PRIOR AUTHORIZATION CRITERIA

This list is current as of 11/01/2015 and pertains to the following formularies:

Independent Health's 2015 Medicare Advantage Individual Part D Formulary	Version 27
Independent Health's 2015 Medicare Advantage Employer Group's Part D Formulary	Version 27
Independent Health's 2015 Medicare Advantage Dual Difference HMO-SNP Formulary	Version 31

Independent Health requires you (or your physician) to get prior authorization for certain drugs listed on our Medicare Advantage Part D formularies. This means that you will need to get approval from us before you fill your prescriptions. If you do not get approval, we may not cover the drug. These drugs are listed with a "PA" in the Requirements/Notes column on the formularies. This document contains the Prior Authorization requirements that are associated with our Medicare Advantage Part D formularies.

Drugs listed under the section "PART B VERSUS PART D" may be covered under Medicare Part B or Part D depending on the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

If you have any questions, please contact Independent Health's Medicare Member Services Department at 1-800-665-1502 or, for TTY users, 1-800-432-1110, October 1st – February 14th: Monday through Sunday from 8 a.m. to 8 p.m., February 15th – September 30th: Monday through Friday from 8 a.m. to 8 p.m.

Independent Health is a Medicare Advantage organization with a Medicare contract offering HMO, HMO-SNP, HMO-POS and PPO plans. Enrollment in Independent Health depends on contract renewal.

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

Verbal translation of written materials is available via free interpreter services. For those with special needs, accessibility to benefit information or alternate formats of written materials are available upon request. If you have any questions, we are able to help. Please call Member Services at the number above.

ACTEMRA SQ

Products Affected

- ACTEMRA SUBCUTANEOUS*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use. TB skin test result obtained within past six months, number of swollen and tender joints, laboratory values to include rheumatoid factor, sed rate, CRP, ANC, platelet count, ALT, AST, and previous trial of at least one DMARD.
Age Restrictions	18 YO or older
Prescriber Restrictions	Limited to Rheumatologists
Coverage Duration	Up to one year
Other Criteria	Continuation of therapy requires submission of objective documentation of positive patient response including effect on number of swollen and tender joints, CRP, rheumatoid factor and/or sed rate. Submission of updated TB skin test result obtained withing the past 12 months and submission of updated ANC, platelet count, ALT and AST.

ACTHAR HP

Products Affected

- HP ACTHAR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Acthar gel requested for IV administration, treatment of patients under 2 years of age in whom congenital infections are suspected, patients diagnosed with scleroderma, osteoporosis, systemic fungal infections, ocular herpes simplex, patients with a history of recent surgery, patients with a history of or the presence of a peptic ulcer, congestive heart failure (CHF), uncontrolled hypertension, primary adrenocortical insufficiency, adrenocortical hyperfunction, sensitivity to proteins of porcine origin "
Required Medical Information	Diagnosis of covered use, submission of patient height and weight, submission of blood pressure reading
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	one year
Other Criteria	If the medication is being obtained at a retail pharmacy, it may be covered under Part D provided the following conditions are satisfied:If a physician is administering the medication, he/she agrees to accept brown bagging of the medication and understands that the enrollee will obtain the medication from a pharmacy and have it in their possession until the enrollee delivers the medication to the physician office for administration, if the medication is being self-administered documentation is provided that the enrollee has been fully trained on how to prepare the injection and to administer the medication safely and effectively if applicable. If these conditions are not satified this medication may be covered under Part B in accordance with the corresponding NCD/LCD if applicable

Adagen

Products Affected

- ADAGEN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Medication is being requested as preparatory or support therapy for bone marrow transplantation, severe thrombocytopenia
Required Medical Information	Diagnosis of covered use,submission of plasma ADA activity and red blood cell dATP level and confirmation these laboratory values are scheduled to be obtained in accordance with the prescribing information,submission of body weight, submission of platelet count
Age Restrictions	Adagen is not approved for the treatment of adult patients
Prescriber Restrictions	
Coverage Duration	Remainder of the contract year
Other Criteria	If the medication is being obtained at a retail pharmacy, it may be covered under Part D provided the following conditions are satisfied:If a physician is administering the medication, he/she agrees to accept brown bagging of the medication and understands that the enrollee will obtain the medication from a pharmacy and have it in their possession until the enrollee delivers the medication to the physician office or clinic for administration, if the medication is being self-administered documentation is provided that the enrollee has been fully trained on how to prepare the injection and to administer the medication safely and effectively if applicable. If these conditions are not satified this medication may be covered under Part B.

ADCIRCA

Products Affected

- ADCIRCA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	diagnosis of severe (Child Pugh Class C) hepatic impairment
Required Medical Information	Diagnosis of covered use, patient weight and serum creatinine
Age Restrictions	
Prescriber Restrictions	Limited to Pulmonology/ Cardiology
Coverage Duration	Indefinite
Other Criteria	None

ADEMPAS

Products Affected

- ADEMPAS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Pregnancy,concurrent use with nitrates or nitric oxide donors in any form, concurrent use with phosphodiesterase (PDE) inhibitors
Required Medical Information	Diagnosis of covered use, negative pregnancy test result for female patients of childbearing age, submsission of documentation that female patient of childbearing age will have monthly pregenancy tests while on therapy and the month following therapy discontinuation, submission of patient weight and serum creatinine (to calculate creatinine clearance)
Age Restrictions	18 YO or older
Prescriber Restrictions	Limited to pulmonologists and cardiologists
Coverage Duration	Indefinite
Other Criteria	

AFINITOR

Products Affected

- AFINITOR
- AFINITOR DISPERZ

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use and if prescribed for the treatment of renal cell carcinoma, documented prior use of sunitinib or sorafenib
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	None

AFREZZA

Products Affected

- AFREZZA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Chronic lung disease, such as asthma or COPD, patient who has demonstrated previous hypersensitivity to regular human insulin or any of the Afrezza excipients
Required Medical Information	Diagnosis of covered use, submission of current HbA1C, documentation that an assessment of pulmonary function (spirometry) including baseline FEV1 and physical examination has been performed to identify potential lung disease, documentation that the patient has been trained on device and administration and signs/symptoms of hypoglycemia, if being requested for the treatment of a Type I diabetic patient-documentation is submitted confirming Afrezza is being used with a long-acting insulin, documentation that Afrezza is not being requested for the for the treatment of diabetic ketoacidosis or for a patient who smokes, submission of baseline serum potassium level
Age Restrictions	18 years and older
Prescriber Restrictions	Limited to Endocrinologists
Coverage Duration	one year
Other Criteria	Submission of documentation that pulmonary function will be assessed after the first 6 months of therapy and annually thereafter, even in the absence of pulmonary symptoms.In patients with active lung cancer or a prior history of lung cancer documentation that the prescriber feels the benefits of therapy outweigh the potential risks.

ALDARA

Products Affected

- ALDARA
- *imiquimod external*
- ZYCLARA
- ZYCLARA PUMP EXTERNAL CREAM 2.5 %

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of Covered Use
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Actinic keratosis,Genital and perianal warts- 16 weeks Superficial basal cell carcinoma- 6 weeks
Other Criteria	Physicians who specialize in the treatment of medical conditions most commonly treated with this medication are exempt from prior authorization.

ALGLUCOSIDASE

Products Affected

- LUMIZYME
- MYOZYME

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of Covered Use
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	If the medication is being obtained at a retail pharmacy, it may be covered under Part D provided the following conditions are satisfied:If a physician is administering the medication, he/she agrees to accept brown bagging of the medication and understands that the enrollee will obtain the medication from a pharmacy and have it in their possession until the enrollee delivers the medication to the physician office for administration, if the medication is being self-administered by the enrollee documentation is provided that the member has been fully trained on how to prepare the medication for injection and to administer the medication safely and effectively if applicable.If these conditions are not satified this medication may be covered under Part B in accordance with the corresponding NCD/LCD if applicable.

AMPYRA

Products Affected

- AMPYRA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	History of seizure disorder, moderate or severe renal impairment (CrCl less than or equal to 50ml/min)
Required Medical Information	Diagnosis of Covered Use and Lab values including serum creatinine and patient weight, objective measurement of walking speed
Age Restrictions	18 YO or older
Prescriber Restrictions	Limited to neurology
Coverage Duration	Two months, then every year
Other Criteria	

Antifungal

Products Affected

- *itraconazole oral*
- SPORANOX
- SPORANOX PULSEPAK

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of Covered Use, fungal culture result identifying causative organism or positive KOH result
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Months
Other Criteria	Infectious Disease are exempt from prior authorization.

ARANESP

Products Affected

- ARANESP (ALBUMIN FREE) INJECTION SOLUTION 10 MCG/0.4ML, 100 MCG/0.5ML, 100 MCG/ML, 150 MCG/0.3ML, 200 MCG/0.4ML, 200 MCG/ML, 25 MCG/0.42ML, 25 MCG/ML, 300 MCG/0.6ML, 300 MCG/ML, 40 MCG/0.4ML, 40 MCG/ML, 500 MCG/ML, 60 MCG/0.3ML, 60 MCG/ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of Covered Use. Lab values from bloodwork indicating hemoglobin and iron levels. Blood pressure is also required.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Months
Other Criteria	None

ARCALYST

Products Affected

- ARCALYST

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of Covered Use, TB skin test result obtained within the past six months
Age Restrictions	12 YO
Prescriber Restrictions	
Coverage Duration	up to 1 year
Other Criteria	None

AUBAGIO

Products Affected

- AUBAGIO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	pregnancy
Required Medical Information	Diagnosis of covered use,TB skin test result, baseline blood pressure reading, laboratory values including:ALT, bilirubin, CBC
Age Restrictions	18 YO or older
Prescriber Restrictions	Limited to neurology
Coverage Duration	one year
Other Criteria	

BELEODAQ

Products Affected

- BELEODAQ

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of covered medical use, submission of baseline CBC including ANC, RBC and platelet count, submission of baseline serum chemistry tests including renal (BUN and serum creatinine) and hepatic (bilirubin, AST and ALT) functions, confirmation CBC will be monitored weekly while on therapy and that serum chemistry tests including renal and hepatic functions will be obtained prior to the start of the first dose of each cycle, submission of patient's height and current weight to calculate BSA to confirm dosage,confirmation of the presence or absence of the UGT1A1*28 allele
Age Restrictions	18 YO or older
Prescriber Restrictions	limited to hematology and oncology
Coverage Duration	1 year
Other Criteria	If the medication is being obtained at a retail pharmacy, it may be covered under Part D provided the following conditions are satisfied:The provider administering the medication agrees to accept brown bagging of the medication and understands that the enrollee will obtain the medication from a pharmacy and have it in their possession until the enrollee delivers the medication to the physician office for administration. If these conditions are not satified this medication may be covered under Part B in accordance with the corresponding NCD/LCD if applicable or this clinical criteria.

BERINERT

Products Affected

- BERINERT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	History of life-threatening immediate hypersensitivity reactions, including anaphylaxis, to C1 esterase inhibitor preparations
Required Medical Information	Diagnosis of covered medical use, submission of documentation that epinephrine will be immediately available in the event of an acute severe hypersensitivity reaction, and submission of patient's current weight for the purposes of dosage verification.
Age Restrictions	12 YO and older
Prescriber Restrictions	
Coverage Duration	One Year
Other Criteria	This medication may be covered as a Part D benefit if the patient is self-administering the medication and documentation is submitted stating that the patient has been provided instruction and training for self-administration outside of a clinic setting by their healthcare provider or if the provider is administering the medication in the office or infusion center and it is being obtained at a retail pharmacy, it may be covered under Part D provided the following conditions are satisfied: The physician/health care provider agrees to accept brown bagging of the medication and understands that the enrollee will obtain the medication from a pharmacy and have it in their possession until the enrollee delivers the medication to the physician office or infusion center for administration. This medication may be covered under Part B if obtained and administered by a physician incident to a physician service if the clinical criteria is met.

Bisphosphonate injection

Products Affected

- *pamidronate disodium intravenous* solution*
- RECLAST
- *zoledronic acid intravenous* concentrate*
- *zoledronic acid intravenous* solution 5 mg/100ml*
- ZOMETA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	For Reclast- creatinie clearance less than 35ml/min, fror all zolendronic acid products-pregnancy
Required Medical Information	Diagnosis of covered use for all products and for Reclast- submission of patient weight and serum creatinine level, submsission of serum calcium level, submission of serum alkaline phosphatase level for treatment of Paget's disease, documentation patient will receive supplemental calcium and Vitamin D, For Zometa-submission of serum calcium level, For pamidronate-submission of serum calcium, magnesium, potassium, creatinine, Hgb and HCT levels, submission of serum alkaline phosphatase level for Paget's disease,
Age Restrictions	18 YO or older
Prescriber Restrictions	
Coverage Duration	remainder of the contract year

PA Criteria	Criteria Details
Other Criteria	If the medication is being obtained at a retail pharmacy or furnished directly to the patient, it may be covered under Part D provided the following conditions are satisfied:A healthcare professional is administering the medication and he/she agrees to accept brown bagging of the medication and understands that the enrollee will obtain the medication from a pharmacy and have it in their possession until the enrollee delivers the medication to the physician office, infusion center or homecare provider for administration If these conditions are not satified this medication may be covered under Part B. Zoledronic acid 5mg/100ml and Recalst 5mg/100ml may be covered under Part B, for women with osteoporosis who meet the criteria for the Medicare home health benefit and have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis. A doctor must certify that the woman is unable to learn how to or unable to give herself the drug by injection.

Boniva injection

Products Affected

- BONIVA INTRAVENOUS*
- *ibandronate sodium intravenous**

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Patients with severe renal impairment (serum creatinie greater than 2.3mg/dL or creatinine clearance less than 30 mL/min), requests for self-administration of this medication, uncorrected hypocalcemia
Required Medical Information	Medication is being administered for one of the following indications-treatment of osteoporosis in postmenopausal women, corticosteroid-induced osteoporosis, Paget's disease or bone metastases in patients with prostate cancer, confirmation of osteoporosis diagnosis either through densitometry (T-score less than or equal to -2.5 at the total hip, femoral neck or lumbar spine) or clinically (documented presence of fragility fracture), submission of patient weight and serum creatinine level,submission of serum calcium level,documentation patient is taking supplemental calcium and vitamin D, submission of documentation stating why the IV formulation of Boniva is being given as opposed to the oral form of the drug which demonstrates one of the following-patient has a diagnosis of esophageal stricture, achalasia, or other severe esophageal dysmotility disorder or patient has a history of severe malabsorption making the use of oral bisphosphonates ineffective or patient has the inability to stand or sit upright for 60 minutes or patient has documented adverse effects following the initiation of treatment with the oral form of the medication that required the discontinuation of the oral form of the medication
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Remainder of the contract year

PA Criteria	Criteria Details
Other Criteria	If the medication is being obtained at a retail pharmacy or furnished directly to the patient, it may be covered under Part D provided the following conditions are satisfied:A healthcare professional is administering the medication and he/she agrees to accept brown bagging of the medication and understands that the enrollee will obtain the medication from a pharmacy and have it in their possession until the enrollee delivers the medication to the physician office, infusion center or homecare provider for administration If these conditions are not satified this medication may be covered under Part B. This medication may be covered under Part B, for women with osteoporosis who meet the criteria for the Medicare home health benefit and have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis. A doctor must certify that the woman is unable to learn how to or unable to give herself the drug by injection.

