Tufts Health Unify

2018 Prior Authorization Medical Necessity Guidelines

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TUFTS Health Plan

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Seven days a week, from 8 a.m. to 8 p.m.
TuftsHealthUnify.org

ACTEMRA

Products Affected

- Actemra

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Cytokine Release Syndrome: The member must have a documented diagnosis of chimeric antigen receptor (CAR) T cell-induced severe or life-threatening cytokine release syndrome. Giant Cell Arteritis: The member must have a documented diagnosis of giant cell arteritis and a documented inadequate response after three (3) months at optimal doses or an inability to take methotrexate orcorticosteroids (e.g., methylprednisolone, prednisolone, prednisone). Polyarticular Juvenile Idiopathic Arthritis (PJIA) and Systemic Juvenile Idiopathic Arthritis (SJIA): The member must have a documented diagnosis of either disease and has a documented inadequate response after three (3) months at optimal doses or an inability to take methotrexate OR BOTH corticosteroids (e.g., methylprednisolone, prednisolone, prednisone) AND NSAIDs (e.g. diclofenac, fenoprofen, ibuprofen, naproxen, etc.). Rheumatoid Arthritis (RA): The member must have a documented diagnosis of RA and a documented inadequate response or inability to tolerate at least one tumor necrosis factor antagonist: Cimzia (certolizumab), Enbrel (etanercept), Humira (adalimumab), Remicade (infliximab), Simponi/Simponi Aria (golimumab).
Age Restrictions	For PJIA and SJIA, the member must be two (2) years of age or older.
Prescriber Restrictions	The prescribing physician must be a rheumatologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

AFINITOR

Products Affected

- Afinitor
- Afinitor Disperz

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Advanced Hormone Receptor-Positive, HER2-Negative Breast Cancer(Advanced HR+ BC): Documented diagnosis of Advanced HR+ BC, themember is postmenopausal, concurrently taking exemestane (Aromasin)and has a documented failure of letrozole (Femara) or anastrozole (Arimidex). Advanced Renal Cell Carcinoma (ARCC): Documented diagnosis of ARCC and the member has a demonstrated disease progression or intolerance following an appropriate trial with Nexavar (sorafenib) or Sutent (sunitinib). Partial-onset Seizures Associated with Tuberous Sclerosis Complex: The member must have a documented diagnosis of partial-onset seizures associated with tuberous sclerosis complex and documentation that Afinitor is being used as adjunctive therapy in combination with other therapies (e.g., anticonvulsants). Progressive Neuroendocrine Tumors (PNET): Documented diagnosis of PNET of pancreatic origin in adult patients with unresectable, locally advanced, or metastatic disease or a documented diagnosis of progressive, well-differentiated, non-functional neuroendocrine tumor located in the gastrointestinal tract or lung. Renal Angiomyolipoma with Tuberous Sclerosis Complex: Documented presence of tuberous sclerosis and renal angiomyolipoma(s) greater than or equal to 3 cm in longest diameter. Subependymal Giant Cell Astrocytoma (SEGA): Documented diagnosis of SEGA associated with tuberous sclerosis and the member is not a candidate for surgical resection.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

ALECENSA

Products Affected

- Alecensa

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Lymphoma Kinase (ALK)-positive, Metastatic Non-small Cell Lung Cancer (NSCLC): The member must have a documented diagnosis of ALK-positive, metastatic NSCLC and has progressed on or is intolerant to Xalkori (crizotinib).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

ALIQOPA

Products Affected

- Aliqopa

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of relapsed follicular lymphoma and has received at least two (2) prior systemic therapies.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a hematologist or oncologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

ALUNBRIG

Products Affected

- Alunbrig

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer (NSCLC) and has had disease progression on or are intolerant to Xalkori (crizotinib).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

AMPYRA

Products Affected

- Ampyra

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of Multiple Sclerosis and the member is receiving concurrent therapy with a disease modifying agent (e.g. Aubagio, Avonex, Betaseron, Copaxone, Extavia, Gilenya, Rebif, Tecfidera, or Tysabri) if indicated, and the member is ambulatory with a baseline timed 25 foot walk between 8 and 45 seconds.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a neurologist.
Coverage Duration	Initial authorization is for a period of 12 weeks.
Other Criteria	Additional authorization may be provided if there is documented improvement in walking speed from pre-treatment baseline. Subsequent authorization is for an FDA-approved duration, balance of contract year or clinically appropriate duration.

APTIOM

Products Affected

- Aptiom

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of partial-onset seizures and has had an insufficient response or intolerance to two (2) or more medications indicated for adjunct partial seizures (e.g. Briviact, felbamate (Felbatol), Fycompa, gabapentin (Fanatrex, Gralise, Neurontin), lamotrigine (Lamictal, Lamictal XR, Lamictal ODT), Lyrica, levetiracetam (Keppra, Keppra XR, Roweepra, Spritam), oxcarbazepine (Oxtellar XR, Trileptal), tiagabine (Gabitril), topiramate (Topamax, Trokendi XR), Potiga, Vimpat, and/or zonisamide (Zonegran)).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a neurologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

ARCALYST

Products Affected

- Arcalyst

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of a Cryopyrin-Associated Periodic Syndrome, Familial Cold Autoinflammatory Syndrome, or Muckle-Wells Syndrome.
Age Restrictions	The member must be 12 years of age or older.
Prescriber Restrictions	None
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

ARMODAFINIL AND MODAFINIL

Products Affected

- *armodafinil*
- *modafinil*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage will not be approved for generalized fatigue, jet lag, or sleep-deprivation not associated with a covered diagnosis.
Required Medical Information	The member must have a physician-documented diagnosis of Narcolepsy, Obstructive Sleep Apnea, or Shift-work sleep disorder.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

AUBAGIO

Products Affected

- Aubagio

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of a relapsing form of multiple sclerosis (relapsing-remitting MS, progressive-relapsing MS, or secondary progressive MS with relapse), or the member has a documented failure, contraindication or intolerance to Gilenya (fingolimod) or Tecfidera (dimethyl fumurate).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a neurologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

AURYXIA

Products Affected

- Auryxia

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage will not be approved for the treatment of iron deficiency anemia in patients with CKD not on dialysis.
Required Medical Information	The member must have a documented diagnosis of hyperphosphatemia associated with chronic kidney disease (CKD) and receiving dialysis.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

