXTAPID

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months initially, 12 months for continuation
Other Criteria	Clinical confirmation that patient has HoFH and failure of Statin and PCSK-9 therapy. Continuation of Juxtapid after 3 month trial based on LDL reduction while on therapy.

KALYDECO

Products Affected

- KALYDECO ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded by part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Genotyping supportive of mutation status in the FDA label

KINERET

Products Affected

- KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	FDA labeled contraindications combination with other biologic
Required Medical Information	Medical notes
Age Restrictions	Ages approved in FDA labeling
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For RA failure of Enbrel and Humira

KISQALI

Products Affected

- KISQALI 200 DOSE
- KISQALI 400 DOSE
- KISQALI 600 DOSE
- KISQALI FEMARA 200 DOSE
- KISQALI FEMARA 400 DOSE
- KISQALI FEMARA 600 DOSE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematology/Oncology
Coverage Duration	12 months or until progression
Other Criteria	N/A

KORLYM

Products Affected

- KORLYM

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	endocrinologist
Coverage Duration	12 months
Other Criteria	Diagnosis of Cushings syndrome , Type 2 diabetes mellitus , Failed surgery OR not a candidate for surgery , Failure of ketoconazole

KUVAN

Products Affected

- KUVAN

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history
Age Restrictions	Ages approved in FDA labeling
Prescriber Restrictions	Medical Geneticist, neurologist, hepatologist,Metabolic specialist
Coverage Duration	12 months
Other Criteria	Coverage will be based on medical history/status, response to previous treatments, and the consideration of other therapeutic options

KYNAMRO

Products Affected

- KYNAMRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months initially, 12 months after response
Other Criteria	Clinical confirmation that patient has HoFH AND failure of Statin AND PCSK-9 therapy. Continuation of Kynamro after 3 month trial based on LDL reduction.

LATUDA

Products Affected

- LATUDA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from part D
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Diagnosis
Age Restrictions	Ages approved in FDA labeling
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

LENVIMA

Products Affected

- LENVIMA 10 MG DAILY DOSE
- LENVIMA 14 MG DAILY DOSE
- LENVIMA 20 MG DAILY DOSE
- LENVIMA 24 MG DAILY DOSE

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded by part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematology Oncology
Coverage Duration	12 months or until disease progression
Other Criteria	N/A

LIDODERM

Products Affected

- *lidocaine external patch 5 %*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes
Age Restrictions	Ages approved in FDA labeling
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Covered for PHN, patient must fail gabapentin

LONG ACTING ANTI-PSYCHOTICS INJECTIONS

Products Affected

- ABILIFY MAINTENA INTRAMUSCULAR PREFILLED SYRINGE
- ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER
- ARISTADA
- GEODON INTRAMUSCULAR
- INVEGA SUSTENNA
- RISPERDAL CONSTA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from part D
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	N/A
Age Restrictions	Ages approved in FDA labeling
Prescriber Restrictions	Neurology Psychiatry
Coverage Duration	12 months
Other Criteria	Failure of two generic anti-psychotics in the past 12 months

LONSURF

Products Affected

- LONSURF

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematology/Oncology
Coverage Duration	12 months
Other Criteria	N/A

LOTRONEX

Products Affected

- *alosetron hcl*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes
Age Restrictions	Ages approved in FDA labeling
Prescriber Restrictions	Gastroenterologist
Coverage Duration	12 months
Other Criteria	Failure of loperimide and cholestyramine. Approved initially for 3 months continuation up to 12 months if patient has improvement in symptoms.

LYNPARZA

Products Affected

- LYNPARZA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematology/Oncology
Coverage Duration	12 months
Other Criteria	N/A

MAVYRET

Products Affected

- MAVYRET

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Gastroenterology, infectious disease, Hepatology
Coverage Duration	8 weeks to 16 weeks
Other Criteria	Information supporting diagnosis,genotype,and Metavir score.

MEKINIST

Products Affected

- MEKINIST

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months or until disease progression
Other Criteria	Mutation analysis showing BRAF V600E or V600K positive, not covered for combination use with other anti-neoplastics unless FDA indication or NCCN recommended with a class 2A or greater evidence rating.