Bosulif

Products Affected

- BOSULIF

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, documentation of resistance or intolerance to at least one prior therapy
Age Restrictions	18 YO or older
Prescriber Restrictions	Limited to oncologist/hematologist
Coverage Duration	indefinite
Other Criteria	None

CARBAGLU

Products Affected

- CARBAGLU

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use and lab values including plasma ammonia leve
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	None

CERDELGA

Products Affected

- CERDELGA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Patients who are CYP2D6 extensive metabolizers (EMs) and intermediate metabolizers (IMs) taking a strong CYP2D6 inhibitor with a strong or moderate CYP3A inhibitor, CYP2D6 IMs and PMs (poor metabolizers) taking a strong CYP3A inhibitor
Required Medical Information	Diagnosis of covered use, CYP2D6 metabolizer status as detected by an FDA-cleared test for determining CYP2D6 genotype, submission of patient's current weight and serum creatinine level or eGFR, submission of baseline ECG
Age Restrictions	18 YO or older
Prescriber Restrictions	
Coverage Duration	one year
Other Criteria	

CEREZYME

Products Affected

- CEREZYME INTRAVENOUS* SOLUTION RECONSTITUTED 400 UNIT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of patient body weight,documentation that Gaucher disease results in one or more of the following conditions-anemia (HGB less than10 g/dL for females, Hgb less than 11 g/dL for males-submission of Hgb required), thrombocytopenia (platelet count less than 100,000/uL-submission of platelet count required),bone disease other than Erlenmeyer flask deformity or mild osteopenia or significant hepatomegaly or splenomegaly as evidenced by MRI or CT scan results showing that spleen is 5 times normal size or liver is 1.25 times normal size,documentation that the healthcare setting and providers are prepared to manage hypersensitivity reactions including anaphylaxis
Age Restrictions	2 YO and older
Prescriber Restrictions	
Coverage Duration	indefinite

PA Criteria	Criteria Details
Other Criteria	If the medication is being obtained at a retail pharmacy or furnished directly to the patient, it may be covered under Part D provided the following conditions are satisfied:A a health care provider is administering the medication and he/she agrees to accept brown bagging of the medication and understands that the enrollee will obtain the medication from a pharmacy and have it in their possession until the enrollee delivers the medication to the physician office, infusion center or to the home care provider for administration If these conditions are not satified this medication may be covered under Part B.

CESAMET

Products Affected

- CESAMET

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation of chemotherapy that causes nausea. Documentation that at least one other agent to prevent nausea has been tried and has not controlled the nausea.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	None

CHENODAL

Products Affected

- CHENODAL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, patient weight, submission of the following laboratory values: AST, ALT, serum cholesterol
Age Restrictions	18 YO or older
Prescriber Restrictions	
Coverage Duration	24 months
Other Criteria	

Chorionic gonadotropin

Products Affected

- *chorionic gonadotropin intramuscular**
- *novarel*
- *pregnyl*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	None

CIMZIA

Products Affected

- CIMZIA
- CIMZIA PREFILLED

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded by Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, TB skin test result obtained within the past six months,able to self-inject and for Rhematoid arthritis-laboratory values to include CRP, sed rate, rheumatoid factor, number of swollen joints, number of tender joints and previous trial of at least one DMARD and for Crohn's disease-previous trial of at least one corticosteroid or one immunosuppressive agent (azathioprine or 6-mercaptopurine)
Age Restrictions	18 YO or older
Prescriber Restrictions	limited to rheumatologist or gastroenterologist
Coverage Duration	Up to one year
Other Criteria	

CINRYZE

Products Affected

- CINRYZE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded by Part D
Exclusion Criteria	
Required Medical Information	diagnosis of covered use,
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	indefinite
Other Criteria	If the medication is being obtained at a retail pharmacy, it may be covered under Part D provided the following conditions are satisfied:A physician/health care provider is administering the medication and he/she agrees to accept brown bagging of the medication and understands that the enrollee will obtain the medication from a pharmacy and have it in their possession until the enrollee delivers the medication to the physician office or infusion center for administration. This medication may be covered under Part B if administered by a physician incident to a physician service.

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 medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, baseline blood pressure reading, baseline laboratory values including urine protein values,serum bilirubin level, AST, ALT , documentation that patient will be monitored for symptoms of GI perforation and fistulas, documnetation that patient does not have recent history of hemorhage or hemoptysis, baseline oral examination results and confirmation oral exams will be performed periodically during therapy
Age Restrictions	18 YO or older
Prescriber Restrictions	Limited to oncology or hematology
Coverage Duration	indefinite
Other Criteria	

CORLANOR

Products Affected

- CORLANOR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Acute decompensated heart failure, Blood pressure less than 90/50 mmHg,Sick sinus syndrome, sinoatrial block or 3rd degree AV block- unless a functioning demand pacemaker is present, Resting heart rate less than 60 bpm prior to treatment, Severe hepatic impairment,Pacemaker dependence (heart rate maintained exclusively by the pacemaker)
Required Medical Information	Diagnosis of covered use described as is indicated to reduce the risk of hospitalization for worsening heart failure in patients with stable, symptomatic chronic heart failure with left ventricular ejection fraction less than or equal to 35%, who are in sinus rhythm with resting heart rate greater than or equal to 70 beats per minute and either are on maximally tolerated doses of beta-blockers or have a contraindication to beta-blocker use,submission of current baseline blood pressure reading, confirmation that patient does not have any of the following: Acute decompensated heart failure, Sick sinus syndrome, sinoatrial block or 3rd degree AV block- unless a functioning demand pacemaker is present, Resting heart rate less than 60 bpm prior to treatment, Severe hepatic impairment or Pacemaker dependence (heart rate maintained exclusively by the pacemaker)
Age Restrictions	18yo or older
Prescriber Restrictions	Requested by or under the documented recommendation of a cardiologist
Coverage Duration	One Year
Other Criteria	

COSENTYX

Products Affected

- COSENTYX
- COSENTYX SENSOREADY PEN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, documentation that the patient is a candidate for systemic therapy or phototherapy, confirmation of moderate to severe plaque psoriasis disease severity defined as a minimum body surface area involvement of 10 % and PASI (Psoriasis Area and Severity Index) Score greater than or equal to 12, documentation that the patient has received all age appropriate immunizations according to current immunization guidelines, documentation that the patient has been evaluated for tuberculosis (TB) via skin test result obtained within the past six months for tuberculosis (TB) infection prior to initiating treatment.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Limited to Dermatologists
Coverage Duration	one year

PA Criteria	Criteria Details
Other Criteria	If the medication is being obtained at a retail pharmacy or furnished directly to the patient, it may be covered under Part D provided the following conditions are satisfied:A healthcare professional is administering the medication and he/she agrees to accept brown bagging of the medication and understands that the enrollee will obtain the medication from a pharmacy and have it in their possession until the enrollee delivers the medication to the physician office, infusion center or homecare provider for administration or the healtcare provider deems it appropriate for the patient to self-inject after proper instruction in subcutaneous injection technique using the Sensoready pen or prefilled syringe. If these conditions are not satified this medication may be covered under Part B. The lyophilized powder for reconstitution is only authorized for healthcare provider use.Cosentyx 150mg may be considered for patients with lower body weight and lower disease severity.Cosentyx is not authorized for patients with active TB infection. Treatment of latent TB should be initiated prior to adminsitering Cosentyx.

CYRAMZA

Products Affected

- CYRAMZA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of covered medical use, if used for treatment of advanced gastric or gastro-esophageal junction adenocarcinoma, documentation of disease progression on or after prior fluopyrimidine or platinum containing regimen, if for treatment of metastatic NSCLC with disease progression on or after platinum-based chemotherapy, if for the treatment of metastataic colorectal cancer, documentation of disease progression on or after prior therapy with bevacizumba, oxaliplatin, and a fluoropyrimidine. Submission of documentation that the Patient will be pretreated with an IV H1 antagonist and if appropriate dexamethasone and APAP. Submission of baseline blood pressure, baseline urinary protein level, baseline thyroid function tests including TSH, patient weight and confirmation patient will be monitored while on therapy for the development of hemorrhage, arterial thromboembolic events, hypertension,GI perforations, impaired wound healing, proteinuria and thyroid dysfunction
Age Restrictions	18 YO or older
Prescriber Restrictions	Limited to Hematology/Oncology Prescribers
Coverage Duration	one year

PA Criteria	Criteria Details
Other Criteria	If the medication is being obtained at a retail pharmacy, it may be covered under Part D provided the following conditions are satisfied:If a physician or health care provider is administering the medication, he/she agrees to accept brown bagging of the medication and understands that the enrollee will obtain the medication from a pharmacy and have it in their possession until the enrollee delivers the medication to the physician office, infusion center or homecare provider for administration.If these conditions are not satified this medication may be covered under Part B in accordance with this criteria and/or an applicable NCD/LCD.

CYSTARAN

Products Affected

- CYSTARAN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded by Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	

Cytovene

Products Affected

- CYTOVENE
- *ganciclovir sodium*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Patients with documented hypersensitivity to ganciclovir or acyclovir.
Required Medical Information	Diagnosis of covered use, submission of patient weight and serum creatinine level, submission of CBC and platelet count, submission of documentation that the potential benefits outweigh the risks when prescribed for the treatment of patients less than 18 years of age
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Remainder of the contract year
Other Criteria	If the medication is being obtained at a retail pharmacy, it may be covered under Part D provided the following conditions are satisfied:A a health care provider is administering the medication and he/she agrees to accept brown bagging of the medication and understands that the enrollee will obtain the medication from a pharmacy and have it in their possession until the enrollee delivers the medication to the physician office, infusion center or to the home care provider for administration If these conditions are not satified this medication may be covered under Part B.

DAKLINZA

Products Affected

- DAKLINZA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	concomitant use with strong CYP3A inducers, including phenytoin, carbamazepine, rifampin, and St. John's wort
Required Medical Information	Diagnosis of covered use and laboratory confirmation of hepatitis C virus (HCV) genotype 3 infection, submission of baseline HCV RNA level, documentation of whether cirrhosis is present or not, confirmation patient will receive concurrent sofosbuvir therapy
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	12 weeks
Other Criteria	Coadministration of amiodarone with Daklinza in combimnation with sofosbuvir is not recommended. In patients with no alternative treatments options, cardiac moniotring is recommended and confirmation that such monitoring will be performed is required

Denosumab

Products Affected

- PROLIA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Hypocalcemia, pregnancy, documented hypersensitivity to denosumab
Required Medical Information	Prolia is being requested for one of the following indications-treatment of postmenopausal women with confirmed diagnosis of osteoporosis at high risk for fracture, treatment to increase bone mass in men with osteoporosis at high risk for fracture, treatment to increase bone mass in men at high risk for frature receiving androgen deprivation therapy for nonmetastatic prostate cancer, treatment to increase bone mass in women at high risk for fracture receiving adjuvant aromatase inhibitor therapy for breast cancer, confirmation of osteoporosis diagnosis either through densitometry (T-score less than or equal to -2.5 at the total hip, femoral neck or lumbar spine) or clinically (documented presence of fragility fracture), high risk for frature is defined as a history of osteoporotic fracture or multiple risk factors for fracture or patients who have failed or are intolerant of other available osteoporosis therapy, submission of serum calcium level, documentation patient will receive supplemental calcium and vitamin D
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Remainder of the contract year

PA Criteria	Criteria Details
Other Criteria	If the medication is being obtained at a retail pharmacy or furnished directly to the patient, it may be covered under Part D provided the following conditions are satisfied:A healthcare professional is administering the medication and he/she agrees to accept brown bagging of the medication and understands that the enrollee will obtain the medication from a pharmacy and have it in their possession until the enrollee delivers the medication to the physician office, infusion center or homecare provider for administration If these conditions are not satified this medication may be covered under Part B.

DIFICID

Products Affected

- DIFICID

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use
Age Restrictions	18 YO or older
Prescriber Restrictions	
Coverage Duration	One course of therapy (10 days)
Other Criteria	None

DUOPA

Products Affected

- DUOPA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	DUOPA is contraindicated in patients taking nonselective monoamine oxidase (MAO) inhibitors
Required Medical Information	Diagnosis of covered use and confirmation patient has a naso-jejunal tube for short-term administration or a PEG-J for long-term administration.
Age Restrictions	18yo or older
Prescriber Restrictions	Limited to Neurology prescribers
Coverage Duration	One year
Other Criteria	

EGRIFTA

Products Affected

- EGRIFTA SUBCUTANEOUS*
  SOLUTION RECONSTITUTED 2 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Pregnancy
Required Medical Information	Diagnosis of covered use, patient weight, patient waist circumference
Age Restrictions	18 YO or older
Prescriber Restrictions	
Coverage Duration	up to one year
Other Criteria	none

Elderly High Risk

Products Affected

- ACTIVELLA
- ALORA
- *amitriptyline hcl oral*
- AMRIX
- ANAFRANIL
- ANGELIQ
- ARBINOXA
- *ascomp-codeine*
- *benztropine mesylate oral*
- BUPAP ORAL TABLET 50-300 MG
- *butalbital-acetaminophen*
- *butalbital-apap-caff-cod*
- *butalbital-apap-caffeine oral capsule*
- *butalbital-apap-caffeine oral tablet 50-325-40 mg*
- *butalbital-asa-caff-codeine*
- *butalbital-aspirin-caffeine oral capsule*
- CAPACET
- *carbinoxamine maleate oral*
- *chlordiazepoxide-amitriptyline*
- *chlorpropamide*
- *chlorzoxazone oral*
- *clemastine fumarate oral syrup*
- *clemastine fumarate oral tablet 2.68 mg*
- CLIMARA
- CLIMARA PRO
- *clomipramine hcl oral*
- COMBIPATCH
- *cyclobenzaprine hcl oral*
- *cyproheptadine hcl oral*
- *digitek oral tablet 250 mcg*
- *digoxin injection*
- *digoxin oral tablet 250 mcg*
- *diphenhydramine hcl oral elixir*
- *dipyridamole oral*
- *disopyramide phosphate oral*
- DIVIGEL TRANSDERMAL 0.5 MG/0.5GM
- *doxepin hcl oral*
- DUAVEE
- ELESTRIN
- ENJUVIA
- ESGIC ORAL TABLET
- ESTRACE ORAL
- *estradiol oral*
- *estradiol transdermal*
- *estradiol-norethindrone acet*
- *estropipate oral*
- EVAMIST
- FEMHRT LOW DOSE
- FEXMID
- FIORICET ORAL CAPSULE
- FIORICET/CODEINE ORAL CAPSULE 50-300-40-30 MG
- FIORINAL
- FIORINAL/CODEINE #3
- *guanfacine hcl er*
- *guanfacine hcl oral*
- *imipramine hcl oral*
- IMIPRAMINE PAMOATE
- INDOCIN ORAL
- *indomethacin er*
- *indomethacin oral*
- INTUNIV
- *jinteli*
- *ketorolac tromethamine oral*
- LANOXIN INJECTION
- LANOXIN ORAL TABLET 0.25 MG, 187.5 MCG
- *lopreeza*
- *margesic*
- MENEST
- MENOSTAR
- *meprobamate*
- *metaxalone*
- *methyldopa oral*
- *methyldopa-hydrochlorothiazide*
- *mimvey*
- *mimvey lo*
- MINIVELLE
- *nifedipine oral*
- *norethindrone-eth estradiol*