BENLYSTA

Products Affected

- Benlysta

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Benlysta (belimumab) will not be approved as monotherapy, for members with severe active lupus nephritis or severe active central nervous system lupus, for members who are autoantibody negative or in combination with other biologics or intravenous cyclophosphamide.
Required Medical Information	The member must have a documented diagnosis of active, autoantibody positive (e.g. ANA, anti-ds-DNA, anti-Sm) systemic lupus erythematosus (SLE) and is concurrently taking standard therapy for SLE (e.g., antimalarials, corticosteroids, or immunosuppressives, alone or in combination).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a rheumatologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

BOSULIF

Products Affected

- Bosulif Oral Tablet 100 MG, 400 MG, 500 MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of chronic, accelerated, or blast phase Philadelphia chromosome-positive (Ph+) chronic myelogenous leukemia (CML) with a documented resistance or intolerance to prior therapy, including imatinib mesylate (Gleevec) or the member is newly diagnosed with chronic phase Ph+ CML.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a hematologist or oncologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

BOTULINUM TOXINS

Products Affected

- Botox
- Dysport
- Xeomin

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Botulinum Toxins are excluded from coverage for cosmetic procedures.
Required Medical Information	Botox: Axillary hyperhidrosis: Diagnosis of severe primary axillary hyperhidrosis. Cervical dystonia: Diagnosis of cervical dystonia in adults to reduce the severity of associated abnormal head position and neck pain. Chronic migraine: Diagnosis of chronic migraine (at least 15 days per month with headache lasting 4 hours a day or longer). Overactive bladder: Diagnosis of overactive bladder with symptoms of urge urinary incontinence, urgency, and frequency in adults who have an inadequate response to or who are intolerant to an anticholinergic medication. Strabismus and blepharospasm (associated with dystonia): Diagnosis of strabismus or blepharospasm associated with dystonia, including benign essential blepharospasm or VII nerve disorders. Urinary incontinence: Diagnosis of urinary incontinence due to detrusor overactivity associated with a neurologic condition (e.g. spinal cord injury [SCI], multiple sclerosis [MS]) in adults who have an inadequate response to or are intolerant of an anticholinergic medication. Diagnosis of lower limb spasticity to decrease the severity of increased muscle tone in ankle and toe flexors (gastrocnemius, soleus, tibialis anterior, tibialis posterior, flexor hallucis longus, and flexor digitorum longus). Botox and Dysport: Diagnosis of upper limb spasticity in adults with need to decrease the severity of increased muscle tone in elbow flexors (biceps), wrist flexors (flexor carpi radialis and flexor carpi ulnaris), and finger flexors (flexor digitorum profundus and flexor digitorum sublimis). Dysport and Xeomin: Diagnosis of cervical dystonia in adults to decrease the severity of abnormal head position and neck pain in toxin-naive and previously treated patients. Xeomin: Blepharospasm: Diagnosis of blepharospasm previously treated with Botox. Sialorrhea: Diagnosis of chronic sialorrhea in adults. Dysport: Diagnosis of lower limb spasticity.
Age Restrictions	None
Prescriber Restrictions	None

PA Criteria	Criteria Details
Coverage Duration	Two (2) years
Other Criteria	None

BRIVIACT

Products Affected

- Briviact

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of partial-onset seizures and has had an insufficient response or intolerance to two (2) or more medications indicated for adjunct partial seizures (e.g. Aptiom, felbamate (Felbatol), Fycompa, gabapentin (Fanatrex, Gralise, Neurontin), lamotrigine (Lamictal, Lamictal XR, Lamictal ODT), Lyrica, levetiracetam (Keppra, Keppra XR), oxcarbazepine (Oxtellar XR, Trileptal), tiagabine (Gabitril), topiramate (Topamax, Trokendi XR), Potiga, Vimpat, and/or zonisamide (Zonegran)).
Age Restrictions	Intravenous: The member must be sixteen (16) years of age or older. Oral: The member must be four (4) years of age or older.
Prescriber Restrictions	The prescribing physician must be a neurologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

BUPRENORPHINE/NALOXONE

Products Affected

- SUBOXONE FILM

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Buprenorphine/naloxone preparations will not be covered to treat pain.
Required Medical Information	The member must have a physician-documented diagnosis of opioid dependence.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Authorization is for one (1) year.
Other Criteria	None

CABOMETYX

Products Affected

- Cabometyx

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of advanced renal cell carcinoma (RCC).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

CALQUENCE

Products Affected

- Calquence

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Mantle Cell Lymphoma (MCL): The member must have a documented diagnosis of MCL and has received at least one (1) prior therapy.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a hematologist or oncologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

CAPRELSA

Products Affected

- Caprelsa Oral Tablet 100 MG, 300 MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of symptomatic or progressive medullary thyroid cancer with unresectable locally advanced or metastatic disease.
Age Restrictions	None
Prescriber Restrictions	The prescriber must be an endocrinologist or oncologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

CARBAGLU

Products Affected

- Carbaglu

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of hyperammonemia due to N-acetylglutamate synthase (NAGS) deficiency.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

CELECOXIB

Products Affected

- *celecoxib*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Coverage may be authorized for members meeting one or more of the following clinical criteria: 1) 65 years of age or older. 2) Diagnosis of Rheumatoid Arthritis and 50 years of age or older. 3) Previous or active GI bleeding or hemorrhage. 4) History of GERD or peptic ulcer disease (PUD). 5) Demonstrated lack of effectiveness in relief of symptoms or inability to tolerate at least two (2) prescription non-COX-2 inhibitor NSAIDs (e.g. diclofenac, fenoprofen, ibuprofen, naproxen, etc). 6) Inability to tolerate one (1) or more agents in the NSAID class as evidenced by any of the following symptoms of GI intolerance (e.g., dyspepsia, gastritis, abdominal or stomach pain, heartburn.) 7) Bleeding diathesis or other medical condition(s) that would constitute a significant predisposition to bleeding (e.g. coagulopathy, hemophilia, low platelet count, surgical procedure booked within 5 days of starting the COX-2 drug, etc.). 8) The member is currently taking any of the following medications: a) Anticoagulants (e.g. Coumadin, Eliquis, enoxaparin, fondaparinux, Fragmin, heparin, Innohep, Lovenox, Pradaxa, Xarelto, warfarin) b) Azathioprine, methotrexate, or other metabolites c) Oral corticosteroids (e.g. prednisone, dexamethasone, etc.) d) Proton pump inhibitors (PPIs) (e.g. esomeprazole, lansoprazole, omeprazole, pantoprazole, rabeprazole). e) H2 antagonists (e.g. cimetidine , famotidine, ranitidine) or misoprostol.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