MENEST

Products Affected

- MENEST ORAL TABLET 0.3 MG, 0.625 MG, 1.25 MG

PA Criteria	Criteria Details
Covered Uses	All FDA-labeled indications not otherwise excluded from Part D
Exclusion Criteria	FDA contraindications
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Covered for palliative treatment of breast cancer. Coverage for Hormone replacement therapy would required failure of formulary estrogens which do not have utilization management (ie. premarin, estradiol, estropipate)

MOVANTIK

Products Affected

- MOVANTIK

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12months
Other Criteria	Failure of Lactulose and polyethylele glycol 3350 (Miralax)

MULTAQ

Products Affected

- MULTAQ

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded by part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Failure of sotalol and amiodarone

MYRBETRIQ

Products Affected

- MYRBETRIQ

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Failure of Toviaz and Oxybutynin

NATPARA

Products Affected

- NATPARA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	iPTH, Calcium
Age Restrictions	N/A
Prescriber Restrictions	endocrinologist
Coverage Duration	12 months
Other Criteria	N/A

NERLYNX

Products Affected

- NERLYNX

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematologist/Oncologist
Coverage Duration	12 months or until disease progression
Other Criteria	N/A

NEUPRO

Products Affected

- NEUPRO

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Failure of Ropinirole and Pramipexole

NEXAVAR

Products Affected

- NEXAVAR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncology
Coverage Duration	12 months or until disease progression
Other Criteria	N/A

NINLARO

Products Affected

- NINLARO

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematology/Oncology
Coverage Duration	12 months
Other Criteria	Failure of Velcade and Revlimid required for coverage

NORTHERA

Products Affected

- NORTHERA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Documented orthostatic hypotension, failure of midodrine or Fludrocortisone. No perquisite drugs required for Dopamine-Beta-Hydroxylase deficiency

NOXAFIL

Products Affected

- NOXAFIL ORAL

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded by part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	Failure, resistance or contraindication to itraconazole,voriconazole

NUEDEXTA

Products Affected

- NUEDEXTA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded by part D
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	neurology
Coverage Duration	12 months
Other Criteria	N/A

NUPLAZID

Products Affected

- NUPLAZID ORAL TABLET 17 MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurology Psychiatry
Coverage Duration	12 months
Other Criteria	Notes supporting dementia with hallucinations or delusions secondary to parkinsons dementia.

ODOMZO

Products Affected

- ODOMZO

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematology/Oncology
Coverage Duration	3 - 12 months
Other Criteria	Approval will initially be for three months, if patient has a response to therapy will be renewed for 12 months

OFEV

Products Affected

- OFEV

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	pulmonologist
Coverage Duration	12 months
Other Criteria	Confirmed Diagnosis of idiopathic pulmonary fibrosis (IPF) through exclusion of other fibrosing conditions/causes and definitive High resolution CT IPF pattern or Biopsy proven IPF. FVC of at least 50% of predicted value DLCO of at least 30%

OMNITROPE

Products Affected

- OMNITROPE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from part D
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, studies establishing diagnosis of indication.
Age Restrictions	Ages approved in FDA labeling
Prescriber Restrictions	Endocrinologist
Coverage Duration	12 months
Other Criteria	N/A

ONFI

Products Affected

- ONFI ORAL SUSPENSION
- ONFI ORAL TABLET 10 MG, 20 MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Diagnosis
Age Restrictions	FDA approved Ages
Prescriber Restrictions	Restricted to Neurology
Coverage Duration	12 Months
Other Criteria	N/A

OPSUMIT

Products Affected

- OPSUMIT

PA Criteria	Criteria Details
Covered Uses	All FDA approved uses not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	pulmonologist/cardiologist
Coverage Duration	12 months
Other Criteria	Failure of sildenafil and Bosentan

ORENITRAM

Products Affected

- ORENITRAM

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Right Heart catheterization to confirm the diagnosis
Age Restrictions	N/A
Prescriber Restrictions	Pulmonologist or Cardiologist
Coverage Duration	12 months
Other Criteria	Failure of combination sildenafil and bosentan

ORKAMBI

Products Affected

- ORKAMBI ORAL TABLET 200-125 MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	CFTR mutation analysis, spirometry
Age Restrictions	Ages approved in FDA label
Prescriber Restrictions	pulmonologist
Coverage Duration	12 months
Other Criteria	CFTR mutation must be supported by FDA approved label such as homozygous F508-deletion

OTEZLA

Products Affected

- OTEZLA ORAL TABLET
- OTEZLA ORAL TABLET THERAPY PACK

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of active psoriatic arthritis or moderate-to-severe plaque psoriasis.
Age Restrictions	N/A
Prescriber Restrictions	Rheumatologist, Dermatologist
Coverage Duration	12 months
Other Criteria	For Plaque Psoriasis patient must Enbrel and Simponi) or have a contraindication to TNF inhibitors and failed MTX and acitretin. For Psoriatic Arthritis patient must fail a preferred TNF inhibitor (simponi/xeljanz) and Xeljanz or have a contraindication to TNF inhibitors or Xeljanz and failed MTX and Leflunomide.