- NORPACE
- NORPACE CR
- *perphenazine-amitriptyline*
- PERSANTINE
- *phenadoz suppository 12.5 mg*
- PHENERGAN
- *phenobarbital oral elixir*
- *phenobarbital oral tablet*
- PREFEST
- PREMARIN ORAL
- PREMPHASE
- PREMPRO
- PROCARDIA
- *promethazine hcl injection*
- *promethazine hcl oral syrup*
- *promethazine hcl oral tablet*
- *promethazine hcl suppository*
- *promethazine vc plain*
- *promethegan suppository 25 mg, 50 mg*
- RESERPINE ORAL TABLET 0.25 MG
- SECONAL
- SKELAXIN
- SPRIX
- SURMONTIL
- TALWIN
- TENCON ORAL TABLET 50-325 MG
- TENEX
- *thioridazine hcl oral*
- *ticlopidine hcl*
- TIGAN ORAL
- TOFRANIL
- TOFRANIL-PM
- *trihexyphenidyl hcl*
- *trimethobenzamide hcl oral*
- VANATOL LQ
- VIVELLE-DOT
- ZEBUTAL ORAL CAPSULE 50-325-40 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	All three of the following criteria are met: 1) Diagnosis of covered use, 2) documentation that provider is aware medication is considered a high risk medication for elderly patients according to the Centers for Medicare and Medicaid services, and 3) documentation that the benefits of the identified drug outweigh the potential risks to the patient.
Age Restrictions	65 YO and older applies to PA, no PA for 64yo and younger
Prescriber Restrictions	
Coverage Duration	Indefinite

PA Criteria	Criteria Details
Other Criteria	

EMSAM

Products Affected

- EMSAM

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of Covered Use
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	None

ENBREL

Products Affected

- ENBREL
- ENBREL SURECLICK

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use,TB skin test result obtained within the past six months, number of tender and swollen joints for rheumatoid arthritis, Laboratory values to include rheumatoid factor, sed rate,and CRP for rheumatoid arthritis and juvenile idiopathis arthritis, CRP for ankylosing spondylitis , able to self-inject, previous trial of at least one DMARD for Rheumatoid Arthritisand juvenile idiopathic arthritis, at least one DMARD and at least one NSAID for psoriatic arthritis, at least one NSAID for anklyosing spondylitis and at least one DMARD for plaque psoriasis
Age Restrictions	
Prescriber Restrictions	Limited to Rheumatologist/Dermatologists
Coverage Duration	Up to 1 year
Other Criteria	None

ENTRESTO

Products Affected

- ENTRESTO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Hypersensitivity to sacubitril or valsartan, history of angioedema related to previous ACE or ARB therapy, concomitant use with ACE inhibitors (within 36 hours), concomitant use with aliskiren in patients with diabetes
Required Medical Information	Diagnosis of covered use as indicated to reduce the risk of cardiovascular death and hospitalization for heart failure in patients with chronic heart failure (NYHA Class II-IV) and reduced ejection fraction, submission of baseline serum creatinine and patient current weight for purposes of calculating creatinine clearance,submission of documentation of the presence or absence of hepatic impairment and if present the Child-Pugh classification of such impairment, documentation as to whether or not patient is currently taking an ACE inhibitor or an ARB or if previously taken at what dose, submission of documentation as to whether or not the patient is diagnosed with diabetes, submission of baseline serum potassium level and confirmation serum potassium level will be monitored periodically while on therapy
Age Restrictions	18 YO or older
Prescriber Restrictions	Requested by or under the documented recommendation of a cardiologist
Coverage Duration	One Year
Other Criteria	

EPOGEN

Products Affected

- EPOGEN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of Covered Use. Lab values from bloodwork indicating hemoglobin and iron levels. Blood pressure is also required.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Months
Other Criteria	None

ERIVEDGE

Products Affected

- ERIVEDGE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, pregnancy status for female patients
Age Restrictions	18 YO or older
Prescriber Restrictions	Limited to oncology or dermatology
Coverage Duration	indefinite
Other Criteria	

ERWINAZE

Products Affected

- ERWINAZE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Erwinaze is contraindicated if patients have a history of serious hypersensitivity reactions including anaphylaxis to Erwinaze, and/or a history of serious pancreatitis, serious thrombosis, or serious hemorrhagic events with prior L-asparaginase therapy
Required Medical Information	Diagnosis of covered use including confirmation that patient has developed hypersensitivity to E. coli-derived asparaginase, submission of patient height and current weight, submission of baseline blood glucose level and confirmation blood glucose levels will be moniotred periodically during treatment, confirmation that this medication is being administered in a setting with the proper resuscitation equipment and other agents necessary (epinephrine, oxygen, intravenous steroids, antihistamines etc) to treat anaphylaxis available
Age Restrictions	
Prescriber Restrictions	Limited to oncology and hematology
Coverage Duration	up to one year
Other Criteria	If the medication is being obtained at a participating pharmacy, it may be covered under Part D provided the following conditions are satisfied: The physician agrees to accept brown bagging of the medication and understands that the enrollee will obtain the medication from a pharmacy and have it in their possession until the enrollee delivers the medication to the physician office or infusion center for administration. If these conditions are not satified this medication may be covered under Part B in accordance with the corresponding NCD/LCD if applicable.

ESBRIET/OFEV

Products Affected

- ESBRIET
- OFEV

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of baseline AST, ALT, and bilirubin, confirmation liver function tests will be monitored monthly for the first 3 months after therapy initiation with Ofev and then at least every 3 months thereafter while on therapy, confirmation that liver function tests will be monitored monthly for the the first 6 months after therapy initiation with Esbriet and every 3 months therafter while on therapy,
Age Restrictions	18 YO or older
Prescriber Restrictions	
Coverage Duration	one year
Other Criteria	For Ofev-prescriber documents that the benefits outweigh the potential risks for patients with known bleeding or gastronitestinal perforation risk.For Esbriet-submission of patient's current weight and serum creatinine level for the purposes of calculating creatinine clearance and if the patient is receiving dialysis treatments

EVZIO

Products Affected

- EVZIO

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patients know to be hypersensitive to naloxone hydrochloride
Required Medical Information	Diagnosis of covered use
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	one year
Other Criteria	

EXJADE

Products Affected

- EXJADE
- JADENU

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of Covered Use, Lab values (ferritin, CBC, LFTs, serum creatinine, urine protein values), previous Opthalmic and Auditory testing
Age Restrictions	2 YO or older
Prescriber Restrictions	
Coverage Duration	3 Months
Other Criteria	None

Fabrazyme

Products Affected

- FABRAZYME INTRAVENOUS*
  SOLUTION RECONSTITUTED 35 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Fabrazyme requested for self-adminsitration in the home setting
Required Medical Information	Diagnosis of covered use, submission of patient weight, documentation that provider and healthcare setting is prepraed to manage life-threatening infusion reactions, documentation that patients with compromised cardiac function will be closely monitored during drug administration
Age Restrictions	8 YO and older
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	If the medication is being obtained at a retail pharmacy, it may be covered under Part D provided the following conditions are satisfied:A physician is administering the medication and he/she agrees to accept brown bagging of the medication and understands that the enrollee will obtain the medication from a pharmacy and have it in their possession until the enrollee delivers the medication to the physician office for administration. If these conditions are not satified this medication may be covered under Part B.

FARYDAK

Products Affected

- FARYDAK

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered medical use, documentation that the patient has received at least 2 prior regimens (including bortezomib and an immunomodulatory agent), submission of baseline CBC documenting platelet count is at least 100 x10 9/L and absolute neutrophil count is at least 1.5 x 10 9/L and confirmation CBC will be monitored at least weekly during treatment, submission of baseline ECG documenting QTcF is less than 450 msec prior to initiation of Farydak therapy, submission of baseline serum electrolytes (including potassium and magnesium), submission of baseline liver function tests (including AST, ALT, and total bilirubin)
Age Restrictions	18 YO or older
Prescriber Restrictions	Restricted to Hematology/Oncology
Coverage Duration	8 cycles initially, an additional 8 cycles if clinical benefit seen
Other Criteria	Farydak therapy is not authorized for patients with a history of recent myocardial infarction, unstable angina or patients with active infectionsFor patients with mild hepatic impairment the maximum starting dose authorized is 15mg.For patients with moderate hepatic impairment or those patients receiving concurrent strong CYP3A inhibitor therapy, the maximum starting dose authorized is 10mg.

Fentanyl transmucosal

Products Affected

- ABSTRAL
- ACTIQ
- *fentanyl citrate buccal*
- FENTORA
- SUBSYS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Treatment of opioid non-tolerant patients, treatment of acute or postoperative pain including headache, migraines or dental pain
Required Medical Information	Diagnosis of covered use, submission of documentation that patient who is already receiving and is tolerant to opioid therapy requires fentanyl transmucosal for the management of their underlying, persistent cancer pain
Age Restrictions	18 years or older (buccal film, buccal tablet,sublingual tablet, sublingual spray) or 16 years or older (lozenge, lollipop)
Prescriber Restrictions	Oncology prescribers are exempt for prior authorization
Coverage Duration	Indefinite
Other Criteria	

FERRIPROX

Products Affected

- FERRIPROX

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, lab values including serum ferritin levels, CBC, ANC, platelet count, serum ALT, plasma zinc level
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	None

FIRAZYR

Products Affected

- FIRAZYR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use
Age Restrictions	18 YO or older
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	None

FLECTOR

Products Affected

- FLECTOR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Flector Patch is contraindicated in patients with a known hypersensitivity to diclofenac.Flector Patch is contraindicated in patients who have experienced asthma, urticaria, orallergic-type reactions after taking aspirin or other NSAIDs. Flector Patch is contraindicated for the treatment of perioperative pain in the setting ofcoronary artery bypass graft (CABG) surgery.· Flector Patch is contraindicated for use on non-intact or damaged skin resulting from anyetiology, including exudative dermatitis, eczema, infection lesions, burns or wounds
Required Medical Information	Diagnosis of covered use
Age Restrictions	18 YO or Older
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	

FORTEO

Products Affected

- FORTEO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of Covered Use, postmenopausal, Lab values (serum calcium level), documentation that other treatment options have failed and has value that asseses fracture risk.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	2 Years
Other Criteria	This medication may be covered under Part B, for women with osteoporosis who meet the criteria for the Medicare home health benefit and have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis. A doctor must certify that the woman is unable to learn how to or unable to give herself the drug by injection.

FULYZAQ

Products Affected

- FULYZAQ

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded by Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use
Age Restrictions	18 YO or older
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	

FYCOMPA

Products Affected

- FYCOMPA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use
Age Restrictions	12 YO or older
Prescriber Restrictions	Neurologist exempt from PA
Coverage Duration	Indefinite
Other Criteria	

GATTEX

Products Affected

- GATTEX

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of documentation that a colonoscopy (or alternate imaging) of the entire colon with polyp removal was performed within 6 months prior to starting treatment and is scheduled to be performed at the end of year 1 of Gattex therapy, submission of baseline laboratory values including bilirubin, alkaline phosphatase, lipase and amylase obtained within 6 months prior to starting Gattex therapy and confirmation these laboratory assessments are scheduled to be performed every 6 months while on therapy, submission of serum creatinine and patient weight for the purposes of creatinine clearance calculation and dose verification
Age Restrictions	18 YO or older
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	

GILOTRIF

Products Affected

- GILOTRIF

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use. Documentation that patient has epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21(L858R) substitution mutations as detected by an FDA-approved test. Documentation that females of reproductive potential have been advised to use highly effective contraception during Gilotrif therapy and for at least two weeks after therapy discontinuation, documentation that patient will have periodic liver function monitoring while on therapy
Age Restrictions	18 YO or older
Prescriber Restrictions	limited to oncology or hematology
Coverage Duration	Up to one year
Other Criteria	

GLEEVEC

Products Affected

- GLEEVEC

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of Covered Use
Age Restrictions	
Prescriber Restrictions	Limited to Oncologists or Hematologists
Coverage Duration	Indefinite
Other Criteria	None

GRANIX

Products Affected

- GRANIX

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of Covered Use, submission of CBC and ANC, submission of patient's current weight
Age Restrictions	18 YO or older
Prescriber Restrictions	
Coverage Duration	6 Months
Other Criteria	None

Grastek

Products Affected

- GRASTEK

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Severe, unstable or uncontrolled asthma, history of any severe systemic allergic reaction, history of any severe local reaction to sublingual allergen immunotherapy, history of eosinophilic esophagitis, hypersensitivity to gelatin, mannitol and sodium hydroxide
Required Medical Information	Grastek is being requested for the treatment of grass pollen induced allergic rhinitis with or without conjunctivitis confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for Timothy grass or cross-reactive grass pollens, therapy is being initiated at least 12 weeks before the expected onset of each grass pollen season, confirmation that the first dose of medication will be administered in a healthcare setting under the supervision of a physician with experience in the diagnosis and treatment of allergic diseases and that the patient will be observed for at least 30 minutes after administration of the first dose to monitor for signs and symptoms of a severe systemic or severe local allergic reaction.
Age Restrictions	Patients 5 through 65 years of age
Prescriber Restrictions	Limited to Allergy or Immunology Prescribers
Coverage Duration	one year
Other Criteria	Confirmation auto-injectable epinephrine therapy has been prescribed and patient has been instructed on the proper use of emergency self-injection epinephrine.

Growth Hormone

Products Affected

- GENOTROPIN
- GENOTROPIN MINIQUICK
- HUMATROPE
- NORDITROPIN FLEXPRO
- NUTROPIN AQ NUSPIN 5
- NUTROPIN AQ PEN
- OMNITROPE
- SAIZEN
- SAIZEN CLICK.EASY
- ZOMACTON

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of Covered Use, growth failure documentation, IGF 1 levels, bone age,height, weight, creatinine clearance, fasting glucose, lipid profile, DEXA scan
Age Restrictions	
Prescriber Restrictions	Limited to Endocrinologist.
Coverage Duration	6 Months
Other Criteria	None

HARVONI

Products Affected

- HARVONI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use and laboratory confirmation of hepatitis C virus (HCV) genotype 1 infection, submission of baseline HCV RNA level, documentation of patient's CHC treatment status as either treatment-naive or treatment-experienced and whether cirrhosis is present or not,submission of eGFR
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	12 or 24 weeks of therapy depending on treatment status and presence of cirrhosis
Other Criteria	For treatment-naive patients with cirrhosis or treatment-naive or treatment-experienced without cirrhosis approval is for 12 weeks of therapy. For treatment-naive patients without cirrhosis who have pre-treatment HCV RNA less than 6 million IU/mL, 8 weeks of therapy may be considered by the provider. For treatment-experienced patients with cirrhosis approval is for 24 weeks of therapy.