CERDELGA

Products Affected

- Cerdelga

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of type 1 Gaucher Disease and documentation the member is a cytochrome P450 2D6 extensive metabolizer (EMs), intermediate metabolizer (IMs), or poor metabolizer (PMs) as detected by an FDA-approved test.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

CHOLBAM

Products Affected

- Cholbam

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Cholbam will not be approved for members with extrahepatic manifestations of bile acid synthesis disorders due to single enzyme defects (SEDs) or peroxisomal disorders (PDs), including Zellweger spectrum disorders.
Required Medical Information	The member must have a documented diagnosis of bile acid synthesis disorders due to single enzyme defects (SEDs). The member must have a documented diagnosis of peroxisomal disorders (PDs), including Zellweger spectrum disorders, who exhibit manifestations of hepatic disease, steatorrhea, or complications from decreased fat soluble vitamin absorption.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

CIALIS

Products Affected

- Cialis

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Cialis is excluded from coverage for the treatment of Erectile Dysfunction.
Required Medical Information	The member must have a documented diagnosis of Benign Prostatic Hyperplasia (BPH) and has had a documented failure, adverse reaction, or contraindication to a 30-day trial of at least two (2) of the following medications: alfuzosin, doxazosin, dutasteride, dutasteride-tamsulosin, finasteride, tamsulosin, or terazosin.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

CIMZIA

Products Affected

- Cimzia
- Cimzia Prefilled

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Ankylosing Spondylitis: The member has a documented diagnosis of active ankylosing spondylitis. Crohn's Disease: The member must have a documented diagnosis of Crohn's disease and an inadequate response to an appropriate trial with two (2) or more of the following agents: a) Corticosteroids (e.g., methylprednisolone, prednisolone, prednisone). b) 5-Aminosalicylates (e.g. balsalazide (Colazal), Dipentum, mesalamine (Asacol), Pentasa, Rowasa, sulfasalazine (Azulfidine)). c) 6-mercaptopurine (6-MP, Purinethol) or azathioprine. d) Methotrexate OR the member has demonstrated failure or intolerance to infliximab (Remicade). Psoriatic Arthritis: The member must have a documented diagnosis of psoriatic arthritis and has had an inadequate response or inability to take methotrexate or sulfasalazine at maximal doses for three (3) months. Rheumatoid Arthritis (RA): The member must have a documented diagnosis of RA and has documented inadequate response after three (3) months at optimal doses or an inability to take methotrexate.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a gastroenterologist or rheumatologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

CINRYZE

Products Affected

- Cinryze

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of Hereditary Angioedema.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an immunologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

COMETRIQ

Products Affected

- Cometriq (100 mg Daily Dose)
- Cometriq (140 mg Daily Dose)
- Cometriq (60 mg Daily Dose)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of progressive, metastatic medullary thyroid cancer.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

CORLANOR

Products Affected

- Corlanor

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of symptomatic chronic heart failure with left ventricular ejection fraction 35% or less, who are in sinus rhythm with resting heart rate at least 70 beats per minute (bpm) and either are on maximally tolerated doses of beta-blockers or have a contraindication to beta-blocker use.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a cardiologist
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

COSENTYX

Products Affected

- Cosentyx 300 Dose
- Cosentyx Sensoready 300 Dose

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Ankylosing Spondylitis: The member must have a documented diagnosis of active ankylosing spondylitis. Plaque Psoriasis: The member must have a documented diagnosis of moderate-to-severe chronic plaque psoriasis and has failed to respond to, or has been unable to tolerate treatment with one (1) of the following medications: cyclosporine, methotrexate, or acitretin (Soriatane). Psoriatic Arthritis: The member must have a documented diagnosis of psoriatic arthritis and has had an inadequate response or inability to take methotrexate or sulfasalazine at maximal doses for three (3) months.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a dermatologist or rheumatologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

COTELLIC

Products Affected

- Cotellic

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Cotellic is not indicated for treatment of patients with wild-type BRAF melanoma.
Required Medical Information	The member must have a documented diagnosis of unresectable or metastatic melanoma with a BRAF V600E or V600K mutation and is being taken in combination with Zelboraf (vemurafenib).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

CRINONE

Products Affected

- Crinone

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Crinone is excluded as part of an assisted reproductive technology (ART) treatment for infertile women with progesterone deficiency.
Required Medical Information	The member must have a physician-documented diagnosis of secondary amenorrhea.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

CYRAMZA

Products Affected

- Cyramza

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Metastatic Colorectal Cancer (mCRC): The member must have a documented diagnosis of mCRC and has previously received, or provider indicates clinical inappropriateness to therapy with bevacizumab, oxaliplatin, and a fluoropyrimidine. Gastric Cancer: The member must have advanced or metastatic gastric or gastroesophageal junction adenocarcinoma with disease progression on or following fluoropyrimidine- or platinum-containing chemotherapy. Non-Small Cell Lung Cancer (NSCLC): The member must have a documented diagnosis of metastatic NSCLC with disease progression on or after platinum-based chemotherapy AND be using Cyramza in combination with docetaxel. Members with EGFR or ALK genomic tumor aberrations should have disease progression on FDA-approved therapy [tyrosine kinase (epidermal growth factor receptor [EGFR] or anaplastic lymphoma kinase [ALK]) inhibitor (e.g., afatinib, ceritinib, crizotinib, erlotinib, gefitinib)] for these aberrations, prior to receiving Cyramza.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

DESOXYN/METHAMPHETAMINE ORAL TABLET

Products Affected

- Desoxyn
- *methamphetamine hcl*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Desoxyn and methamphetamine oral tablets are not covered for narcolepsy and are excluded from coverage for exogenous obesity.
Required Medical Information	The member must have a physician-documented diagnosis of Attention-Deficit/Hyperactivity Disorder (ADHD).
Age Restrictions	The member must be 6 years of age or older.
Prescriber Restrictions	None
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