OXANDROLONE

Products Affected

- *oxandrolone oral tablet 2.5 mg*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

PHENOXYBENZAMINE

Products Affected

- *phenoxybenzamine hcl oral*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

POMALYST

Products Affected

- POMALYST

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	FDA contraindications
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematology/Oncology
Coverage Duration	12 months
Other Criteria	Approve for patients with multiple myeloma who have received at least two prior therapies including lenalidomide and bortezomib and have demonstrated disease progression on or within 60 days of completion of the last therapy

PROCRIT

Products Affected

- PROCRIT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from part D
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, Scr, HGB, T-sat, Ferritin
Age Restrictions	Ages approved in FDA labeling
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	Hemoglobin must be within FDA approved ranges for initiation and maintenance. Patient must have adequate iron stores to initiate and continue treatment. ESRD will be covered under Medicare Part B

PROLASTIN-C

Products Affected

- PROLASTIN-C INTRAVENOUS SOLUTION RECONSTITUTED 1000 MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 Year
Other Criteria	N/A

PROLIA

Products Affected

- PROLIA

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded by Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Intolerance or contraindication to injectable bisphosphonate required for coverage of prolia

PROMACTA

Products Affected

- PROMACTA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from part D
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical Notes, CBC ,Platelet count less than 50,000/ml for ITP, Platelet count of less than 75,000/ml for HCV
Age Restrictions	Ages approved in FDA labeling
Prescriber Restrictions	Hematologist/oncologist, Hepatologist, Infectious Disease
Coverage Duration	12 months
Other Criteria	Chronic ITP Refractory to IVIG, corticosteroids or splenectomy as per FDA approval studies not applicable to HCV related thrombocytopenia

PULMOZYME

Products Affected

- PULMOZYME

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from part D
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, Spirometry
Age Restrictions	Ages approved in FDA labeling
Prescriber Restrictions	Pulmonologist
Coverage Duration	12 months
Other Criteria	For Patients with Cystic Fibrosis who have had recurrent pulmonary infections

QUININE

Products Affected

- *quinine sulfate oral*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded by part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Notes supporting diagnosis of malaria

RANEXA

Products Affected

- RANEXA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from part D
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Recent Cardiology notes, previous treatment history for angina
Age Restrictions	Ages approved in FDA labeling
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Pt must fail one agent in two of the three following medication classes used for angina- Long acting nitrates including isosorbide dinitrate or isosorbide mononitrate, CCB including amlodipine and nifedapine and a Beta blocker metoprolol, atenolol, carvedilol, propranolol, labetalol.

RAVICTI

Products Affected

- RAVICTI

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	hepatologist or metabolic specialist such as a endocrinologist or geneticist
Coverage Duration	12 months
Other Criteria	Clinical Failure of Buphenyl

REBIF

Products Affected

- REBIF REBIDOSE SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- REBIF REBIDOSE TITRATION PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- REBIF SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- REBIF TITRATION PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Failure of glatiramer

REPATHA

Products Affected

- REPATHA
- REPATHA PUSHTRONEX SYSTEM
- REPATHA SURECLICK

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For patients with HoFH, HeFH, or with established atherosclerotic cardiovascular disease who require additional LDL lowering: Failure of rosuvastatin 40mg or Atorvastatin 80 combined with ezetimibe 10mg. Diagnosis of must be HeFH supported by Dutch Lipid Clinic Network criteria. Diagnosis of HOFH must be confirmed by genetic testing. Patients who are intolerant to rosuvastatin/ atorvastatin can use an alternative statin + Ezetimibe 10mg.For statin intolerant patients who required additional LDL lowering and have established cardiovascular disease, HoFH, or HeFH: History of statin intolerance to a hydrophillic statin such as fluvastatin, pravastatin, rosuvastatin in the absence of fibrates or other combinations which can increase risk of myopathy or myalgia when used in combination with a statin.

REVATIO

Products Affected

- *sildenafil citrate oral tablet 20 mg*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from part D
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history, 6 min walk, diffusion studies,Rt Heart Cath
Age Restrictions	Ages approved in FDA labeling
Prescriber Restrictions	Pulmonologist/Cardiologist
Coverage Duration	12 months
Other Criteria	Pulmonary hypertension must be diagnosed by heart catheterization ,Evaluation, EKG, diffusion studies, catheterization results and an objective test of exercise ability (6 minute walk) must be submitted with referral ,Coverage will be based on medical history/status, vasoreactivity tests.