Hemangeol

Products Affected

- HEMANGEOL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	asthma or history of bronchospasm, premature infant with corrected age less than 5 weeks, infants weighing less than 2 kg, bradycardia (less than 80 beats per minute), greater than first degree heart block, decompensated heart failure, blood pressure less than 50/30mmHg, pheochromocytoma, known hypersensitivity to propranolol
Required Medical Information	Diagnosis of covered use, Infant is at least 5 weeks corrected age or older, submission of current weight (must be at least 2 kg),treatment is being initiated at ages 5 weeks to 5 months
Age Restrictions	Minimum patient age of 5 weeks up to 1 year of age
Prescriber Restrictions	limited to pediatric otolarangologist or ENT specialist or pediatric ophthalmologist
Coverage Duration	6 months
Other Criteria	

HETLIOZ

Products Affected

- HETLIOZ

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of covered use, documentation patient does not have severe hepatic impairment (Child-Pugh Class C)
Age Restrictions	18 YO or older
Prescriber Restrictions	limited to sleep specialists
Coverage Duration	Indefinite
Other Criteria	

HUMIRA

Products Affected

- HUMIRA
- HUMIRA PEN-CROHNS STARTER

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, TB skin test result obtained within the past six months, Laboratory values to include CRP, sed rate, rheumatoid factor for rheumatoid arthritis and juvenile idiopathic arthritis, CRP for ankylosing spondylitis, able to self-inject. Number of tender and swollen joints for rheumatoid arthritis.Previous trial of at least one DMARD for Rheumatoid arthritis and juvenile idiopathic arthritis. At least one DMARD and at least one NSAID for psoriatic arthritis. At least one NSAID for ankylosing spondylitis. At least one DMARD for plaque psoriasis. At least one antibiotic OR one corticosteroid and use of either mesalamine OR azathioprine/mercaptopurine for Crohn's disease
Age Restrictions	
Prescriber Restrictions	Limited to Rheumatologist/Dermatologists/ Gastroenterologists
Coverage Duration	Up to 1 year
Other Criteria	None

IBRANCE

Products Affected

- IBRANCE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered medical use, submission confirming HER2-negative status, confirmation that the treatment regimen will include concomitant use of letrozole, submission of baseline CBC.
Age Restrictions	
Prescriber Restrictions	Limited to Hematology/Oncology
Coverage Duration	28 Days
Other Criteria	Continuation of therapy requires documentation that CBC will be monitored at the beginning of each cycle, as well as on Day 14 of the first two cycles.

ILARIS

Products Affected

- ILARIS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use. TB skin test result obtained within past six months, submission of pediatric patient weight, submission of documentation that patient has received all recommended vaccinations as appropriate including pneumococcal vaccine and inactivated influenza vaccine prior to initiation of therapy . When requested for the treatment of CAPS-confirmed diagnosis of CAPS including genetic testing for variant FCAS or MWS, patient is 4 years of age or older, documentation patient is not receiving concomitant TNF inhibitor therapy. When requested for the treatment of SJIA-patient with confirmed diagnosis of active SJIA defined by the prominence of systemic and inflammatory features including spiking fevers, rash, swelling and inflammation of lymph nodes, liver and spleen, and high white blood cell and platelet counts, submission of CBC including platelet count, patient is 2 years of age or older.
Age Restrictions	2 YO and older
Prescriber Restrictions	when requetsed for SJIA limited to rheumatology
Coverage Duration	1 year

PA Criteria	Criteria Details
Other Criteria	If the medication is being obtained at a retail pharmacy, it may be covered under Part D provided the following conditions are satisfied:A physician/health care provider is administering the medication and he/she agrees to accept brown bagging of the medication and understands that the enrollee will obtain the medication from a pharmacy and have it in their possession until the enrollee delivers the medication to the physician office or infusion center for administration. This medication may be covered under Part B if administered by a physician incident to a physician service. Continuation of therapy requires submission of objective documentation of positive patient response or maintenance of response, Submission of updated TB skin test result obtained within the past 12 months.

IMBRUVICA

Products Affected

- IMBRUVICA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of baseline CBC and confirmation that patient will have CBC checked monthly, submission of baseline serum creatinine level and confirmation that patient's serum creatinine levels will be monitored periodically while on therapy
Age Restrictions	18 YO or older
Prescriber Restrictions	limited to oncology and hematology
Coverage Duration	Indefinite
Other Criteria	

INCRELEX/IPLEX

Products Affected

- INCRELEX

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of Covered Use, documentation of primary IGFD or growth hormone gene deletion in patients who have developed neutralizing antibodies to growth hormone, IGF-1 level, growth hormone level
Age Restrictions	
Prescriber Restrictions	Limited to Endocrinologist.
Coverage Duration	6 Months
Other Criteria	None

Injectable Oncology Drugs

Products Affected

- ABRAXANE
- ALIMTA INTRAVENOUS* SOLUTION RECONSTITUTED 500 MG
- ALKERAN INTRAVENOUS*
- ARRANON
- ARZERRA INTRAVENOUS* CONCENTRATE 100 MG/5ML
- AVASTIN
- *azacitidine*
- BICNU
- *bleomycin sulfate injection solution reconstituted 30 unit*
- BUSULFEX
- CAMPTOSAR INTRAVENOUS* SOLUTION 100 MG/5ML
- *cisplatin intravenous* solution 100 mg/100ml*
- *cladribine*
- CLOLAR
- COSMEGEN
- *cytarabine (pf) injection solution 100 mg/ml*
- *cytarabine injection solution*
- *dacarbazine intravenous* solution reconstituted 200 mg*
- DACOGEN
- *daunorubicin hcl intravenous* injectable*
- *decitabine*
- *dexrazoxane intravenous* solution reconstituted 250 mg*
- DOCEFREZ INTRAVENOUS* SOLUTION RECONSTITUTED 20 MG
- DOCETAXEL INTRAVENOUS* CONCENTRATE 80 MG/4ML
- DOCETAXEL INTRAVENOUS* SOLUTION 80 MG/8ML
- DOXIL
- *doxorubicin hcl intravenous* solution*
- ELITEK INTRAVENOUS* SOLUTION RECONSTITUTED 1.5 MG
- ELLENCE INTRAVENOUS* SOLUTION 200 MG/100ML
- ELOXATIN INTRAVENOUS* SOLUTION 100 MG/20ML
- *epirubicin hcl intravenous* solution 50 mg/25ml*
- ERBITUX INTRAVENOUS* SOLUTION 100 MG/50ML
- FASLODEX
- *fludarabine phosphate intravenous* solution reconstituted*
- FOLOTYN INTRAVENOUS* SOLUTION 40 MG/2ML
- *gemcitabine hcl intravenous* solution reconstituted 1 gm*
- GEMZAR INTRAVENOUS* SOLUTION RECONSTITUTED 1 GM
- HALAVEN
- HERCEPTIN
- IDAMYCIN PFS INTRAVENOUS* SOLUTION 20 MG/20ML
- *idarubicin hcl intravenous* solution 10 mg/10ml*
- IFEX INTRAVENOUS* SOLUTION RECONSTITUTED 1 GM
- *ifosfamide intravenous* solution reconstituted 1 gm*
- *irinotecan hcl intravenous* solution 100 mg/5ml*
- ISTODAX
- IXEMPRA KIT INTRAVENOUS* SOLUTION RECONSTITUTED 45 MG
- JEVTANA
- *melphalan hcl*
- *mesna*
- MESNEX INTRAVENOUS*
- *mitomycin intravenous* solution reconstituted 20 mg*
- *mitoxantrone hcl intravenous* concentrate 25 mg/12.5ml*
- MUSTARGEN

- NIPENT
- *oxaliplatin intravenous* solution 100 mg/20ml*
- *paclitaxel intravenous* concentrate 300 mg/50ml*
- PROLEUKIN
- RITUXAN
- SYNRIBO
- TAXOTERE INTRAVENOUS* CONCENTRATE 80 MG/4ML
- TREANDA INTRAVENOUS* SOLUTION 45 MG/0.5ML
- TREANDA INTRAVENOUS* SOLUTION RECONSTITUTED 100 MG
- TRELSTAR MIXJECT
- TRISENOX
- VELCADE
- VIDAZA
- VINBLASTINE SULFATE INTRAVENOUS* SOLUTION
- *vincasar pfs*
- *vincristine sulfate intravenous**
- *vinorelbine tartrate intravenous* solution 50 mg/5ml*
- YERVOY INTRAVENOUS* SOLUTION 50 MG/10ML
- ZANOSAR
- ZINECARD INTRAVENOUS* SOLUTION RECONSTITUTED 250 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded by Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of CBC including platelet count
Age Restrictions	
Prescriber Restrictions	limited to oncology
Coverage Duration	Indefinite

PA Criteria	Criteria Details
Other Criteria	If the medication is being obtained at a retail pharmacy, it may be covered under Part D provided the following conditions are satisfied:If a physician is administering the medication, he/she agrees to accept brown bagging of the medication and understands that the enrollee will obtain the medication from a pharmacy and have it in their possession until the enrollee delivers the medication to the physician office or infusion center for administration, if the medication is being administered in the enrollee?s home, there are no associated safety concerns with preparation and/or administration of the medication documented in the prescribing information and if the medication is being administered in the enrollee?s home by a route other than orally or subcutaneously, documentation is provided that the member has been fully trained on how to administer the medication safely and effectively if applicable. If these conditions are not satified these medications may be covered under Part B in accordance with the corresponding NCD/LCD if applicable.

INLYTA

Products Affected

- INLYTA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, documentation of one prior systemic therapy failure, submission of laboratory values including baseline ALT, AST, bilirubin, TSH, urine protein values, pregnancy status for female patients, submission of baseline blood pressure reading
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	indefinite
Other Criteria	None

INTRON-A

Products Affected

- INTRON A INJECTION SOLUTION 6000000 UNIT/ML
- INTRON A INJECTION SOLUTION RECONSTITUTED

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	autoimmune hepatitis, decompensated liver disease
Required Medical Information	Diagnosis of covered use, for all approved indications for use-submission of triglyceride levels, hemoglobin, complete and differential white blood cell counts, platelet count, serum electrolytes, ALT,serum bilirubin level, serum albumin level, TSH, for the treatment of malignant melanoma- submission of the date of surgical treatment,for the treatment of AIDS-Related Kaposi's Sarcoma-submission of total CD4 count,for the treatment of chronic hepatitis C- submission of the following laboratory values HCV RNA, prothrombin time, baseline serum creatinine level, liver biopsy results confirming diagnosis of chronic hepatitis C, documentation of previous response to therapy if applicable, for chronic Hepatitis B infection-documentation patient has been serum HBsAG positive for at least 6 months with evidence of HBV replication, submission of the following laboratory values Prothrombin time,
Age Restrictions	18 YO ot older for the treatment of Hairy Cell Leukemia, malignant melanoma, follicular lymphoma,Condylomata Acuminata, AIDS-Related Kaposi's Sarcoma 3 YO or older for the treatment of Chronic Hepatitis C 1 YO or older for the treatment of Chronic Hepatitis B
Prescriber Restrictions	
Coverage Duration	Indefinite

PA Criteria	Criteria Details
Other Criteria	If the medication is being obtained at a retail pharmacy, it may be covered under Part D provided the following conditions are satisfied:If a physician is administering the medication, he/she agrees to accept brown bagging of the medication and understands that the enrollee will obtain the medication from a pharmacy and have it in their possession until the enrollee delivers the medication to the physician office or infusion center for administration, if the medication is being administered in the enrollee?s home, documentation is provided that the member has been fully trained on how to prepare the injection and to administer the medication safely and effectively. If these conditions are not satified this medication may be covered under Part B in accordance with the corresponding NCD/LCD if applicable.

INVEGA TRINZA

Products Affected

- INVEGA TRINZA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Known hypersensitivity to paliperidone, risperidone, or to any excipients in the formulation
Required Medical Information	Diagnosis of covered medical use, documentation that the patient has been adequately treated with the 1-month palipderidone palmitate extended-release injectable suspension for at least four (4) months, submission of the previous 1-month paliperidone palmitate extended-release injectable suspension dose when therapy is being initiated with Invega Trinza,documenation that each injection will be administered only by a health care professional, submission of patient current weight and serum creatinine level for the pruposes of calculating creatinie clearance, confirmation that glucose levels will be monitored frequently in patients with or at risk for diabetes, confirmation that weight gain will be monitored, confirmation complete blood count will be monitored in patients with a history of clinically significant low white blood cell count or a drug induced leukopenia/neutropenia.
Age Restrictions	18 YO and older
Prescriber Restrictions	
Coverage Duration	One Year

PA Criteria	Criteria Details
Other Criteria	Invega Trinza is not approved nor authorized for use in patinets with dementia-related psychosis. If the medication is being obtained at a retail pharmacy, it may be covered under Part D provided the following conditions are satisfied: A physician/health care provider is administering the medication and he/she agrees to accept brown bagging of the medication and understands that the enrollee will obtain the medication from a pharmacy and have it in their possession until the enrollee delivers the medication to the physician office or infusion center for administration If these conditions are not satisfied this medication may be covered under Part B provided the clincal criteria above is met.

IVIG

Products Affected

- BIVIGAM INTRAVENOUS* SOLUTION 10 GM/100ML
- CARIMUNE NF INTRAVENOUS* SOLUTION RECONSTITUTED 6 GM
- FLEBOGAMMA DIF INTRAVENOUS* SOLUTION 5 GM/50ML
- GAMASTAN S/D
- GAMMAGARD INJECTION SOLUTION 2.5 GM/25ML
- GAMMAKED INJECTION SOLUTION 1 GM/10ML
- GAMMAPLEX INTRAVENOUS* SOLUTION 10 GM/200ML
- GAMUNEX-C INJECTION SOLUTION 1 GM/10ML
- OCTAGAM INTRAVENOUS* SOLUTION 2 GM/20ML, 25 GM/500ML
- PRIVIGEN INTRAVENOUS* SOLUTION 20 GM/200ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	IgA deficient patients with antibodies against IgA and a history of hypersensitivity, patients with a history of severe systemic reactions to human immunoglobulin

PA Criteria	Criteria Details
Required Medical Information	IVIG is requested for one of the following conditions-Primary Immunodeficiency,Immune-mediated Thrombocytopenia (ITP),Kawasaki disease,Human Immunodeficiency Virus (HIV)(for pediatric use only),Bone marrow transplantation,Chronic B-cell lymphocytic leukemia (CLL) and for the following biopsy-proven conditions-Pemphigus vulgaris, Pemphigus foliaceus,Bullous pemphigoid,Mucous membrane pemphigoid,benign mucous membrane pemphigoid, with or without mention of ocular movement,Epidermolysis bullosa acquisita in patients who demonstrate at least 1 of the following- Failed conventional therapy,Conventional therapy is contraindicated,Have rapidly progressive disease in which a clinical response could not be affected quickly enough using conventional agents.Primary humoral immunodeficiency is defined as severe impairment of antibody capacity with 1 of the following conditions: Congenital agamma-globulinemia,Common variable immunodeficiency,Wiskott-Aldrich syndrome,X-linked immunodeficiency with hyper-IgM,Severe combined immunodeficiencies,Deficient qualitative or quantitative antibody production, patients with at least 1 bacterial infection directly attributable to this deficiency. For ITP submission of platelet count,for CLL-IgG level of less than 600 mg/dl and Recent history of serious bacterial infection requiring either oral or IV antibiotic therapy,for HIV-Age younger than 14 years old and Evidence of qualitative or quantitative humoral immunologic defects and Current bacterial infections, despite appropriate antimicrobial prophylaxis, for CIDP-unequivocal CIDP diagnosis and patient has proved refractory to or intolerant of prednisone or azathioprine given in therapeutic doses over at least 3 months and patient has a Rankin Scale neurologic function assessment score of at least 3 at the time of initial therapy,for Dermatomyositis, Polymyositis-patient with severe active illness for whom other interventions have been unsuccessful,not tolerated or contraindicated.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	remainder of the contract year

PA Criteria	Criteria Details
Other Criteria	IVIG is covered as a part B benefit if administered in the home for the treatment of primary immune deficiency. It is covered as a Part D benefit for all other indications when administered in the home. For all indications if administered in the physician office or infusion center it is covered as a Part B benefit.