DIFICID

Products Affected

- Dificid

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of Clostridium difficile infection with a treatment failure or inadequate response to metronidazole or vancomycin.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

DOPTELET

Products Affected

- Doptelet

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of thrombocytopenia associated with chronic liver disease (CLD) and is scheduled to undergo a procedure.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

DUPIXENT

Products Affected

- Dupixent

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of moderate-to-severe atopic dermatitis and an inadequate treatment response, intolerance, or contraindication to BOTH a high potency topical corticosteroid and a topical calineurin inhibitor (i.e. tacrolimus, Elidel).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an allergist, dermatologist, or immunologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

EGRIFTA

Products Affected

- Egrifta

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of HIV-associated lipodystrophy with excess abdominal fat.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

EMFLAZA

Products Affected

- Emflaza Oral Suspension
- Emflaza Oral Tablet

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of Duchenne muscular dystrophy (DMD).
Age Restrictions	The member must be 5 years of age or older.
Prescriber Restrictions	The prescribing physician must be a neurologist or a provider who specializes in the treatment of DMD.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

ENBREL

Products Affected

- Enbrel Subcutaneous Solution Prefilled Syringe 25 MG/0.5ML, 50 MG/ML
- Enbrel Subcutaneous Solution Reconstituted
- Enbrel SureClick

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Ankylosing Spondylitis: The member must have a documented diagnosis of active ankylosing spondylitis. Plaque Psoriasis: The member must have a documented diagnosis of moderate-to-severe chronic plaque psoriasis and has failed to respond to, or has been unable to tolerate treatment with one (1) of the following medications: cyclosporine, methotrexate, or acitretin (Soriatane). Rheumatoid Arthritis (RA) and Polyarticular Juvenile Idiopathic Arthritis (PJIA): The member must have a documented diagnosis of either disease and has a documented inadequate response after three (3) months at optimal doses or an inability to take methotrexate. Psoriatic Arthritis: The member must have a documented diagnosis of psoriatic arthritis and has had an inadequate response or inability to take methotrexate or sulfasalazine at maximal doses for three (3) months.
Age Restrictions	The member must be 2 years of age or older.
Prescriber Restrictions	The prescribing physician must be a dermatologist or rheumatologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

ENTRESTO

Products Affected

- Entresto

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Entresto will not be covered if the member is concomitantly taking an angiotensin-converting enzyme (ACE) inhibitor or an angiotensin II receptor blocker (ARB).
Required Medical Information	The member must have a documented diagnosis of chronic heart failure (NYHA Class II-IV) and reduced ejection fraction.
Age Restrictions	None
Prescriber Restrictions	The medication is being prescribed by or in consultation with a cardiologist or pulmonologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

EPCLUSA

Products Affected

- Epclusa

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Criteria will be applied consistent with current AASLD-IDSA guidance.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a gastroenterologist, hepatologist, or an infectious disease specialist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

ERIVEDGE

Products Affected

- Erivedge

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of metastatic basal cell carcinoma or locally advanced basal cell carcinoma that has recurred following surgery, or who are not candidates for surgery or radiation.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

ERLEADA

Products Affected

- Erleada

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of nonmetastatic, castration-resistant prostate cancer.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist or urologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

ESBRIET

Products Affected

- Esbriet Oral Capsule
- Esbriet Oral Tablet

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of idiopathic pulmonary fibrosis (IPF) and is not currently taking Ofev (nintedanib).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a pulmonologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

EUCRISA

Products Affected

- Eucrisa

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Members 2 years to 17 years of age: The member must have a documented diagnosis of mild-to-moderate atopic dermatitis and an inadequate treatment response, intolerance, or contraindication to BOTH a low potency topical corticosteroid and a topical cancineurin inhibitor (i.e. tacrolimus, Elidel). Members 18 years of age or older: The member must have a documented diagnosis of mild-to-moderate atopic dermatitis and inadequate treatment response, intolerance, or contraindication to BOTH a high potency topical corticosteroid and a topical calineurin inhibitor (i.e. tacrolimus, Elidel).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a dermatologist or pediatrician.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

EVZIO

Products Affected

- Evzio

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Evzio may be approved for coverage if there is a FDA-confirmed shortage of Narcan [naloxone] nasal spray or the member or the member?s caregivers would be unable to utilize Narcan [naloxone] nasal spray due to significant visual, physical, or functional impairment.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

EXONDYS 51

Products Affected

- Exondys 51

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of Duchenne Muscular Dystrophy (DMD) in patients who have a confirmed mutation of the DMD gene that is amenable to exon 51 skipping.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

FABRAZYME

Products Affected

- Fabrazyme

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of Fabry disease.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

FARYDAK

Products Affected

- Farydak

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of multiple myeloma and has received at least two (2) prior therapies including Velcade (bortezomib) and an immunomodulatory agent, and Farydak is being used in combination with dexamethasone and Velcade.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

FASENRA

Products Affected

- Fasenra

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of severe asthma with aneosinophilic phenotype and documentation that underlying conditions ortriggers for asthma or pulmonary disease are being maximally managed.
Age Restrictions	The member must be 12 years of age or older.
Prescriber Restrictions	The prescriber must be an asthma specialist (e.g., allergist, immunologist,pulmonologist).
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

FIRAZYR

Products Affected

- Firazyr

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Firazyr (icatibant) will not be approved for members with acquired angioedema. Firazyr will not be approved for members concurrently taking an angiotensin converting enzyme (ACE) inhibitor.
Required Medical Information	The member must have a documented diagnosis of Hereditary Angioedema (HAE) with a history of at least one severe attack in the past six (6) months. For HAE Types 1 & 2, the diagnosis must be confirmed by laboratory testing (e.g., low C4 level, reduced C1 esterase inhibitor level or function).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an allergist, hematologist or immunologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

FORTEO

Products Affected

- Forteo

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage of Forteo will not be approved when used in combination with any of the other osteoporosis agents listed in the ""Required Medical Information"" section.
Required Medical Information	Coverage of Forteo may be authorized when the requesting physician has documented that the member is at high risk for fracture and has a T score less than or equal to -2.0 as evidenced via bone density scan or the requesting physician has documented that the member has had one or more osteoporotic fractures. For either condition previously listed, the member must also have had an inadequate response to, or is unable to tolerate therapy with at least one of the traditional osteoporosis treatments: alendronate (Fosamax), calcitonin (Miacalcin), denosumab (Prolia), ibandronate (Boniva), raloxifene (Evista), risedronate (Actonel) or zoledronic acid (Reclast).
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Coverage of Forteo is limited to 24 months.
Other Criteria	None