REVLIMID

Products Affected

- REVLIMID

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from part D
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, CBC, Bone Marrow Biopsy, Karyotype
Age Restrictions	Ages approved in FDA labeling
Prescriber Restrictions	Hematologist/oncologist
Coverage Duration	12 months
Other Criteria	N/A

REXULTI

Products Affected

- REXULTI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12months
Other Criteria	Failure of aripiprazole and risperidone for schizophrenia or failure of combination SSRI and aripiprazole for major depressive disorder.

RILUTEK

Products Affected

- *riluzole*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history, associated studies
Age Restrictions	Ages approved in FDA labeling
Prescriber Restrictions	Neurologist
Coverage Duration	12 months
Other Criteria	Diagnosis is definite or probable ALS by Neurology, symptoms present for less than 5 years, Vital Capacity is 60% or more of predicted, patient does not have a tracheotomy

ROZEREM

Products Affected

- ROZEREM

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded by part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	failure of Zolpidem and one other medication used for insomnia, such as temazepam, zaleplon, doxepin, trazodone.

RUBRACA

Products Affected

- RUBRACA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncology/Hematology
Coverage Duration	12 months or until disease progression
Other Criteria	N/A

RYDAPT

Products Affected

- RYDAPT

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematology/Oncology
Coverage Duration	12 months or until progression
Other Criteria	Labs supporting FLT3 mutation if being used for AML, not required for systemic mastocytosis

SABRIL

Products Affected

- SABRIL ORAL TABLET
- *vigabatrin*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from part D
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes
Age Restrictions	Ages approved in FDA labeling
Prescriber Restrictions	Neurologist
Coverage Duration	12 months
Other Criteria	Patient must fail treat with adjunctive treatment combination (applies to Refractory Partial Complex only)

SAPHRIS

Products Affected

- SAPHRIS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from part D
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Diagnosis
Age Restrictions	Ages approved in FDA labeling
Prescriber Restrictions	Psychiatry/ Neurology
Coverage Duration	12 months
Other Criteria	N/A

SENSIPAR

Products Affected

- SENSIPAR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history, associated studies
Age Restrictions	Ages approved in FDA labeling
Prescriber Restrictions	Nephrologist/endocrinologist/oncologist
Coverage Duration	12 months
Other Criteria	For secondary hyperparathyroidism related to CKD, patient must fail active vit-D therapy/phosphate binders. ESRD use is excluded from medicare Part D and this authorization will include a determination of Part D vs Part B coverage based indication

SIGNIFOR

Products Affected

- SIGNIFOR

PA Criteria	Criteria Details
Covered Uses	All FDA approved uses not excluded form part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Endocrinologist
Coverage Duration	12 months
Other Criteria	For Cushings Disease Failed or poor surgical candidate for pituitary resection For Acromegaly Failed or poor surgical candidate for pituitary resection Failure of octreotide

SIMPONI

Products Affected

- SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/0.5ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For RA Patient must fail 3 month trial of MTX in combination with a DMARD in past 6 months. If MTX contraindicated, must try combination of 2-nonbiologic DMARDS. For Ankylosing Spondylitis PT must fail 2 NSAIDS within past 6 months. For Psoriatic Arthritis Patient must fail adequate trial of MTX or LEF in past 6 months. For ulcerative colitis patient must fail Azathioprine/6MP in combination with a 5-ASA compound.

SOLARAZE

Products Affected

- *diclofenac sodium transdermal gel 3 %*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from part D
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Diagnosis
Age Restrictions	Ages approved in FDA labeling
Prescriber Restrictions	Dermatologist, oncologist
Coverage Duration	12 months
Other Criteria	N/A

SOMATULINE

Products Affected

- SOMATULINE DEPOT

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded by Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	endocrinologist, oncologist , medical geneticist
Coverage Duration	12 Months
Other Criteria	Need clinical notes and labs supporting diagnosis of Acromegaly GH, IGF-1

SOMAVERT

Products Affected

- SOMAVERT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from part D
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes
Age Restrictions	Ages approved in FDA labeling
Prescriber Restrictions	Endocrinologist
Coverage Duration	12 months
Other Criteria	N/A

SPRYCEL

Products Affected

- SPRYCEL

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months or until disease progression
Other Criteria	N/A