Jakafi

Products Affected

- JAKAFI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use and lab values including CBC, platelet count. Patient's creatinine clearance is required.
Age Restrictions	18 YO or older
Prescriber Restrictions	Limited to oncology or hematology
Coverage Duration	Indefinite
Other Criteria	

JARDIANCE

Products Affected

- JARDIANCE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Serious hypersensitivity to empagliflozin or any component of the formulation, severe renal impairment (estimated glomerular filtration rate less than 30 mL/min/1.73 m2), end-stage renal disease, or dialysis
Required Medical Information	Diagnosis of covered use (DM Type II), submission of current GFR
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	one year
Other Criteria	

Jublia/Kerydin

Products Affected

- JUBLIA
- KERYDIN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of culture proven Trichophyton rubrum or Trichophyton mentagrophytes infection, patient has tried and failed to respond to or tolerate oral terbinafine therapy or a documented contraindication to its use exists
Age Restrictions	18 YO or older
Prescriber Restrictions	
Coverage Duration	48 weeks
Other Criteria	

JUXTAPID

Products Affected

- JUXTAPID

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Pregnancy or moderate or severe hepatic impairment (Child-Pugh Class B or C) or active liver disease.
Required Medical Information	Diagnosis of covered use and lab values including baseline transaminase levels including: ALT, AST,alkaline phosphatase, total bilirubin, baseline LDL-C, total cholesterol (TC), apoB, non-HDL-C, documentation of negative pregnancy test result in females of reproductive potential, confirmed diagnosis of HoFH and renal indices
Age Restrictions	18 YO or older
Prescriber Restrictions	
Coverage Duration	indefinite
Other Criteria	

KALYDECO

Products Affected

- KALYDECO ORAL PACKET
- KALYDECO ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, cystic fibrosis mutation test result, baseline ALT and AST laboratory values
Age Restrictions	6 YO or older
Prescriber Restrictions	
Coverage Duration	indefinite
Other Criteria	None

KETOCONAZOLE

Products Affected

- *ketoconazole oral*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Patients with acute or chronic liver diease, treatment of fungal meningitis or fungal infections of the skin or nails, patients receiving concomitant therapy with aplrazolam, midazolam, triazolam,cisapride,dofetilide, HMG-CoA reductase inhibitors, nisoldipine, pimozide,eplerenone, ergot alkaloids or quinidine
Required Medical Information	Ketoconazole is being requested for the treatment of one of the following culture proven, systemic fungal infections in patients who have failed or who are intolerant to other therapies: blastomycosis, coccidioidomycosis, histoplasmosis, chromomycosis or paracoccidioidomycosis, submission of baseline ALT, AST, total bilirubin, alkaline phosphatase, prothrombin time and INR, confirmation patient's ALT will be moniotred weekly for the duration of treatment,confirmation from the prescriber that the potential benefits of therapy outweigh the risks
Age Restrictions	2 YO or older
Prescriber Restrictions	limited to infectious disease specialists
Coverage Duration	Six months
Other Criteria	

KEYTRUDA

Products Affected

- KEYTRUDA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, documentation of unresectable or metastatic melanoma and disease progression following ipilimumab and, if BRAF V600 mutation positive, a BRAF inhibitor, submission of baseline LFTs (including AST, ALT, and total bilirubin), baseline thyroid function tests including TSH, baseline serum creatinine, baseline blood glucose level and confirmation patient will be monitored for the development of Type 1 diabetets while on therapy, and patient weight
Age Restrictions	18 YO or older
Prescriber Restrictions	Limited to Hematology/Oncology prescribers
Coverage Duration	one year
Other Criteria	If the medication is being obtained at a retail pharmacy, it may be covered under Part D provided the following conditions are satisfied:If a physician or health care provider is administering the medication, he/she agrees to accept brown bagging of the medication and understands that the enrollee will obtain the medication from a pharmacy and have it in their possession until the enrollee delivers the medication to the physician office, infusion center or homecare provider for administration. If these conditions are not satified this medication may be covered under Part B in accordance with this criteria and/or an applicable NCD/LCD.

KINERET

Products Affected

- KINERET

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, Laboratory values to include rheumatoid factor, CRP, sed rate, able to self-inject, previous trial of at least one DMARD, TB skin test result obtained within the past six months, number of tender and swollen joints
Age Restrictions	18 YO or older
Prescriber Restrictions	Limited to Rheumatologist
Coverage Duration	Up to 1 year
Other Criteria	None

KORLYM

Products Affected

- KORLYM

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	pregnancy, patients on concurrent long-term, life-saving corticosteroid therapy, patients on concurrent simvastatin, lovastatin, or CYP3A substrates with narrow therapeutic ranges, such as cyclosporine, dihydroergotamine, ergotamine, fentanyl, pimozide, quinidine, sirolimus, and tacrolimus, female patient with a histoy of unexplained vaginal bleeding, female patient with endometrial hyperplasia with atypia or endometrial carcinoma
Required Medical Information	Diagnosis of covered use,submission of baseline serum potassium level, submission of negative pregnancy test result in female patients of reproductive potential, submission of serum creatinine level and patient's weight (for creatinie clearance calculation and dose verification), submission of baseline AST, ALT and alkaline phosphatase
Age Restrictions	18 YO or older
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	

KUVAN

Products Affected

- KUVAN ORAL PACKET 500 MG
- KUVAN ORAL TABLET SOLUBLE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, phenylalanine level, restricted diet is being followed, patient weight
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	none

KYNAMRO

Products Affected

- KYNAMRO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Patients with moderate or severe hepatic impairment, or active liver disease, including unexplained persistent elevations of serum transamniases
Required Medical Information	Diagnosis of covered use, submission of the following baseline lab values ALT, AST, alkaline phosphatase, total bilirubin, LDL-C, apo B, TC, non-HDL-C, documentation patient is using Kynamro as an adjunct to lipid-lowering medications and diet
Age Restrictions	18 YO or older
Prescriber Restrictions	
Coverage Duration	six months
Other Criteria	

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 medically accepted indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered medical use, submission of creatinine clearance or current body weight and serum creatinine level for the purposes of calculation of creatinine clearance by the Cockcroft-Gault equation, submission of baseline blood pressure showing blood pressure is controlled, confirmation patient will be monitored for clinical symptoms or signs of cardiac decompensation, submission of baseline ALT and AST, submission of baseline protinuria evaluation via dipstick (at least less than 2 grams), submission of baseline serum calcium and TSH level, Documentation that blood pressure will be monitored after 1 week, then every 2 weeks for the first 2 months, and then at least monthly thereafter, documentation that liver function will be evaluated before initiation, then every 2 weeks for the first 2 months, and a least monthly thereafter, documentation that serum calcium will be monitored at least monthly, documentation that TSH will be monitored monthly
Age Restrictions	18 YO or older
Prescriber Restrictions	Limited to Hematology/Oncology
Coverage Duration	one year
Other Criteria	For patients with severe renal impairment (CrCl less than 30ml/min) or severe hepatic impairment (Child-Pugh C) the maximum dose authorized is 14mg once daily

Letairis

Products Affected

- LETAIRIS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Pregnancy, idiopathic pulmonary fibrosis
Required Medical Information	Diagnosis of covered use,negative pregnancy test result for female patients of childbearing age, submission of baseline AST, ALT and bilirubin levels, submission of basline HGB level and confirmation HGB will be measured after 1 month of therapy and periodically thereafter
Age Restrictions	18 YO or older
Prescriber Restrictions	Limited to Pulmonologists and Cardiologists
Coverage Duration	Indefinite
Other Criteria	None

Leukine

Products Affected

- LEUKINE INTRAVENOUS*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, WBC count, ANC
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Months
Other Criteria	None

LIDODERM

Products Affected

- *lidocaine external patch*
- LIDODERM

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	LIDODERM is contraindicated in patients with a known history of sensitivity to local anesthetics of the amide type, or to any other component of the product.
Required Medical Information	Diagnosis of covered use
Age Restrictions	18YO or older
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	

LYNPARZA

Products Affected

- LYNPARZA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, BRCA mutation status, documentation that the patient has been treated with three or more prior lines of chemotherapy, submission of baseline CBC and confirmation that CBC will be monitored monthly thereafter.
Age Restrictions	18 YO or older
Prescriber Restrictions	Limited to hematology and oncology prescribers
Coverage Duration	one year
Other Criteria	

MEKINIST

Products Affected

- MEKINIST

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of FDA- approved test confirming presence of BRAF V600E or V600K mutation, submission of baseline LVEF and confirmation that LVEF is scheduled to re-assessed after one month of treatment and then every 2 to 3 months thereafte, submission of blood pressure reading
Age Restrictions	18 YO or older
Prescriber Restrictions	Limited to oncology or hematology
Coverage Duration	Indefinite
Other Criteria	Mekinist is not indicated for the treatment of patients who have received prior-BRAF-inhibitor therapy

Methyl Testosterone Products

Products Affected

- ANDROID
- METHITEST
- TESTRED

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Male patients with carcinomas of the breast or prostate, female patients who are or may become pregnant
Required Medical Information	Diagnosis of Covered Use, fo male patients- documentation that patient has been evaluated for the presence of prostate cancer prior to initiation of therapy, for female patients diagnosed with disseminated breast carcinoma who are 1 to 5 years postmenopausa- submission of baseline urine and serum calcium levels and confirmation calcium levels will be monitored during the course of androgen therapy, submission of baseline X-ray bone age examination result of the hand or wrist in prepubertal male patients and confirmation re-examinations will be performed every 6 months, for all patients-submission of baseline HGB, HCT, ALT, AST and total bilirubin levels and confirmation liver function tests will continue to be monitored periodically while on therapy, submission of baseline GFR
Age Restrictions	
Prescriber Restrictions	Endocrinologist, Oncologist and Urologist are exempt from PA
Coverage Duration	one year
Other Criteria	For patients 65 years of age and older- submission of documentation that provider is aware medication is considered a high risk medication for elderly patients according to the Centers for Medicare and Medicaid services and that the benefits of methyltestosterone therapy outweighs the potential risks to the patient.

MIRVASO

Products Affected

- MIRVASO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use and previous trial of azelaic acid
Age Restrictions	18 YO or older
Prescriber Restrictions	limited to dermatology
Coverage Duration	one year
Other Criteria	

MOZOBIL

Products Affected

- MOZOBIL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of baseline CBC and platelet counts, confirmation medication is being used in combination with granulocyte-colony stimulating factor, submission of patient's current weight, submission of baseline serum creatinine level.
Age Restrictions	18 YO or older
Prescriber Restrictions	limited to oncology and hematology
Coverage Duration	one treatment course (4 days of therapy)
Other Criteria	If the medication is being obtained at a retail pharmacy, it may be covered under Part D provided the following conditions are satisfied:A physician/health care provider is administering the medication and he/she agrees to accept brown bagging of the medication and understands that the enrollee will obtain the medication from a pharmacy and have it in their possession until the enrollee delivers the medication to the physician office or infusion center for administration. This medication may be covered under Part B if administered by a physician incident to a physician service.

Multiple Sclerosis

Products Affected

- BETASERON
- EXTAVIA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of Covered Use
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	Neurologist exempt from PA

MYALEPT

Products Affected

- MYALEPT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	patients with general obesity not associated with congenital leptin deficiency
Required Medical Information	diagnosis of covered use, submission of patient weight, submission of leptin level laboratory test result confirming leptin deficiency, submission of baseline HbA1c, fasting glucose and fasting triglyceride levels
Age Restrictions	1 YO or older
Prescriber Restrictions	
Coverage Duration	up to one year
Other Criteria	Continuation of approval requires submission of patient weight, updated HbA1c, fasting glucose and fasting triglyceride levels

Naglazyme

Products Affected

- NAGLAZYME

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of patient weight, documentation that the healthcare setting and provider are prepared to manageinfusion reactions including life-threatening anaphylaxis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	indefinite
Other Criteria	If the medication is being obtained at a retail pharmacy, it may be covered under Part D provided the following conditions are satisfied:A a physician is administering the medication and he/she agrees to accept brown bagging of the medication and understands that the enrollee will obtain the medication from a pharmacy and have it in their possession until the enrollee delivers the medication to the physician office or infusion center for administration If these conditions are not satified this medication may be covered under Part B.

NAMZARIC

Products Affected

- NAMZARIC

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of covered medical use, submission of documentation that the patient has been stablizied on memantine hydrochloride (5mg twice daily, 10mg twice daily, 14mg extended-release daily, or 28mg extended-release daily) and donepezil hydrochloride 10mg daily, submission of patient current weight and serum creatinine level for the purposes of calculating creatinine clearance
Age Restrictions	18 YO or older
Prescriber Restrictions	
Coverage Duration	one year
Other Criteria	

NATPARA

Products Affected

- NATPARA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered medical use, prior to initiation of therapy documentation that serum calcium (albumin-corrected) is greater than 7.5 mg/dL and confirmation that 25-hydroxyvitamin D stores are sufficient, documentation that the patient cannot be well-controlled on calcium supplementation and active forms of vitamin D alone, confirmation that serum calcium concentration will be measured every 3 to 7 days after starting or adjusting Natpara dose and when adjusting either active Vitamin D or calcium supplements dose while using Natpara
Age Restrictions	18 YO or older
Prescriber Restrictions	Natpara REMS program certified healthcare providers
Coverage Duration	one year
Other Criteria	Patients and caregivers who will administer Natpara will receive appropriate training and instruction by a trained healthcare professional prior to the first use of Natpara

NEULASTA

Products Affected

- NEULASTA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	PBPC Mobilization
Required Medical Information	Diagnosis of Covered Use
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 Months
Other Criteria	None

Neumega

Products Affected

- NEUMEGA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, platelet count
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Up to 3 Months
Other Criteria	None

NEUPOGEN

Products Affected

- NEUPOGEN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of Covered Use and Lab values (ANC)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 Months
Other Criteria	None

NEXAVAR

Products Affected

- NEXAVAR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of Covered Use
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	None

NORTHERA

Products Affected

- NORTHERA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use
Age Restrictions	18 years of age
Prescriber Restrictions	
Coverage Duration	2 weeks
Other Criteria	

OLYSIO

Products Affected

- OLYSIO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of Covered Use and Lab values (HCV RNA, ALT, genotype), confirmation that Olysio is not being used as monotherapy, documentation that patient with HCV genotype 1a infection has been screened at baseline for the presence of virus with the NS3 Q80K polymorphism, documentation patient has not previously failed therapy with a treatment regimen including Olysio or other HCV protease inhibitors, submission of patient's treatment status either treatment naive, prior relapser or prior non-responder
Age Restrictions	18 YO or older
Prescriber Restrictions	
Coverage Duration	12 weeks or 24 weeks based on diagnosis
Other Criteria	

ONCASPAR

Products Affected

- ONCASPAR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Oncaspar is contraindicated if patients have a history of serious allergic reactions to Oncaspar, and/or a history of pancreatitis, serious thrombosis, or serious hemorrhagic events with prior L-asparaginase therapy
Required Medical Information	Diagnosis of covered use, submission of patient height and current weight, submission of baseline blood glucose level and confirmation blood glucose levels will be moniotred periodically during treatment, confirmation that this medication is being administered in a setting with the proper resuscitation equipment and other agents necessary (epinephrine, oxygen, intravenous steroids, antihistamines etc) to treat anaphylaxis available and that patients will be observed for one hour after Oncaspar administration
Age Restrictions	
Prescriber Restrictions	limited to oncology and hematology
Coverage Duration	up to one year
Other Criteria	

ONFI

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use and patient's weight is required.
Age Restrictions	2 YO or older
Prescriber Restrictions	limited to neurology
Coverage Duration	indefinite
Other Criteria	

OPDIVO

Products Affected

- OPDIVO INTRAVENOUS* SOLUTION
  40 MG/4ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered medical use, submission of baseline LFTs (including AST, ALT, and total bilirubin), baseline serum creatinine, baseline thyroid function tests, submission of patient current weight, documentation patient with unresctable or metastatic melanoma has experienced disease progression following ipilimumab and if BRAF V600 mutation positive, a BRAF inhibitor, documenation patient with metastatic squamous non-small cell lung cancer has experienced disease progression on or after platinum-based chemotherapy
Age Restrictions	18 YO or older
Prescriber Restrictions	Limited to Hematology/Oncology prescribers
Coverage Duration	one year
Other Criteria	

OPSUMIT

Products Affected

- OPSUMIT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Pregnancy
Required Medical Information	Diagnosis of covered use, negative pregnancy test result for female patients of childbearing age and confirmation pregnancy will be excluded monthly during treatment and for 1 month after stopping treatment, submission of baseline AST, ALT and bilirubin levels, and submission of baseline HGB level and confirmation that these lab values will be monitored during treatment as clinically indicated
Age Restrictions	18 YO or older
Prescriber Restrictions	Limited to pulmonologists and cardiologists
Coverage Duration	Indefinie
Other Criteria	

ORALAIR

Products Affected

- ORALAIR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Severe, unstable or uncontrolled asthma, history of any severe systemic allergic reaction, history of any severe local reaction to sublingual allergen immunotherapy, hypersensitivity to mannitol, microcrystalline cellulose, croscarmellose sodium, colloidal anhydrous silica, magnesium stearate or lactose monohydrate
Required Medical Information	Oralair is being requested for the treatment of grass pollen induced allergic rhinitis with or without conjunctivitis confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for any of the following grass sepcies:Sweet Vernal, Orchard, Perennial Rye, Timothy and Kentucky Blue Grass, therapy is being initiated 4 months before the expected onset of each grass pollen season, confirmation that the first dose of medication will be administered in a healthcare setting under the supervision of a physician with experience in the diagnosis and treatment of severe allergic reactions and that the patient will be observed for at least 30 minutes after administration of the first dose to monitor for signs and symptoms of a severe systemic or severe local allergic reaction.
Age Restrictions	Patients 10 through 65 years of age
Prescriber Restrictions	Limited to allergy and immunology
Coverage Duration	one year
Other Criteria	Confirmation auto-injectable epinephrine therapy has been prescribed and patient has been instructed on the proper use of emergency self-injection epinephrine.