FYCOMPA

Products Affected

- Fycompa

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Partial-onset Seizures: The member must have a documented diagnosis of partial-onset seizures and has had an insufficient response or intolerance to two (2) or more medications indicated for adjunct partial seizures (e.g. Aptiom, Briviact, felbamate (Felbatol), gabapentin (Fanatrex, Gralise, Neurontin), lamotrigine (Lamictal, Lamictal XR, Lamictal ODT), Lyrica, levetiracetam (Keppra, Keppra XR, Roweepra, Spritam), oxcarbazepine (Oxtellar XR, Trileptal), tiagabine (Gabitril), topiramate (Topamax, Trokendi XR), Potiga, Vimpat, and/or zonisamide (Zonegran)). Primary Generalized Tonic-clonic Seizures: The member must have a documented diagnosis of primary generalized tonic-clonic seizures and has had an insufficient response or intolerance to two (2) or more medications indicated for primary generalized tonic-clonic seizures (e.g. carbamazepine, felbamate, lamotrigine, levetiracetam, phenytoin, topiramate, and valproate).
Age Restrictions	The member must be 12 years of age or older.
Prescriber Restrictions	The prescribing physician must be a neurologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

GATTEX

Products Affected

- Gattex

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of Short Bowel Syndrome (SBS) and is dependent on parenteral nutrition (PN).
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

GAUCHER DISEASE TYPE 1 TREATMENTS

Products Affected

- Cerezyme
- Elelyso
- Vpriv

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage will not be approved for Type 2 or Type 3 Gaucher Disease.
Required Medical Information	The member must have a documented diagnosis of Type 1 Gaucher disease with at least a minimal level of disease severity.
Age Restrictions	For Elelyso and Vpriv, the member must be 4 years of age or older.
Prescriber Restrictions	None
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

GILENYA

Products Affected

- Gilenya

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of either relapsing remitting multiple sclerosis or secondary progressive multiple sclerosis, or the member has a documented failure, contraindication, or intolerance to dimethyl fumurate (Tecfidera) or teriflunomide (Aubagio).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a neurologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

GILOTRIF

Products Affected

- Gilotrif

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of metastatic non-small cell lung cancer (NSCLC) and non-resistant epidermal growth factor receptor (EGFR) mutations as detected by an FDA-approved test OR the member has a documented diagnosis of metastatic, squamous cell NSCLC and documentation that the disease has progressed following platinum-based chemotherapy.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

GROWTH HORMONE REPLACEMENT THERAPY

Products Affected

- Genotropin
- Genotropin MiniQuick
- Humatrope
- Norditropin FlexPro
- Nutropin AQ NuSpin 10
- Nutropin AQ NuSpin 20
- Nutropin AQ NuSpin 5
- Omnitrope
- Saizen
- Saizenprep
- Serostim
- Zomacton
- Zorbtive

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Pediatric GHD, Initiation: Member must be evaluated and treated by a pediatric endocrinologist, have not attained epiphyseal closure as determined by X-ray, have failed to respond to at least TWO standard GH stimulation test, have documented gender-specific delayed bone age, have the height at initiation of therapy at greater than 2 standard deviations below normal mean for age and sex. Member must have one of the following: Chronic Renal Insufficiency prior to transplantation, Turner Syndrome, Prader-Willi Syndrome, Intrauterine Growth Retardation or Noonan Syndrome. Pediatric GHD, Continuation: Documentation of the following is required: Medical history as it relates to growth, including any test results and growth chart, continuing care plan and an improvement in the annualized pre-treatment growth rate after the first six (6) months of therapy. Continuation of Therapy after Completion of Linear Growth: Member will be re-evaluated after GH treatments have been stopped for at least three (3) months to determine growth hormone status AND member must have failed to respond to at least one standard GH stimulation test. Acquired GHD: Member must have failed to respond to at least one standard GH stimulation test. AIDS Wasting Syndrome: Documented diagnosis of AIDS AND a weight loss of at least 10% from baseline weight OR a BMI of less than 20. Short Bowel Syndrome: Documented diagnosis of Short Bowel Syndrome from a gastroenterologist AND a documented dependence on IPN for nutritional support.
Age Restrictions	None

PA Criteria	Criteria Details
Prescriber Restrictions	None
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

HAEGARDA

Products Affected

- Haegarda

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of HereditaryAngioedema.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an immunologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

HARVONI

Products Affected

- Harvoni

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Criteria will be applied consistent with current AASLD-IDSA guidance.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a gastroenterologist, hepatologist, or an infectious disease specialist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

HETLIOZ

Products Affected

- Hetlioz

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage will not be authorized for the diagnosis of insomnia.
Required Medical Information	The member must be completely blind and have a physician-documented diagnosis of non-24-hour sleep-wake disorder (non-24).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a neurologist or sleep specialist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration.
Other Criteria	None

HRM:ANTIPARKINSON AGENTS

Products Affected

- *benztropine mesylate oral*
- *trihexyphenidyl hcl*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented inadequate treatment response, intolerance or contraindication to one or more non-HRM alternative formulary drug listed in the OTHER CRITERIA field. Please provide the name(s) of the drug(s) to which the member has had an inadequate treatment response, intolerance or contraindication and the prescriber acknowledges that medication benefits outweigh potential risks in the member 65 years of age or older.
Age Restrictions	The Prior Authorization requirement only applies to members 65 years of age or older who are newly starting the prescribed medication.
Prescriber Restrictions	None
Coverage Duration	Initial Approval: 1 year. Subsequent approval: Life of Plan.
Other Criteria	Non-HRM Alternatives include, but are not limited to: amantadine, carbidopa/levodopa, tolcapone.