STIVARGA

Products Affected

- STIVARGA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncology
Coverage Duration	12 months or until disease progression
Other Criteria	N/A

SUTENT

Products Affected

- SUTENT

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncology
Coverage Duration	12 months or until disease progression
Other Criteria	N/A

SYLATRON

Products Affected

- SYLATRON SUBCUTANEOUS KIT 200 MCG, 300 MCG, 600 MCG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from part D
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	N/A
Age Restrictions	Ages approved in FDA labeling
Prescriber Restrictions	oncology
Coverage Duration	12 months
Other Criteria	Must be used as adjuvant treatment within 84 days of surgical resection in patients with metastatic melanoma with nodal involvement

SYMLIN

Products Affected

- SYMLINPEN 120 SUBCUTANEOUS SOLUTION PEN-INJECTOR
- SYMLINPEN 60 SUBCUTANEOUS SOLUTION PEN-INJECTOR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history, HA1c BG
Age Restrictions	Ages approved in FDA labeling
Prescriber Restrictions	Endocrinologist, Internist
Coverage Duration	12 months
Other Criteria	Patient BG must be non-controlled on optimal doses of insulin

SYNAREL

Products Affected

- SYNAREL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from part D
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Diagnosis, Notes, Previous treatment history
Age Restrictions	Ages approved in FDA Label
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Covered after patient fails treatment with Lupron for endometriosis or precocious puberty

TAFINLAR

Products Affected

- TAFINLAR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months or until disease progression
Other Criteria	Mutation analysis showing BRAF V600E or V600K positive, not covered for combination use with other anti-neoplastics unless FDA indication or NCCN recommended with a class 2A or greater evidence rating.

TAGRISSO

Products Affected

- TAGRISSO

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematology/Oncology
Coverage Duration	12 months
Other Criteria	Coverage requires Diagnosis of Non Small Cell Lung cancer, progression on an EGRF TKI inhibitor, and confirmation of T790M mutation

TARCEVA

Products Affected

- TARCEVA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncology
Coverage Duration	12 months or until disease progression
Other Criteria	N/A

TARGRETIN

Products Affected

- TARGRETIN EXTERNAL

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncology
Coverage Duration	12 months or until disease progression
Other Criteria	N/A

TASIGNA

Products Affected

- TASIGNA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes
Age Restrictions	Ages approved in FDA labeling
Prescriber Restrictions	Hematologist/oncologist
Coverage Duration	12 months
Other Criteria	Covered for failure or relapse of CML when previously treated with imatinib. Covered for newly diagnosed CML patients who are Philadelphia chromosome +. Will also be covered for intolerance or adverse reaction to imatinib. Combination therapy with other tyrosine kinase inhibitors or MTOR inhibitors for CML is not supported.

TAZORAC

Products Affected

- *tazarotene external*
- TAZORAC EXTERNAL CREAM 0.05 %
- TAZORAC EXTERNAL GEL

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Previous treatment history
Age Restrictions	Ages approved in FDA labeling
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For Psoriasis patient must have failed medium to high potency topical corticosteroid, For acne patient must have failed Tretinoin and oral antibiotic

TECFIDARA

Products Affected

- TECFIDERA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurology
Coverage Duration	12 months
Other Criteria	Failure of Gilenya

TETRABENAZINE

Products Affected

- *tetrabenazine*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Neurology or Psychiatry
Coverage Duration	12 months
Other Criteria	For tardive dyskinesia causative drug must be discontinued or tried at a lower dose

THALOMID

Products Affected

- THALOMID

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	N/A
Age Restrictions	Ages approved in FDA labeling
Prescriber Restrictions	Hematologist/oncologist/infectious disease
Coverage Duration	12 months
Other Criteria	N/A

TOBI PODHALER

Products Affected

- TOBI PODHALER

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Medical notes describing indication for the management of cystic fibrosis patients with Pseudomonas aeruginosa and with forced expiratory volume in 1 second (FEV1) greater than 25% or less than 80%.
Age Restrictions	6 years and older
Prescriber Restrictions	N/A
Coverage Duration	Through benefit year
Other Criteria	Safety and efficacy have not been demonstrated in patients with forced expiratory volume in 1 second (FEV1) less than 25% or greater than 80%, or patients colonized with Burkholderia cepacia