ORENCIA

Products Affected

- ORENCIA SUBCUTANEOUS*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use,TB skin test result obtained within the past six months, Number of swollen joints, number of tender joints, Laboratory values to include rheumatoid factor, sed rate, and CRP , able to self- inject, previous trial of at least one DMARD
Age Restrictions	6 YO or older
Prescriber Restrictions	Limited to rheumatologists
Coverage Duration	12 weeks then up to 1 year
Other Criteria	None

ORENITRAM

Products Affected

- ORENITRAM

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Pregnancy, idiopathic pulmonary fibrosis, including idiopathic pulmonary fibrosis patients with pulmonary hypertension or WHO group 3.
Required Medical Information	Diagnosis of covered use,negative pregnancy test result for female patients of childbearing age, submission of baseline AST, ALT and bilirubin levels, submission of basline HGB level and confirmation HGB will be measured after 1 month of therapy and periodically thereafter
Age Restrictions	18 YO or older
Prescriber Restrictions	Limited to Pulmonologists and Cardiologists
Coverage Duration	Indefinite
Other Criteria	

ORFADIN

Products Affected

- ORFADIN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, urine succinylacetone levels, liver function tests, alpha-fetoprotein level, serum tyrosine level, serum phenylalanine level, restricted diet is being followed, patient weight
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	up to 6 months
Other Criteria	None

ORKAMBI

Products Affected

- ORKAMBI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, documentation that the patient is homozygous for the F508del mutation in the CFTR gene provided from an FDA-cleared CF mutation test, submission of baseline AST/ALT, bilirubin, and documentation of the patients ppFEV1, submission of documentation that baseline and follow-up ophthalmologic exams will be performed in pediatric patients starting on therapy.
Age Restrictions	12 years of age and older
Prescriber Restrictions	Limited to Pulmonology
Coverage Duration	One Year
Other Criteria	Submission of documentation the liver function tests will be assessed every 3 months during the first year of treatment, and annually thereafter. Additional monitoring may be required for patients with ppFEV1 less than 40 percent.

Otezla

Products Affected

- OTEZLA ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of Covered Use, submission of current weight and serum creatinine level,trial of at at least one DMARD and at least one NSAID for psoriatic arthritis (PsA), submission of the number of swollen and tender joints and the number of psoriatic skin lesions for PsA, trial of at least one DMARD for plaque psoriasis, submission of the perecntage of body surface area (BSA) involvement for plaque psoriasis
Age Restrictions	18 YO or older
Prescriber Restrictions	Limited to Rheumatologist and Dermatologists
Coverage Duration	One Year
Other Criteria	Prescriber documents that the benefits of therapy outweigh the potential risks for patients with a history of depression and/or suicidal thoughts or behaviors. Continuation of therapy requires submission of objective documentation of patient's response to therapy including affect on the number of swollen and tender joints and psoriatic skin lesions for PsA and the percentage of BSA involvement for plaque psoriasis.

OTREXUP

Products Affected

- OTREXUP

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Pregnancy, treatment of nursing mother, patient with alcoholism or liver disease, patient with immunodeficiency syndromes or preexisitng blood dyscrasias
Required Medical Information	Diagnosis of covered use, documentation of other therapies tried and patient response, submission of negative pregnancy test result for women of reproductive potential, submission of baseline complete blood counts, renal function tests, liver functions tests and confirmation that complete blood counts, renal function tests and liver function tests are scheduled to be monitored periodically while on therapy, submission of pediatric patient weight
Age Restrictions	2 YO or older
Prescriber Restrictions	Limited to rheumatologists or dermatologists
Coverage Duration	up to one year
Other Criteria	

PEGYLATED INTERFERONS/RIBAVIRIN

Products Affected

- COPEGUS
- MODERIBA 1200 DOSE PACK
- MODERIBA 800 DOSE PACK
- MODERIBA ORAL TABLET
- PEG-INTRON REDIPEN
- PEG-INTRON SUBCUTANEOUS* KIT 50 MCG/0.5ML
- PEGASYS PROCLICK
- PEGASYS SUBCUTANEOUS* SOLUTION
- PEGINTRON SUBCUTANEOUS* KIT 120 MCG/0.5ML, 150 MCG/0.5ML, 80 MCG/0.5ML
- REBETOL
- RIBASPHERE
- RIBASPHERE RIBAPAK ORAL TABLET 400 & 600 MG, 400 MG, 600 MG
- *ribavirin oral*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	automimmune hepatitis, hepatic decompensation (Child-Pugh score greater than 6 [class B and C]) in cirrhotic CHC patients before or during treatment, for combination therapy with ribavirin-pregnant women and men whose female partners are pregnant, patients diagnosed with hemoglobinopathies (thalassemia majore, sickel-cell anemia), creatinine clearance less than 50ml/min
Required Medical Information	Diagnosis of Covered Use and submission of Lab values (HCV RNA level, ALT, AST, genotype), patient weight, for patients receiving combination therapy with ribavirin- submission of neagtive preganancy test result prior to therapy, documentation that at least two forms of contraception will be used during treatment and that patient will undergo monthly pregnancy tests, submission of current (obtained within the previous three months) serum creatinine level to calculate creatinine clearance
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	48 weeks

PA Criteria	Criteria Details
Other Criteria	None

POMALYST

Products Affected

- POMALYST

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Pregnancy
Required Medical Information	Diagnosis of covered use, submission of baseline laboratory values including serum creatinine, serum bilirubin, AST and ALT, CBC including ANC and platelet count
Age Restrictions	18 YO or older
Prescriber Restrictions	Limited to oncology or hematology
Coverage Duration	Indefinite
Other Criteria	

Prior Auth to Override Specialty Restrictions

Products Affected

- *acitretin*
- APOKYN
- APTIOM
- *calcipotriene-betameth diprop*
- FABIOR
- ICLUSIG
- LAZANDA
- NUEDEXTA
- *olanzapine-fluoxetine hcl*
- SOOLANTRA
- SORIATANE
- SYLATRON SUBCUTANEOUS* KIT 200 MCG, 300 MCG, 600 MCG
- SYMBYAX
- TACLONEX
- TAZORAC
- VALCHLOR
- XYREM

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of Covered Use
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	Physicians who specialize in the treatment of medical conditions most commonly treated with this medication are exempt from prior authorization.

PROCRIT

Products Affected

- PROCRIT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of Covered Use. Lab values from bloodwork indicating hemoglobin and iron levels. Blood pressure is also required.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Months
Other Criteria	None

PROCYSBI

Products Affected

- PROCYSBI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Hypersensitivity to cysteamine, penicillamine, or any component of the formulation
Required Medical Information	Diagnosis of covered use
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	one year
Other Criteria	

Promacta

Products Affected

- PROMACTA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, previous therapies tried (corticosteroids, immunoglobulins), lab values (including ALT, AST, bilirubin, CBC with differentials and platelet count)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	up to six months
Other Criteria	None

PROVIGIL/NUVIGIL

Products Affected

- *modafinil*
- NUVIGIL
- PROVIGIL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use and sleep latency test results may be required
Age Restrictions	17 YO or older
Prescriber Restrictions	
Coverage Duration	one year
Other Criteria	

Purified Proteinase Inhibitor

Products Affected

- ARALAST NP INTRAVENOUS* SOLUTION RECONSTITUTED 400 MG
- GLASSIA
- PROLASTIN-C
- ZEMAIRA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Individuals with immunoglobulin A (IgA) deficiency who have known antibodies against IgA, patients who have previously demonstrated hypersensitivity, anaphylaxis or severe systemic response to alpha1-proteinase inhibitor products
Required Medical Information	Diagnosis of covered use, submission of patient body weight, confirmation that patient has clinically evident emphysema secondary to congenital alpha-PI deficiency by submission of pulmonary function testing (e.g. spirometry or body plethysmography), X-ray radiography or Diffusing capacity of the lung for carbon monoxide (DLCO).
Age Restrictions	18 YO or older
Prescriber Restrictions	Limited to pulmonology
Coverage Duration	indefinite

PA Criteria	Criteria Details
Other Criteria	If the medication is being obtained at a retail pharmacy, it may be covered under Part D provided the following conditions are satisfied:If a physician or health care provider is administering the medication, he/she agrees to accept brown bagging of the medication and understands that the enrollee will obtain the medication from a pharmacy and have it in their possession until the enrollee delivers the medication to the physician office, infusion centeror homecare provider for administration, if the medication is being self-administered documentation is provided that the enrollee has been fully trained on how to prepare the injection and to administer the medication safely and effectively if applicable. If these conditions are not satified this medication may be covered under Part B.

QUDEXY XR

Products Affected

- QUDEXY XR
- *topiramate er*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Patients with metabolic acidosis taking concomitant metformin
Required Medical Information	Diagnosis of Covered use and submission of baseline serum creatinine and patient weight (to calculate creatinine clearance), documentation patient will have periodic evaluations of intraocular pressure, submission of baseline serum bicarbonate level and confirmation this will be periodically monitored while on therapy
Age Restrictions	2 yo or older
Prescriber Restrictions	
Coverage Duration	one year
Other Criteria	

RAGWITEK

Products Affected

- RAGWITEK

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Severe, unstable or uncontrolled asthma, history of any severe systemic allergic reaction or any severe local reaction to sublingual allergen immunotherapy, history of eosinophilic esophagitis,hypersensitivity to gelatin, mannitol, or sodium hydroxide
Required Medical Information	Ragwitek is being requested for the treatment of grass pollen induced allergic rhinitis with or without conjunctivitis confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for short ragweed pollen, therapy is being initiated at least 12 weeks before the expected onset of ragweed pollen season, confirmation that the first dose of medication will be administered in a healthcare setting under the supervision of a physician with experience in the diagnosis and treatment of allergic diseases and that the patient will be observed for at least 30 minutes after administration of the first dose to monitor for signs and symptoms of a severe systemic or severe local allergic reaction.
Age Restrictions	Patients 18 through 65 years of age
Prescriber Restrictions	Limited to allergy and immunology
Coverage Duration	one year
Other Criteria	Confirmation auto-injectable epinephrine therapy has been prescribed and patient has been instructed on the proper use of emergency self-injection epinephrine.

RASUVO

Products Affected

- RASUVO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Contraindicated in pregnancy, nursing mothers, alcoholism or liver disease, immunodeficiency syndromes, preexisting blood dyscrasias, hypersensitivity to methotrexate, treatment of neoplastic conditions
Required Medical Information	Diagnosis of covered use, documentation of intolerance or inadequate response to first-line therapy, submission of complete blood count (CBC)with differential and platelet count, submission of baseline hepatic enzymes, renal function tests and a chest X-ray, submission of current height and weight for pediatric patients for the purposes of dosage verification
Age Restrictions	
Prescriber Restrictions	limited to rheumatology or dermatology
Coverage Duration	One Year
Other Criteria	

RAVICTI

Products Affected

- RAVICTI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Patients less than 2 months of age, patients with a known hypersensitivity to phenylbutyrate
Required Medical Information	Diagnosis of covered use, submission of documentation that patient's urea cycle disorder (UCD) cannot be managed by dietary protein restriction and/or amino acid supplementation alone, confirmation that medication is being used in conjunction with dietary protein restriction, confirmation that medication is being prescribed by a physician experienced in the management of UCDs, submission of patient's height and current weight for dose verification purposes, submission of baseline fasting plasma ammonia level
Age Restrictions	2 YO or older
Prescriber Restrictions	
Coverage Duration	remainder of the contract year
Other Criteria	

Remicade

Products Affected

- REMICADE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Remicade doses greater than 5mg/kg in patients with moderate to severe heart failure, patients with a history of severe hypersensitivity reaction to Remicade
Required Medical Information	Diagnosis of covered use,TB skin test result obtained within the past six months, Laboratory values to include CRP, sed rate, rheumatoid factor for rheumatoid arthritis , CRP for ankylosing spondylitis. Number of tender and swollen joints for rheumatoid arthritis.Previous trial of at least one DMARD for Rheumatoid arthritis. Trial of at least one DMARD and at least one NSAID for psoriatic arthritis. Trial of at least one NSAID for ankylosing spondylitis. Documentation that the percentage of body surface area involved is at least 10% and a trial of at least one DMARD for plaque psoriasis. Trial of at least one antibiotic OR one oral corticosteroid and use of either mesalamine OR azathioprine/mercaptopurine for Crohn's disease, trial of one oral corticosteroid and at least one of the following-6-mercaptopurine, azathioprine or methotrexate for ulcerative colitis, documentation that the healthcare setting and providers are prepared to manageinfusion reactions including anaphylaxis
Age Restrictions	6 YO ot older
Prescriber Restrictions	Limited to rheumatology, dermatology, gastroenterology
Coverage Duration	up to 4 months initially then to the remainder of the contract year

PA Criteria	Criteria Details
Other Criteria	If the medication is being obtained at a retail pharmacy, it may be covered under Part D provided the following conditions are satisfied:A a physician/health care provider is administering the medication and he/she agrees to accept brown bagging of the medication and understands that the enrollee will obtain the medication from a pharmacy and have it in their possession until the enrollee delivers the medication to the physician office or infusion center for administration If these conditions are not satified this medication may be covered under Part B.