HRM:ESTROGEN-CONTAINING PRODUCTS

Products Affected

- Alora
- CombiPatch
- Duavee
- *estradiol oral*
- *estradiol transdermal*
- *estropipate*
- Femhrt Low Dose
- *fyavolv*
- Menest
- Menostar
- Premarin Oral
- Premphase
- Prempro

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	This criterion applies to estrogen-containing oral and topical patch products only, with or without progesterone.
Required Medical Information	The member must have a documented inadequate treatment response, intolerance or contraindication to one or more non-HRM alternative formulary drug listed in the OTHER CRITERIA field. Please provide the name(s) of the drug(s) to which the member has had an inadequate treatment response, intolerance or contraindication and the prescriber acknowledges that medication benefits outweigh potential risks in the member 65 years of age or older.
Age Restrictions	The Prior Authorization requirement only applies to members 65 years of age or older who are newly starting the prescribed medication.
Prescriber Restrictions	None
Coverage Duration	Initial Approval: 1 year. Subsequent approval: Life of Plan.
Other Criteria	Non-HRM Alternatives include, but are not limited to: alendronate, calcitonin, Forteo, ibandronate, Prolia, raloxifene, risedronate, zoledronic acid (osteoporosis), estradiol vaginal cream, vaginal tab, vaginal ring (menopausal/vaginal symptoms).

HRM:FIRST GENERATION ANTIPSYCHOTICS

Products Affected

- *thioridazine hcl*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented inadequate treatment response, intolerance or contraindication to one or more non-HRM alternative formulary drug listed in the OTHER CRITERIA field. Please provide the name(s) of the drug(s) to which the member has had an inadequate treatment response, intolerance or contraindication and the prescriber acknowledges that medication benefits outweigh potential risks in the member 65 years of age or older.
Age Restrictions	The Prior Authorization requirement only applies to members 65 years of age or older who are newly starting the prescribed medication.
Prescriber Restrictions	None
Coverage Duration	Initial Approval: 1 year. Subsequent approval: Life of Plan.
Other Criteria	Non-HRM Alternatives include, but are not limited to: olanzapine, quetiapine, risperidone, ziprasidone (some may require STPA for approval).

HRM:HYDROXYZINE

Products Affected

- *hydroxyzine hcl oral*
- *hydroxyzine pamoate*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented inadequate treatment response, intolerance or contraindication to one or more non-HRM alternative formulary drug listed in the OTHER CRITERIA field. Please provide the name(s) of the drug(s) to which the member has had an inadequate treatment response, intolerance or contraindication and the prescriber acknowledges that medication benefits outweigh potential risks in the member 65 years of age or older.
Age Restrictions	The Prior Authorization requirement only applies to members 65 years of age or older who are newly starting the prescribed medication.
Prescriber Restrictions	None
Coverage Duration	Initial Approval: 1 year. Subsequent approval: Life of Plan.
Other Criteria	Non-HRM Alternatives include, but are not limited to: desloratadine, levocetirizine (pruritus), duloxetine, escitalopram, venlafaxine ER (anxiety), alprazolam, temazepam (sedation).

HRM:HYPNOTICS

Products Affected

- *eszopiclone*
- *zaleplon*
- *zolpidem tartrate*
- *zolpidem tartrate er*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented inadequate treatment response, intolerance or contraindication to one or more non-HRM alternative formulary drug listed in the OTHER CRITERIA field. Please provide the name(s) of the drug(s) to which the member has had an inadequate treatment response, intolerance or contraindication and the prescriber acknowledges that medication benefits outweigh potential risks in the member 65 years of age or older.
Age Restrictions	The Prior Authorization requirement only applies to members 65 years of age or older who are newly starting the prescribed medication.
Prescriber Restrictions	None
Coverage Duration	Initial Approval: 1 year. Subsequent approval: Life of Plan.
Other Criteria	Non-HRM Alternatives include, but are not limited to: Rozerem, Silenor, temazepam.

HRM:MISCELLANEOUS

Products Affected

- *cyclobenzaprine hcl*
- *cyproheptadine hcl*
- *digitek oral tablet 250 mcg*
- *digox oral tablet 250 mcg*
- *digoxin oral solution*
- *digoxin oral tablet 250 mcg*
- *dihydroergotamine mesylate injection*
- *dipyridamole*
- *disopyramide phosphate*
- *doxepin hcl oral*
- *guanfacine hcl er*
- *indomethacin*
- *indomethacin er*
- Lanoxin Oral Tablet 250 MCG
- *megestrol acetate*
- *nifedipine*
- Norpace CR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented inadequate treatment response, intolerance or contraindication to one or more non-HRM alternative formulary drug listed in the OTHER CRITERIA field. Please provide the name(s) of the drug(s) to which the member has had an inadequate treatment response, intolerance or contraindication and the prescriber acknowledges that medication benefits outweigh potential risks in the member 65 years of age or older.
Age Restrictions	The Prior Authorization requirement only applies to members 65 years of age or older who are newly starting the prescribed medication.
Prescriber Restrictions	None
Coverage Duration	Initial Approval: 1 year. Subsequent approval: Life of Plan.

PA Criteria	Criteria Details
Other Criteria	Non-HRM Alternatives include, but are not limited to: cyproheptadine (levocetirizine, desloratadine or physician attestation that the benefit outweighs the risk for beneficiaries age 65 or older), digoxin/Lanoxin 250 mcg (consider reducing dose to 0.125 mg daily or lower), dipyridamole immediate-release (Aggrenox, anagrelide, clopidogrel, Brilinta, Effient), disopyramide (amiodarone, flecainide, mexiletine, propafenone, quinidine, sotalol), doxepin (citalopram, duloxetine, escitalopram, fluoxetine, fluvoxamine, paroxetine, sertraline, venlafaxine), guanfacine extended-release (amphetamine salt combo, dexmethylphenidate, dextroamphetamine, methamphetamine, methylphenidate), indomethacin (celecoxib, ibuprofen, naproxen, tramadol), megestrol tablets (covered without authorization for advanced carcinoma of the breast or endometrium), megestrol oral suspension (dronabinol) nifedipine immediate-release (isosorbide dinitrate, isosorbide mononitriate, Nitro-BID), Norpace CR (acebutolol, flecainine, mexiletine, propafenone, quinidine, sotelol), reserpine (Hypertension: ACE-Inhibitor or angiotensin-receptor blocker. Psychoses: olanzapine, quetiapine, risperidone, ziprasidone (some may require STPA for approval)). Cyclobenzaprine may be approved for relief of muscle spasm associated with acute, painful musculoskeletal conditions.