TRACLEER

Products Affected

- TRACLEER

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, Right heart Catheterization, 6 Minute Walk time
Age Restrictions	Ages approved in FDA labeling
Prescriber Restrictions	Pulmonologist or cardiologist
Coverage Duration	12 months
Other Criteria	Pulmonary hypertension must be diagnosed by heart catheterization ,Evaluation, EKG, diffusion studies, catheterization results and an objective test of exercise ability (6 minute walk) must be submitted with referral ,Coverage will be based on medical history/status, vasoreactivity tests, failure of sildenafil. Sildenafil failure does not apply to pediatric patients with congental or ideopathic PAH

TRANSDERM-SCOP

Products Affected

- *scopolamine*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	4 weeks
Other Criteria	Failure of two oral anti-emetics

TRETINOIN CAPSULE

Products Affected

- TRETINOIN ORAL

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Diagnosis
Age Restrictions	Ages approved in FDA labeling
Prescriber Restrictions	Hematologist/oncologist
Coverage Duration	12 months
Other Criteria	N/A

TRETINOIN TOPICAL

Products Affected

- *tretinoin external cream*
- *tretinoin external gel 0.01 %, 0.025 %*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	FDA labeled contraindications, treatment of photoaging, wrinkles
Required Medical Information	Diagnosis
Age Restrictions	Ages approved in FDA labeling
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

TRINTELLIX

Products Affected

- TRINTELLIX

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Failure of two generically available anti-depressants within past 6 months

TYKERB

Products Affected

- TYKERB

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history, associated studies
Age Restrictions	Ages approved in FDA labeling
Prescriber Restrictions	Oncologist/hematologist
Coverage Duration	12 months
Other Criteria	Patient is using in combination with capecitabine for HER/NEU + Metastatic breast CA, having failed an anthracycline, Herceptin and a taxane, or Patient must be using in combination with an aromatase inhibitor and have HER/NEU+ HR+ metastatic breast CA

TYMLOS

Products Affected

- TYMLOS

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	FDA labeled contraindications/ cumulative tx more than 24month
Required Medical Information	Medical notes, previous treatment history, BMD, PTH, VITD
Age Restrictions	Late adolescents and Adults only
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Patient must fail or have contraindication to bisphosphonates, Vitamin D (25,OH), PTH must be WNL

UPTRAVI

Products Affected

- UPTRAVI

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Right heart catheterization supporting diagnosis of PAH
Age Restrictions	N/A
Prescriber Restrictions	Pulmonology or Cardiology
Coverage Duration	12 months
Other Criteria	diagnosis of WHO group 1 PAH, failure of bosentan and sildenafil,

VALCHOR

Products Affected

- VALCHLOR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncology
Coverage Duration	12 months or until disease progression
Other Criteria	N/A

VANCOMYCIN CAPSULES

Products Affected

- *vancomycin hcl oral*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Diagnostic confirmation of clostridium difficile diarrhea or staphylcoccal enterocolitis
Age Restrictions	N/A
Prescriber Restrictions	Gastroenterology, infectious disease, oncology
Coverage Duration	10 days
Other Criteria	Failure or contraindication to oral metronidazole

VENCLEXTA

Products Affected

- VENCLEXTA
- VENCLEXTA STARTING PACK

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Notes supporting Diagnosis and documentation of 17p deletion
Age Restrictions	N/A
Prescriber Restrictions	Hematology/Oncology
Coverage Duration	12 months
Other Criteria	N/A

VERZENIO

Products Affected

- VERZENIO

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematology/Oncology
Coverage Duration	12 months or clinical progresion
Other Criteria	N/A

VIMPAT

Products Affected

- VIMPAT ORAL

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	Neurology
Coverage Duration	12 months
Other Criteria	N/A

VORICONAZOLE

Products Affected

- *voriconazole intravenous*
- *voriconazole oral*

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded by Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	Covered when two of the following medications have been tried, unless resistance or contraindication precludes use, Itraconazole, fluconazole, ketoconazole. Exclusions to prerequisite medications are Invasive pulmonary aspergillosis, Scedosporium apiospermum, Fusarium

VOTRIENT

Products Affected

- VOTRIENT

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Oncology
Coverage Duration	12 months or until disease progression
Other Criteria	N/A

VRAYLAR

Products Affected

- VRAYLAR ORAL CAPSULE
- VRAYLAR ORAL CAPSULE THERAPY PACK

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Psychiatry or Neurology
Coverage Duration	12 months
Other Criteria	Requires failure of aripiprazole and risperidone.