Remodulin

Products Affected

- REMODULIN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of patient weight
Age Restrictions	16 YO and older
Prescriber Restrictions	Limited to pulmonology or cardiology
Coverage Duration	indefinite
Other Criteria	

REPATHA

Products Affected

- REPATHA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Patients with a history of serious hypersensitivity reaction to Repatha
Required Medical Information	Diagnosis of covered medical use as medically indicated for the treatment of homozygous familial hypercholesterolemia (HoFH), heterozygous familial hypercholesterolemia (HeFH) or ASCVD. If medication is being requested for HoFH, submission of one of the following is required: genetic testing showing at least one LDL receptor-defective mutation, clinical diagnosis based on LDL greater than 55 mg/dL and the presence of tendon xanthomas before the age of 10 years, or the presence of untreated elevated LDL consistent with HeFH in both parents and submission of documentation that Repatha is being used as an adjunct to diet and other LDL-lowering therapies (statins, ezetimibe, LDL apheresis). If medication is required for the treatment of HeFH, documentation of genetic test results with a HeFH score of greater than 8 based on MedPac and WHO and submission of documentation that Repatha is being used as an adjunct to diet and maximally tolerated statin therapy. If requested for treatment of ASCVD, patient has history of one of the following: MI, ACS, stable or unstable angina, coronary or other arterial revascularization, stroke, TIA, PAD and ASCVD risk score is equal to or greater than 7.5% and submission of documentation that Repatha is being used as an adjunct to diet and maximally tolerated statin therapy. Submission of LDL level obtained within the previous 6 months and LDL-C goal
Age Restrictions	13 years of age or older for the treatment of HoFH 18 years of age or older for the treatment of HeFH or ASCVD
Prescriber Restrictions	The authorization must be submitted by or under the documented recommendation of a cardiologist or lipidologist
Coverage Duration	6 months initially, then annually thereafter

PA Criteria	Criteria Details
Other Criteria	Submission of LDL level documenting clinically significant response to therapy will be required for reauthorization.

REVATIO

Products Affected

- REVATIO
- *sildenafil citrate intravenous**
- *sildenafil citrate oral*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of Covered Use
Age Restrictions	
Prescriber Restrictions	Limited to Pulmonologists/Cardiologists
Coverage Duration	Indefinite
Other Criteria	None

REVLIMID

Products Affected

- REVLIMID

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of Covered Use, pregnancy negative, Lab values (CBC)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	None

RUCONEST

Products Affected

- RUCONEST

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Known or suspected allergy to rabbits and rabbit-derived products, history of immediate hypersensitivity to C1 esterase inhibitors
Required Medical Information	Diagnosis of covered use, submission of patient's current weight, confirmation treatment will be initiated under the supervision of a qualified healthcare professional experienced in the treatment of hereditary angioedema
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	Member has been instructed on proper administration technique if self-administering

SAMSCA

Products Affected

- SAMSCA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of Covered Use and Lab Values (Serum sodium)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	30 days
Other Criteria	None

SAVAYSA

Products Affected

- SAVAYSA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D. All medically-accepted indications not otherwise excluded from Part D
Exclusion Criteria	patients with active pathological bleeding
Required Medical Information	Diagnosis of covered medical use, submission of creatinine clearance or current body weight and serum creatinine level for the purposes of creatinine clearance calculation using the Cockcroft-Gault equation for all covered uses, confirmation that patient has received 5 to 10 days of initial therapy with a parenteral anticoagulant and submission of current weight if being prescribed for the treatment of Deep Vein Thrombosis(DVT) or Pulmonary Embolism (PE)
Age Restrictions	18 YO or older
Prescriber Restrictions	
Coverage Duration	one year
Other Criteria	When used for the treatment of nonvalvular atrial fibrillation, Savaysa is not authorized for patients with CrCl greater than 95 mL/min.When used for the treatment of DVT or PE for patients with CrCl 15 to 50ml/minute, who weigh 60 kg or less or who are taking certain concomitant P-gp inhibitor medications (verapamil and quinidine or the short-term concomitatnt administration of azithromycin, clarithromycin, erynthromycin, oral itraconazole or oral ketoconazole)the maxiumum dosage authorized is 30mg once daily.

Self Injectable Drug Policy

Products Affected

- ACTIMMUNE
- ELIGARD
- FIRMAGON
- *leuprolide acetate injection*
- LUPRON DEPOT
- LUPRON DEPOT-PED INTRAMUSCULAR* KIT 11.25 MG, 15 MG
- *octreotide acetate injection solution 100 mcg/ml, 1000 mcg/ml, 200 mcg/ml, 50 mcg/ml, 500 mcg/ml*
- SANDOSTATIN
- SANDOSTATIN LAR DEPOT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of Covered Use
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	None

SEROSTIM

Products Affected

- SEROSTIM

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of Covered Use, patient height and weight
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	None

SIGNIFOR

Products Affected

- SIGNIFOR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of the following lab values-fasting plasma glucose, hemoglobin A1c, ALT,aspartate aminotransferase, alkaline phosphatase, total bilirubin, TSH, free T4, GH/IGF-1, 24-hour urinary free cortisol, submission of ECG results, submission of gallbladder ultrasound results
Age Restrictions	18 YO or older
Prescriber Restrictions	
Coverage Duration	Two months initially then one year
Other Criteria	

SIMPONI

Products Affected

- SIMPONI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered Use. TB skin test result obtained within past six months , number of swollen and tender joints for rheumatoid arthritis, Laboratory values to include rheumatoid factor, sed rate, CRP for rheumatoid arthritis, CRP for ankylosing spondylitis, able to self-inject, previous trial of at least one DMARD for rheumatoid arthritis, at least one DMARD for psoriatic arthritis, at least one NSAID for ankylosing spondylitis and for ulcerative colitis documentation of patient?s corticosteroid dependence or a trial of at least one of the following: oral aminosalicylates, oral corticosteroids, azathioprine, or 6-mercaptopurine.
Age Restrictions	
Prescriber Restrictions	Limited to Rheumatology/Dermatology/gastroenterology
Coverage Duration	One Year
Other Criteria	None

Simponi Aria

Products Affected

- SIMPONI ARIA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, TB skin test result obtained within past six months ,Hepatitis B surface antigen test result obtained within the past six months, number of swollen and tender joints, Laboratory values to include rheumatoid factor, sed rate, CRP, previous trial of at least one DMARD, documentation patient will receive concurrent methotrexate therapy,submission of patient weight,documentation that the healthcare setting and providers are prepared to manage infusion reactions including anaphylaxis
Age Restrictions	18 YO or older
Prescriber Restrictions	limited to rheumatology
Coverage Duration	up to 6 months initially then for the remainder of the contract year

PA Criteria	Criteria Details
Other Criteria	If the medication is being obtained at a retail pharmacy, it may be covered under Part D provided the following conditions are satisfied:A a physician/health care provider is preparing and administering the medication and he/she agrees to accept brown bagging of the medication and understands that the enrollee will obtain the medication from a pharmacy and have it in their possession until the enrollee delivers the medication to the physician office or infusion center for administration If these conditions are not satified this medication may be covered under Part B. Continuation of therapy requires submission of objective documentation of positive patient response including effect on number of swollen and tender joints, CRP, rheumatoid factor and/or sed rate. Submission of updated TB skin test result obtained withing the past 12 months and submission of updated patient weight.

SIMVASTATIN HIGH DOSE

Products Affected

- *simvastatin oral tablet 80 mg*
- ZOCOR ORAL TABLET 80 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Any new start to therapy: not recommended as initial therapy nor for patients already taking lower doses of simvastatin whose response is not adequate, coadministration with strong cytochrome P450 (CYP-450) 3A4 inhibitors (eg, itraconazole, ketoconazole, posaconazole, voriconazole, HIV protease inhibitors, boceprevir, telaprevir, erythromycin, clarithromycin, telithromycin, nefazodone, cobicistat-containing products), gemfibrozil, cyclosporine, or danazol, patients with active liver disease, nursing mothers, women who are pregnant or may become pregnant
Required Medical Information	Diagnosis of covered use, submission of documentation that patient has been taking simvastatin for 12 months or longer without ill effect, submssion of current (obtained within the previous three months) lipid panel including HDL, LDL and triglyceride levels, submission of current (obtained within the previous three months) liver function tests including ALT, AST and total bilirubin, submission of current (obtained within the previous three months) serum creatinine level and patient weight, for women of childbearing age submission of negative pregnancy test result and documenation that patient has been counseled about the potential hazards of therapy if pregnancy occurs,
Age Restrictions	10 YO or older
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	

SIRTURO

Products Affected

- SIRTURO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded by Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, confirmation that patient will receive at least 3 other drugs in combination with Sirturo to which the patient's infection has been shown to be susceptible, submission of baseline ECG and confirmation that ECG will be obtained at 2, 12 and 24 weeks after starting therapy, submission of baseline serum potassium, calcium and magnesium levels, submission of baseline ALT, AST, alkaline phosphatase and bilirubin and confirmation these lab values will be obtained monthly while on treatment
Age Restrictions	18 YO or older
Prescriber Restrictions	Limited to infectious disease specialist
Coverage Duration	24 weeks
Other Criteria	

SIVEXTRO

Products Affected

- SIVEXTRO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of culture proven infection caused by susceptible isolates of one of the following Gram-positive micoorganisms: Staphyloccocus aureus (including methiciliin-resistant MRSA) and methicillin-susceptible (MSSA) isolates, Stretococcus pyogenes, Streptococcus agalactiae, Streptococcus anginosus Group(including Streptococcus anginosus, intermedius and constellatus), and Enterococcus faecalis, submission of baseline neutrophil count documenting at least 1000 cells/mm3.
Age Restrictions	18 YO or older
Prescriber Restrictions	Limited to infectious disease specialist
Coverage Duration	6 days of therapy
Other Criteria	If this medication is being administered in the enrollee's home via an infusion pump it is covered as a Part B benefit. If it being administered in the enrollee's home via IV drip it is covered as a Part D benefit.

SOMATULINE DEPOT

Products Affected

- SOMATULINE DEPOT SUBCUTANEOUS* SOLUTION 120 MG/0.5ML, 60 MG/0.2ML, 90 MG/0.3ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded by Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use and for the treatment of acromegaly-submission of serum GH and IGF-1 levels, documentation of degree of control of clinical acromegaly symptoms patient has, submission of TSH and blood glucose levels and confirmation that blood glucose levels will be monitored if the dose is altered, submission of current serum creatinine level and patient weight for the purposes of calculating creatinine clearance, submission of documentation of the presence or absence of hepatic impairment and if present the severity of such impairment
Age Restrictions	18 YO or older
Prescriber Restrictions	
Coverage Duration	3 months intially then one year

PA Criteria	Criteria Details
Other Criteria	If the medication is being obtained at a retail pharmacy, it may be covered under Part D provided the following conditions are satisfied:If a physician is administering the medication, he/she agrees to accept brown bagging of the medication and understands that the enrollee will obtain the medication from a pharmacy and have it in their possession until the enrollee delivers the medication to the physician office for administration, if the medication is being self-administered by the enrollee documentation is provided that the member has been fully trained on how to prepare the medication for injection and to administer the medication safely and effectively if applicable. If these conditions are not satified this medication may be covered under Part B in accordance with the corresponding NCD/LCD if applicable.

SOMAVERT

Products Affected

- SOMAVERT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of Covered Use and Lab values (IGF-1 levels, LFTs)
Age Restrictions	
Prescriber Restrictions	Limited to Endocrinologist
Coverage Duration	6 wks, then every 6 Months
Other Criteria	None

SOVALDI

Products Affected

- SOVALDI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use and laboratory confirmation of hepatitis C virus (HCV) genotype infection, including those with hepatocellular carcinoma meeting Milan criteria (awaiting liver transplantation) and those with HCV/HIV-1 co-infection. Also confirmation that Sovaldi is not being used as monotherapy, and whether or not patient is eligible to receive an interferon-based regimen, documentation of patient's liver transplant status, documentation of patient's CHC treatment status either treatment naive, prior relapser or prior non-responder.
Age Restrictions	18 YO or older
Prescriber Restrictions	
Coverage Duration	24 weeks based on genotype or 48 weeks for hepatocellular carcinoma pts awaiting transplant
Other Criteria	

SPRYCEL

Products Affected

- SPRYCEL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of Covered Use, documentation of prior therapy (except for the treatment of adults with newly diagnosed Philadelphia chromosome-positive (Ph+) chronic myeloid leukemia (CML) in chronic phase) for Philadelphia chromosome-positive acute lymphoblastic leukemia and chronic, accelerated, or myeloid or lymphoid blast phase Philadelphia chromosome-positive chronic myeloid leukemia, CBC including platelet count and ANC.
Age Restrictions	18 YO or older
Prescriber Restrictions	Limited to Oncologists/Hematologists.
Coverage Duration	Indefinite
Other Criteria	None

STELARA

Products Affected

- STELARA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use. TB screening prior to initiating and periodically during therapy, complete blood cell count, ustekinumab-antibody formation, previous trial of at least one DMARD.
Age Restrictions	18 YO or older
Prescriber Restrictions	Limited to Rheumatologists or Dermatologist
Coverage Duration	one year
Other Criteria	monitor for signs/symptoms of infection, RPLS, and squamous cell skin carcinoma, yearly TB screening

STIVARGA

Products Affected

- STIVARGA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of the following laboratory tests: ALT, AST, serum bilirubin, submission of baseline blood pressure reading
Age Restrictions	18 YO or older
Prescriber Restrictions	limited to oncologists/hematologists
Coverage Duration	indefinite
Other Criteria	

SUCRAID

Products Affected

- SUCRAID

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of Covered Use
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	

Sutent

Products Affected

- SUTENT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of Covered Use
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	None

SYMLIN

Products Affected

- SYMLINPEN 120
- SYMLINPEN 60

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of Covered Use, HbA1C, Diabetes educator involvement required,previous or current use of an insulin
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Up to 1 year
Other Criteria	Endocrinologists are exempt from PA.

SYNAGIS

Products Affected

- SYNAGIS INTRAMUSCULAR*
  SOLUTION 50 MG/0.5ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of patient's current weight. For the treatment of BPD- patient is 24 months of age or less at the start of Synagis season, patient required ventilatory support or supplemental oxygen beyond 36 weeks gestational age, within the six months preceding Synagis administration infant had one or more of the following clinical needs-Daily use of inhaled or oral bronchodilators, Recent use of oral or inhaled corticosteroid therapy or Regular or intermittent use of diuretics to treat pulmonary disease. For the treatment of CHD-patient is 24 months of age or less at the start of Synagis season, patient is receiving medication to control congestive heart failure or patient has moderate to severe pulmonary hypertension or patient has cyanotic heart disease. For patients with a history of premature birth-submission of patient's gestational age at birth. For patients 28 weeks gestational age at birth or less patient is 12 months of chronological age or less at the start of Synagis season, for patients 29 ? 32 weeks gestation age at birth patient is less than 6 months of chronological age at the start of Synagis season, for patients 32 weeks, 0 days through 34 weeks, 6 days gestation age at birth, patient was born less than three months prior to the start of Synagis season or is born during the RSV season and one of the following two risk factors is present: Currently attends day care or has a sibling younger than 5 years of age.
Age Restrictions	patients up to 24 months of age
Prescriber Restrictions	

PA Criteria	Criteria Details
Coverage Duration	One complete season (a maximum of 5 doses to be administered from November 1st-March 31st)
Other Criteria	If the medication is being obtained at a retail pharmacy, it may be covered under Part D provided the following conditions are satisfied:A physician/health care provider is administering the medication and he/she agrees to accept brown bagging of the medication and understands that the enrollee will obtain the medication from a pharmacy and have it in their possession until the enrollee delivers the medication to the physician office or infusion center for administration. This medication may be covered under Part B if administered by a physician incident to a physician service. Synagis may be authorized for a maxiumum of five doses (one complete season) from November 1st-March 31st depending on patient diagnosis, history of prematurity and when during the RSV season treatment is begun.