HRM:NITROFURANTOIN

Products Affected

- *nitrofurantoin macrocrystal*
- *nitrofurantoin monohyd macro*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented inadequate treatment response, intolerance or contraindication to one or more non-HRM alternative formulary drug listed in the OTHER CRITERIA field. Please provide the name(s) of the drug(s) to which the member has had an inadequate treatment response, intolerance or contraindication and the prescriber acknowledges that medication benefits outweigh potential risks in the member 65 years of age or older.
Age Restrictions	The Prior Authorization requirement only applies to members 65 years of age or older who are newly starting the prescribed medication.
Prescriber Restrictions	None
Coverage Duration	Initial Approval: 1 year. Subsequent approval: Life of Plan.
Other Criteria	Non-HRM Alternatives include, but are not limited to: ciprofloxacin, levofloxacin, sulfamethoxazole/trimethoprim, trimethoprim.

HRM:ORAL HYPOGLYCEMICS

Products Affected

- *chlorpropamide*
- *glyburide*
- *glyburide micronized*
- *glyburide-metformin*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented inadequate treatment response, intolerance or contraindication to one or more non-HRM alternative formulary drug listed in the OTHER CRITERIA field. Please provide the name(s) of the drug(s) to which the member has had an inadequate treatment response, intolerance or contraindication and the prescriber acknowledges that medication benefits outweigh potential risks in the member 65 years of age or older.
Age Restrictions	The Prior Authorization requirement only applies to members 65 years of age or older who are newly starting the prescribed medication.
Prescriber Restrictions	None
Coverage Duration	Initial Approval: 1 year. Subsequent approval: Life of Plan.
Other Criteria	Non-HRM Alternatives include, but are not limited to: glimepiride, glipizide, glipizide-metformin, metformin, tolazamide, tolbutamide.

HRM:PHENOBARBITAL

Products Affected

- *phenobarbital*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented inadequate treatment response, intolerance or contraindication to one or more non-HRM alternative formulary drug listed in the OTHER CRITERIA field. Please provide the name(s) of the drug(s) to which the member has had an inadequate treatment response, intolerance or contraindication and the prescriber acknowledges that medication benefits outweigh potential risks in the member 65 years of age or older.
Age Restrictions	The Prior Authorization requirement only applies to members 65 years of age or older who are newly starting the prescribed medication.
Prescriber Restrictions	None
Coverage Duration	Initial Approval: 1 year. Subsequent approval: Life of Plan.
Other Criteria	Non-HRM Alternatives include, but are not limited to: alprazolam, temazepam (sedation), fosphenytoin, lorazepam, carbamazepine, lamotrigine, levetiracetam, topiramate, valproate (seizures).

HRM:PROMETHAZINE

Products Affected

- *promethazine hcl oral*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented inadequate treatment response, intolerance or contraindication to one or more non-HRM alternative formulary drug listed in the OTHER CRITERIA field. Please provide the name(s) of the drug(s) to which the member has had an inadequate treatment response, intolerance or contraindication and the prescriber acknowledges that medication benefits outweigh potential risks in the member 65 years of age or older.
Age Restrictions	The Prior Authorization requirement only applies to members 65 years of age or older who are newly starting the prescribed medication.
Prescriber Restrictions	None
Coverage Duration	Initial Approval: 1 year. Subsequent approval: Life of Plan.
Other Criteria	Non-HRM Alternatives include, but are not limited to: budesonide nasal, desloratadine, fluticasone nasal, flunisolide nasal, levocetirizine, triamcinolone nasal (allergic rhinitis), Anzemet, aprepitant, Cesamet, Emend, granisetron, meclizine, perphenazine, ondansetron, prochlorperazine, Sancuso (emesis/motion sickness), alprazolam, temazepam (sedation), desloratadine, levocetirizine (urticaria).

HRM:TRICYCLIC ANTIDEPRESSANTS

Products Affected

- *amitriptyline hcl*
- *clomipramine hcl*
- *imipramine hcl*
- *imipramine pamoate*
- Surmontil
- *trimipramine maleate*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented inadequate treatment response, intolerance or contraindication to one or more non-HRM alternative formulary drug listed in the OTHER CRITERIA field. Please provide the name(s) of the drug(s) to which the member has had an inadequate treatment response, intolerance or contraindication and the prescriber acknowledges that medication benefits outweigh potential risks in the member 65 years of age or older.
Age Restrictions	The Prior Authorization requirement only applies to members 65 years of age or older who are newly starting the prescribed medication.
Prescriber Restrictions	None
Coverage Duration	Initial Approval: 1 year. Subsequent approval: Life of Plan.
Other Criteria	Non-HRM Alternatives include, but are not limited to: citalopram, duloxetine, escitalopram, venlafaxine (depression), fluoxetine, fluvoxamine, paroxetine, sertraline (depression/OCD). Imipramine is covered for the diagnosis of enuresis.

HUMIRA

Products Affected

- Humira
- Humira Pediatric Crohns Start
- Humira Pen
- Humira Pen-CD/UC/HS Starter
- Humira Pen-Ps/UV Starter

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Ankylosing Spondylitis: The member must have a documented diagnosis of active ankylosing spondylitis. Crohn's Disease and Ulcerative Colitis (UC): The member must have a documented diagnosis of either disease and an inadequate response to an appropriate trial with two (2) or more of the following agents: a) Corticosteroids (e.g., methylprednisolone, prednisolone, prednisone). b) 5-Aminosalicylates (e.g. balsalazide (Colazal), Dipentum, mesalamine (Asacol), Pentasa, Rowasa, sulfasalazine (Azulfidine)). c) 6-mercaptopurine (6-MP, Purinethol) or azathioprine. d) Methotrexate OR the member has demonstrated failure or intolerance to infliximab (Remicade). Hidradenitis Suppurativa: The member must have a documented diagnosis of moderate-to-severe hidradenitis suppurativa. Plaque Psoriasis: The member must have a documented diagnosis of moderate-to-severe chronic plaque psoriasis and has failed to respond to, or has been unable to tolerate treatment with one (1) of the following medications: cyclosporine, methotrexate, or acitretin (Soriatane). Psoriatic Arthritis: The member must have a documented diagnosis of active psoriatic arthritis and has had an inadequate response or inability to take methotrexate or sulfasalazine at maximal doses for three (3) months. Rheumatoid Arthritis (RA) and Polyarticular Juvenile Idiopathic Arthritis (PJIA): The member must have a documented diagnosis of either disease and has a documented inadequate response after three (3) months at optimal doses or an inability to take methotrexate. Uveitis: The member must have a documented diagnosis of non-infectious intermediate, posterior, and panuveitis.
Age Restrictions	Crohn's Disease: The member must be six (6) years of age or older. PJIA: The member must be two (2) years of age or older.
Prescriber Restrictions	The prescribing physician must be a dermatologist, gastroenterologist, ophthalmologist, or rheumatologist.