XALKORI

Products Affected

- XALKORI

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from part D, locally advanced or metastatic ALK+ NSCLC
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, documentation support ALK+ NSLC or ROS1 Positive
Age Restrictions	Ages approved in FDA labeling
Prescriber Restrictions	Hematology-oncology
Coverage Duration	6 months
Other Criteria	Continuation will be based on lack of disease progression

XELJANZ

Products Affected

- XELJANZ
- XELJANZ XR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Rheumatology/Gastroenterologist
Coverage Duration	12 months
Other Criteria	For Rheumatoid arthritis- 3 month trial of Combination DMARD therapy in past 6 months, For Psoriatic Arthritis Patient must fail adequate trial of MTX or LEF in past 6 months. For ulcerative colitis patient must fail Azathioprine/6MP in combination with a 5-ASA compound.

XGEVA

Products Affected

- XGEVA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	oncology/endocrinology
Coverage Duration	12 months
Other Criteria	Failure or contraindication to bisphosphonate for osteolytic cancer indications other than giant cell tumor of the bone.

XOLAIR

Products Affected

- XOLAIR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical Notes, Previous treatment history, For asthma please submit RAST, aeroallergens results, IgE values
Age Restrictions	Ages approved in FDA labeling
Prescriber Restrictions	Pulmonologist, allergist, Dermatologist
Coverage Duration	12 months
Other Criteria	For Asthma patient Must Fail Combination LABA/ICS. For chronic ideopathic urticaria failure of hydroxyzine and H-2 antagonist.

XTANDI

Products Affected

- XTANDI

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months or until disease progression
Other Criteria	Failure of docetaxel and Abiraterone

XYREM

Products Affected

- XYREM

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded by part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Physician Board certified in Sleep Medicine or neurologist
Coverage Duration	12 months
Other Criteria	Failure of Modafanil/Armodafinil and amphetamine/dextroamphetamine or failure of fluoxetine for narcolepsy with cataplexy

ZAVESCA

Products Affected

- *miglustat*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history, associated studies
Age Restrictions	Ages approved in FDA labeling
Prescriber Restrictions	Oncologist/Hematologist, Neurologist, Medical Geneticist, Metabolic Specialist.
Coverage Duration	12 months
Other Criteria	Coverage will be based on medical history/status, response to previous treatments, and the consideration of other therapeutic options

ZEJULA

Products Affected

- ZEJULA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematology/Oncology
Coverage Duration	12 months or until progression
Other Criteria	Supporting BRCA results

ZELBORAF

Products Affected

- ZELBORAF

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from part D, Metastatic Melanoma Stage IIIC unresectable or Stage IV
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Ages approved in FDA labeling
Prescriber Restrictions	Oncology
Coverage Duration	3 months
Other Criteria	Authorization for continuation past 90 days will be based on absence of disease progression.

ZEMPLAR

Products Affected

- *paricalcitol oral*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical notes, previous treatment history, CA PO4, iPTH
Age Restrictions	Ages approved in FDA labeling
Prescriber Restrictions	Nephrologist/endocrinologist
Coverage Duration	12 months
Other Criteria	Patient must fail or have contraindication to Calcitriol or phosphate binder if appropriate

ZEPATIER

Products Affected

- ZEPATIER

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Gentotype, Viral Load, Fibroscan/Fibrosure or liver biopsy, RAV NS5A panel
Age Restrictions	N/A
Prescriber Restrictions	Infectious disease, Gastroenterology/Hepatology
Coverage Duration	12 or 16 weeks depending on RAV profile as supported by current AASLD guidelines
Other Criteria	Contraindication to GLECAPREVIR/PIBRENTASVIR

ZOLINZA

Products Affected

- ZOLINZA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Medical Notes
Age Restrictions	Ages approved in FDA labeling
Prescriber Restrictions	Oncologist/hematologist/dermatologist
Coverage Duration	12 months
Other Criteria	Failed minimum of two systemic treatments, one of which must be Targretin, unless contraindicated

ZYDELIG

Products Affected

- ZYDELIG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematology/Oncology
Coverage Duration	12 months or until disease progression
Other Criteria	N/A

ZYKADIA

Products Affected

- ZYKADIA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Hematology/Oncology
Coverage Duration	12 months or until disease progression
Other Criteria	Restricted to use in ALK+ Non Small Cell Lung Cancer

ZYPREXA INJECTION

Products Affected

- *olanzapine intramuscular*
- ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION RECONSTITUTED 210 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from part D
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Diagnosis
Age Restrictions	Ages approved in FDA labeling
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Failure of two generic anti-psychotics in the past 12 months

ZYTIGA

Products Affected

- ZYTIGA ORAL TABLET 250 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from part D
Exclusion Criteria	FDA labeled contraindications
Required Medical Information	Diagnosis
Age Restrictions	Ages approved in FDA labeling
Prescriber Restrictions	Oncology/urology
Coverage Duration	12 months
Other Criteria	N/A