SYNAREL

Products Affected

- SYNAREL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of Covered Use
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	None

SYPRINE

Products Affected

- SYPRINE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use and intolerant to penicillamine
Age Restrictions	6 YO and older
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	

TAFINLAR

Products Affected

- TAFINLAR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of FDA- approved test confirming presence of BRAF V600E mutation, documentation is submitted stating female patient of reproductive potential has been advised to use a highly effective non-hormonal method of contraception during treatment and for 4 weeks after treatment
Age Restrictions	18 YO or older
Prescriber Restrictions	limited to oncology and hematology
Coverage Duration	indefinite
Other Criteria	

TECHNIVIE

Products Affected

- TECHNIVIE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	patients with severe hepatic impairment (Child-Pugh C), co-administration with drugs that are highly dependent on CYP3A for clearance, or moderate and strong inducers of CYP3A, known hypersensitivitity to ritonavir,and for patients taking concurrent ribavirin therapy-pregnant women and men whose female partners are pregnant, patients diagnosed with hemoglobinopathies (thalassemia major, sickel-cell anemia), creatinine clearance less than 50ml/min, coadministration with didanosine, hypersensitivity, including serious skin reaction to ribavirin and autoimmune hepatitis
Required Medical Information	Diagnosis of covered use and laboratory confirmation of hepatitis C virus (HCV) genotype 4 infection, submission of baseline HCV RNA level, documentation of patient's CHC treatment status as either treatment-naive or treatment-experienced and whether cirrhosis is present or not, submission of baseline ALT,confirmation that treatment experienced patients will receive concurrent ribavirin therapy, submission of documentation of the presence or absence of hepatic impairment and if present the Child-Pugh classification of such impairment, for patients who will receive concurrent ribavirin therapy-submission of baseline serum creatinine and current weight for the purposes of calculating creatinine clearance
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	12 weeks
Other Criteria	12 weeks of treatment may be considered for treatment-naive patients who cannot tolerate ribavirin.

Testosterone Replacement

Products Affected

- ANDRODERM TRANSDERMAL PATCH 24 HR 2 MG/24HR, 4 MG/24HR
- ANDROGEL
- ANDROGEL PUMP
- AXIRON
- DEPO-TESTOSTERONE
- FORTESTA
- NATESTO
- STRIANT
- TESTIM
- *testosterone cypionate intramuscular* solution 200 mg/ml*
- *testosterone enanthate intramuscular**
- TESTOSTERONE TRANSDERMAL 10 MG/ACT (2%)
- *testosterone transdermal 25 mg/2.5gm (1%)*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of Covered Use, serum testosterone level, documentation that patient has been evaluated for the presence of prostate cancer prior to initiation of therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	Endocrinologist and Urologist are exempt from PA

TOBI PODHALER

Products Affected

- TOBI PODHALER

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	28 days
Other Criteria	

TRACLEER

Products Affected

- TRACLEER

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Pregnancy
Required Medical Information	Diagnosis of Covered Use, Liver function tests, failure of sildenafil or tadalafil
Age Restrictions	
Prescriber Restrictions	Limited to Pulmonologists or Cardiologists
Coverage Duration	Indefinite
Other Criteria	None

TROKENDI XR

Products Affected

- TROKENDI XR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	patients with metabolic acidosis taking concomitant metformin
Required Medical Information	Diagnosis of covered use, submission of baseline serum creatinine and patient's weight (to calculate creatinine clearance)
Age Restrictions	6 YO or older
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	

TYKERB

Products Affected

- TYKERB

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Documentation that Tykerb is being requested for the treatment of human epidermal growth factor receptor type 2 (HER2) overexpressing advanced or metastatic breast cancer in combination with capecitabine in patients who have received prior therapy including an anthracycline, a taxane, and trastuzumab or for the treatment of HER2 overexpressing hormone receptor?positive metastatic breast cancer in combination with letrozole in postmenopausal women where hormone therapy is indicted, submission of baseline ECG and LVEF and confirmation that evaluations of LVEF will continue during treatment, submission of baseline ALT ,AST and total bilirubin and confirmation liver functions tests will be monitored as clinically indicated during treatment, submission of baseline serum potassium and magnesium levels
Age Restrictions	18 YO or older
Prescriber Restrictions	Limited to Oncologists/Hematologists
Coverage Duration	Indefinite
Other Criteria	

Tysabri

Products Affected

- TYSABRI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Patients who have or have had PML, patients who have had a hypersensitivity reaction to Tysabri, requests for doses greater than 300mg every four weeks
Required Medical Information	Diagnosis of covered use, documentation of previous therapies tried for MS or Crohn's diease and patient's response to these therapies,documentation that the patient is not receiving concurrent antineoplastic, immunosuppressant, or immunomodulating agents,forthe treatment of Crohn's disease- submission of CDAI score, confirmation that the medication is being prescribed, dispensed and administered in accordance with the TOUCH prescribing program to patients enrolled in and who meet all the requirements of the TOUCH precribing program,documentation that the healthcare setting and providers are prepared to manage infusion related reactions including life-threatening anaphylaxis
Age Restrictions	18YO or older
Prescriber Restrictions	Limited to neurology or gastroenterology
Coverage Duration	For MS-indefinitely, for CD 12 weeks initially then if positive patient response-indefinitely
Other Criteria	If the medication is being obtained at a retail pharmacy, it may be covered under Part D provided the following conditions are satisfied:A a physician is administering the medication and he/she agrees to accept brown bagging of the medication and understands that the enrollee will obtain the medication from a pharmacy and have it in their possession until the enrollee delivers the medication to the physician office or infusion center for administration If these conditions are not satified this medication may be covered under Part B.

VANDETANIB

Products Affected

- CAPRELSA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Patients with congenital long QT syndrome
Required Medical Information	Diagnosis of covered use and lab values including: serum potassium, calcium, magnesium, bilirubin, and TSH, creatinine clearance, baseline ECG
Age Restrictions	18 YO or older
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	None

VECAMYL

Products Affected

- VECAMYL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	patients with mild, moderate, labile hypertension, patients with coronary insufficiency or history of recent myocardial infarction (MI), patients diagnsoed with uremia, glaucoma or organic pyloric stenosis, patients receiving antibiotic and sulfonamide therapy
Required Medical Information	Diagnosis of covered use,submission of patient weight, submission of serum creatinine and BUN values, submission of documentation confirming patient does not have any of the following- coronary insufficiency, history of recent MI, uremia, glaucoma, organic pyloric stenoisis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	remainder of the contract year
Other Criteria	

Ventavis

Products Affected

- VENTAVIS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use,submission of baseline blood pressure reading,documentation that Ventavis will be inhaled using either the I-neb AAD system or the Prodose AAD system
Age Restrictions	18 YO or older
Prescriber Restrictions	limited to cardiology or pulmonology
Coverage Duration	indefinite
Other Criteria	This medication is covered as a Part B benefit except for enrollees residing in a long-term care facility

VFEND

Products Affected

- VFEND
- VFEND IV
- *voriconazole oral*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of Covered Use,patient weight
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Months
Other Criteria	Infectious Disease Specialists are exempt from prior authorization.

VOTRIENT

Products Affected

- VOTRIENT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of Covered Use
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	None

XALKORI

Products Affected

- XALKORI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, Lab values including ALT, AST, total bilirubin, CBC
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	None

XELJANZ

Products Affected

- XELJANZ

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use,TB skin test, Laboratory values to include rheumatoid factor, sed rate, CRP,lymphocyte count, ANC, hemoglobin, AST, ALT
Age Restrictions	18 YO or older
Prescriber Restrictions	limited to rheumatology
Coverage Duration	one year
Other Criteria	

XENAZINE

Products Affected

- *tetrabenazine*
- XENAZINE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	None

Xolair

Products Affected

- XOLAIR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	self-administration by the patient, based on the dosing table in the prescribing information patients who serum IgE level and body weight place them in the do not dose category
Required Medical Information	Diagnosis of covered use, submission of patient body weight and serum IgE level,submission of pulmonary function test results including FEV1, submission of positive skin test result or demonstrated in-vitro reactivity (RAST test) to a perennial aeroallergen, submission of documentation that patients symptoms are poorly controlled with inhaled corticosteroids, requency of inhaled short-acting beta2-agonist therapy, submission of frequency of daily and nighttime symptoms and exacerbations, effect of exacerbations on activity, submission of documentation that patient will receive treatment in a doctor's office or clinic and be observed for an appropriate amount of time after each treatment, documentation that the healthcare setting and providers are prepared to manage life-threatening anaphylaxis
Age Restrictions	12 YO or older
Prescriber Restrictions	Limited to allergy and pulmonology
Coverage Duration	Up to one year
Other Criteria	If the medication is being obtained at a retail pharmacy, it may be covered under Part D provided the following conditions are satisfied:A a physician is administering the medication and he/she agrees to accept brown bagging of the medication and understands that the enrollee will obtain the medication from a pharmacy and have it in their possession until the enrollee delivers the medication to the physician office or clinic for administration If these conditions are not satified this medication may be covered under Part B.

XTANDI

Products Affected

- XTANDI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	diagnosis of covered use
Age Restrictions	18 YO or older
Prescriber Restrictions	Limited to oncologists/hematologists
Coverage Duration	indefinite
Other Criteria	

ZAVESCA

Products Affected

- ZAVESCA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of Covered Use and documentation that other treatment options have failed
Age Restrictions	18 YO or older
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	None

ZELBORAF

Products Affected

- ZELBORAF

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, lab values including ECG, serum potassium, magnesium and calcium levels, ALT and bilirubin, dermatological exam
Age Restrictions	18 YO or older
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	None

ZERBAXA

Products Affected

- ZERBAXA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D. All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Known serious hypersensitivity to ceftolozane/tazobactam, piperacillin/tazobactam, or other members of the beta-lactam class
Required Medical Information	Diagnosis of Covered Use, submission of patient current weight and serum creatinine level for the purposes of calculating creatinine clearance and dosage verification, confirmation patient will receive concurrent metronidazole therapy when used for the treatment of complicated intra-abdominal infections
Age Restrictions	18 YO or older
Prescriber Restrictions	
Coverage Duration	up to 14 Days based on severity and site of infection
Other Criteria	If the medication is being obtained at a retail pharmacy, it may be covered under Part D provided the following conditions are satisfied:If a physician is administering the medication, he/she agrees to accept brown bagging of the medication and understands that the enrollee will obtain the medication from a pharmacy and have it in their possession until the enrollee delivers the medication to the physician office for administration. If these conditions are not satified or this medication is being administered in the patient's home via an external infusion pump this medication may be covered under Part B in accordance with the corresponding NCD/LCD if applicable. If this medication is being administred in the patients' home via IV drip it is covered as a Part D benefit.Up to 14 days of therapy may be authorized for the treatment of complicated intra-abdominal infectins.7 days of therapy may be authroized for the treatment of urinary tract infections including pyelonephritis.

ZONTIVITY

Products Affected

- ZONTIVITY

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Do not use ZONTIVITY in patients with a history of stroke,transient ischemic attack (TIA), intracranial hemorrhage (ICH) or active pathological bleeding.
Required Medical Information	Diagnosis of Covered Use, documentation of concurrent use with apririn and/or clopidogrel
Age Restrictions	18 YO or older
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	

Zorbtive

Products Affected

- ZORBTIVE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of Covered Use
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Four weeks
Other Criteria	None

ZYDELIG

Products Affected

- ZYDELIG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	History of serious hypersensitivity reactions, including anaphylaxis and toxic epidermal necrolysis
Required Medical Information	Diagnosis of covered use, documentation of prior use of at least two systemic therapies for the treatment of Relapsed follicular B-cell non-Hodgkin lymphoma (FL) and Relapsed small lymphocytic lymphoma (SLL),submission of baseline CBC including ANC and platelet counts, submission of baseline hepatic function including ALT, AST and bilirubin, confirmation ALT and AST will be monitored every two weeks for the first 3 months of therapy, every 4 weeks for the next 3 months, then every 1 to 3 months thereafter while on therapy
Age Restrictions	18 YO or older
Prescriber Restrictions	Limited to oncology or hematology
Coverage Duration	One year
Other Criteria	Provider documents patient has been advised to report any of the following symptoms: jaundice, bruising, severe abdominal pain, bleeding, increase in the number of bowel movements by six or more per day, new or worsening respiratory symptoms including cough or dyspnea, severe skin reaction or development of a fever or any signs of infection.

ZYFLO

Products Affected

- ZYFLO
- ZYFLO CR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of Covered Use and Lab values including: ALT levels and PFT's, prior use of high dose inhaled corticosteroid and long acting beta agonist combination product
Age Restrictions	12 YO
Prescriber Restrictions	Limited to Allergists/Pulmonologists
Coverage Duration	one year
Other Criteria	None

ZYKADIA

Products Affected

- ZYKADIA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of baseline ALT, AST and total bilirubin obtained within the previous three months and confirmation liver function tests will be monitored monthly, submission of baseline ECG, heart rate and serum electrolyte levels obatined within the previous three months, submission of baseline serum glucose level obtained within the previous three months, documentation of progression while on or intolerance to crizotinib
Age Restrictions	18 YO or older
Prescriber Restrictions	limited to oncology and hematology
Coverage Duration	indefinite
Other Criteria	

ZYTIGA

Products Affected

- ZYTIGA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, documentation of other treatments tried, confirmation patient will receive concurrent prednisone, baseline ALT, AST, bilirubin, and serum potassium level, baseline LVEF
Age Restrictions	18 YO or older
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	None

ZYVOX

Products Affected

- *linezolid*
- ZYVOX

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	Diagnosis of Covered Use and Culture
Age Restrictions	
Prescriber Restrictions	Limited to Infectious Disease Specialist
Coverage Duration	up to 28 Days
Other Criteria	None

Zyvox injection

Products Affected

- ZYVOX

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Known hypersensitivity to linezolid, patients taking any medicinal product that inhibits monoamine oxidases A or B (eg, isocarboxazid, phenelzine) or within 2 weeks of taking any such medicinal product, uncontrolled hypertension, pheochromocytoma, thyrotoxicosis, and/or patients taking any of the following types of medications- directly and indirectly acting sympathomimetic agents (eg, pseudoephedrine), vasopressive agents (eg, epinephrine, norepinephrine), or dopaminergic agents (eg, dopamine, dobutamine), unless patient is monitored for potential increase in blood pressure, carcinoid syndrome and/or patients taking any of the following medications- serotonin reuptake inhibitors, tricyclic antidepressants, serotonin 5-HT1 receptor agonists (triptans), meperidine, or buspirone, unless carefully observed for signs and/or symptoms of serotonin syndrome.
Required Medical Information	Diagnosis of covered use confirmed by submission of culture and sensitivity results, submission of CBC
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	up to 4 weeks

PA Criteria	Criteria Details
Other Criteria	If the medication is being obtained at a retail pharmacy, it may be covered under Part D provided the following conditions are satisfied: If a physicianor healthcare provider is administering the medication, he/she agrees to accept brown bagging of the medication and understands that the enrollee will obtain the medication from a pharmacy and have it in their possession until the enrollee delivers the medication to the physician office or clinic for administration, if the medication is being self-administered documentation is provided that the enrollee has been fully trained on how to prepare the injection and to administer the medication safely and effectively if applicable. If these conditions are not satified this medication may be covered under Part B.

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