PART B VERSUS PART D

These drugs may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination

Products Affected

- *acetylcysteine inhalation solution 10 %, 20 %*
- *acyclovir sodium intravenous solution 50 mg/ml*
- *albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, 0.63 mg/3ml, 1.25 mg/3ml*
- *amphotericin b injection solution reconstituted 50 mg*
- *azathioprine oral tablet 50 mg*
- BCG VACCINE INJECTION INJECTABLE
- *budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml, 1 mg/2ml*
- *cromolyn sodium inhalation nebulization solution 20 mg/2ml*
- *cyclophosphamide oral capsule 25 mg, 50 mg*
- *cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg*
- *cyclosporine modified oral solution 100 mg/ml*
- *cyclosporine oral capsule 100 mg, 25 mg*
- *duramorph injection solution 0.5 mg/ml, 1 mg/ml*
- ENGERIX-B INJECTION SUSPENSION 10 MCG/0.5ML, 20 MCG/ML
- HUMULIN R U-500 (CONCENTRATED) SUBCUTANEOUS SOLUTION 500 UNIT/ML
- *hydromorphone hcl injection solution 2 mg/ml*
- IMOVAX RABIES INTRAMUSCULAR INJECTABLE 2.5 UNIT/ML
- INTRALIPID INTRAVENOUS EMULSION 30 %
- *ipratropium bromide inhalation solution 0.02 %*
- *ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml*
- *magnesium sulfate injection solution 50 %*
- *mycophenolate mofetil oral capsule 250 mg*
- *mycophenolate mofetil oral suspension reconstituted 200 mg/ml*
- *mycophenolate mofetil oral tablet 500 mg*
- *mycophenolate sodium oral tablet delayed release 180 mg, 360 mg*
- NEBUPENT INHALATION SOLUTION RECONSTITUTED 300 MG
- *ondansetron hcl oral solution 4 mg/5ml*
- *ondansetron hcl oral tablet 4 mg, 8 mg*
- *ondansetron oral tablet dispersible 4 mg, 8 mg*
- PENTAM INJECTION SOLUTION RECONSTITUTED 300 MG
- *potassium chloride intravenous solution 2 meq/ml*
- RABAVERT INTRAMUSCULAR SUSPENSION RECONSTITUTED
- RAPAMUNE ORAL SOLUTION 1 MG/ML
- RECOMBIVAX HB INJECTION SUSPENSION 10 MCG/ML, 10 MCG/ML (1ML SYRINGE), 40 MCG/ML, 5 MCG/0.5ML
- *sirolimus oral tablet 0.5 mg, 1 mg, 2 mg*
- *tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg*
- ZORTRESS ORAL TABLET 0.25 MG, 0.5 MG, 0.75 MG

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FHCP Medicare
An Affiliate of Florida Blue

Section 1557 Notification: Discrimination is Against the Law

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

FHCP Medicare:

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

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

If you need these services, contact:

- FHCP Medicare : 1-833-866-6559

If you believe that FHCP Medicare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

FHCP Medicare
Civil Rights Coordinator
1340 Ridgewood Avenue
Holly Hill, FL 32117
Phone: 1-844-219-6137
TTY: 1-800-955-8770
Fax: 386-676-7149
Email: rights@fhcp.com

You can file grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

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

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FHCP Medicare
An Affiliate of Florida Blue

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-833-866-6559. (TTY: 1-800-955-8770)**

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-833-866-6559** (TTY: **1-800-955-8770**).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-833-866-6559 (TTY: 1-800-955-8770).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-833-866-6559 (TTY: 1-800-955-8770).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-833-866-6559 (TTY: 1-800-955-8770).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-833-866-6559

（TTY：1-800-955-8770）

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-833-866-6559 (ATS : 1-800-955-8770).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-833-866-6559 (TTY: 1-800-955-8770).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-833-866-6559 (телетайп: 1-800-955-8770).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-833-866-6559 (رقم هاتف الصم والبكم: 1-800-955-8770).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-833-866-6559 (TTY: 1-800-955-8770).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-833-866-6559 (TTY: 1-800-955-8770).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-833-866-6559 (TTY: 1-800-955-8770)번으로 전화해 주십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-833-866-6559 (TTY: 1-800-955-8770).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-833-866-6559 (TTY: 1-800-955-8770).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-833-866-6559 (TTY: 1-800-955-8770).