PA Criteria	Criteria Details
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

HUNTINGTON'S CHOREA

Products Affected

- Austedo
- *tetrabenazine*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of chorea associated with Huntington's Disease. Austedo only: The member must have a documented diagnosis of tardive dyskinesia.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a neurologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

IBRANCE-UNDER REVIEW

Products Affected

- Ibrance

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	
Other Criteria	

ICLUSIG

Products Affected

- Iclusig

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Iclusig will not be approved for members with newly diagnosed chronic phase CML.
Required Medical Information	Acute Lymphoblastic Leukemia (ALL): The member must be T315I positive or have a documented diagnosis of Philadelphia chromosome-positive ALL (Ph+ALL) for which no other tyrosine kinase inhibitor therapy is indicated. Chronic Myeloid Leukemia (CML): The member must be T315I positive or have a documented diagnosis of chronic phase, accelerated phase, or blast phase CML for which no other tyrosine kinase inhibitor therapy is indicated.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a hematologist or oncologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

IDHIFA

Products Affected

- IDHIFA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of relapsed or refractory acute myeloid leukemia (AML) with an isocitrate dehydrogenase-2 (IDH2) mutation as detected by an FDA-approved test.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

ILARIS

Products Affected

- Ilaris

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Cryopyrin-Associated Periodic Syndromes (CAPS): The member must have a documented diagnosis of CAPS including Familial Cold Autoinflammatory Syndrome (FCAS), or Muckle-Wells Syndrome (MWS). Familial Mediterranean Fever (FMF): The member must have a documented diagnosis of FMF. Hyperimmunoglobulin D Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD): The member must have a documented diagnosis of HIDS/MKD. Systemic Juvenile Idiopathic Arthritis (SJIA): The member must have a documented diagnosis of SJIA and has had a documented inadequate response after three (3) months at optimal doses or an inability to take methotrexate OR BOTH corticosteroids (e.g., methylprednisolone, prednisolone, prednisone) AND NSAIDs (e.g. diclofenac, fenoprofen, ibuprofen, naproxen, etc.). Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS): The member must have a documented diagnosis of TRAPS.
Age Restrictions	CAPS: The member must be four (4) years of age or older. SJIA: The member must be two (2) years of age or older.
Prescriber Restrictions	SJIA: The prescribing physician must be a rheumatologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

IMBRUVICA

Products Affected

- Imbruvica

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Chronic Graft versus Host Disease (cGVHD): The member must have a documented diagnosis of cGVHD and has had a documented inadequate response, contraindication, or inability to tolerate an appropriate trial with one (1) or more lines of systemic therapy. Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL): The member must have a documented diagnosis of CLL/SLL. Mantle Cell Lymphoma (MCL): The member must have a documented diagnosis of MCL and has received at least one (1) prior therapy. Marginal Zone Lymphoma (MZL): The member must have a documented diagnosis of MZL and has received at least one (1) prior anti-CD20-based therapy. Waldenstrom Macroglobulinemia: The member must have a documented diagnosis of Waldenstrom macroglobulinemia.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a hematologist or oncologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

INCRELEX

Products Affected

- Increlex

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage of Increlex will not be authorized for conditions resulting in secondary forms of IGF-1 deficiency that include, but are not limited to: GH deficiency, malnutrition, hypothyroidism, or chronic steroid therapy.
Required Medical Information	The member must have a documented diagnosis of severe primary IGF-1 deficiency as defined by a height SD score less than or equal to -3.0, a basal IGF-1 SD score less than or equal to -3.0 , normal or elevated GH level OR GH gene deletion and has developed neutralizing antibodies to GH. Radiographs documenting open epiphyses are required for members who are Tanner stage III or greater.
Age Restrictions	The member must be aged 2 to 18 years.
Prescriber Restrictions	The prescribing physician must be an endocrinologist.
Coverage Duration	Initial authorization is for six (6) months. Subsequent authorizations are for one (1) year.
Other Criteria	None

INFLECTRA

Products Affected

- Inflectra

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Ankylosing Spondylitis: The member must have a documented diagnosis of active ankylosing spondylitis. Crohn's Disease and Ulcerative Colitis (UC): The member must have a documented diagnosis of either disease and an inadequate response to an appropriate trial with two (2) or more of the following agents: a) Corticosteroids (e.g., methylprednisolone, prednisolone, prednisone). b) 5-Aminosalicylates (e.g. balsalazide (Colazal), Dipentum, mesalamine (Asacol), Pentasa, Rowasa, sulfasalazine (Azulfidine)). c) 6-mercaptopurine (6-MP, Purinethol) or azathioprine. d) Methotrexate OR the member has demonstrated failure or intolerance to infliximab (Remicade). Plaque Psoriasis: The member must have a documented diagnosis of moderate-to-severe chronic plaque psoriasis and has failed to respond to, or has been unable to tolerate treatment with one (1) of the following medications: cyclosporine, methotrexate, or acitretin (Soriatane). Psoriatic Arthritis: The member must have a documented diagnosis of psoriatic arthritis and has had an inadequate response or inability to take methotrexate or sulfasalazine at maximal doses for three (3) months. Rheumatoid Arthritis (RA): The member must have a documented diagnosis of moderately-to-severely active RA and has a documented inadequate response after three (3) months at optimal doses or an inability to take methotrexate.
Age Restrictions	The member must be six (6) years of age or older.
Prescriber Restrictions	The prescribing physician must be a dermatologist, gastroenterologist, ophthalmologist, or rheumatologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

INGREZZA

Products Affected

- Ingrezza

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of tardive dyskinesia and has had a documented inadequate response, contraindication, or inability to tolerate an appropriate trial with conventional treatment options.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

INLYTA

Products Affected

- Inlyta

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of advanced renal cell carcinoma and has failed a trial of at least one (1) first-line systemic therapy (e.g. Afinitor, Avastin, Nexavar, Sutent, Torisel, Votrient).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

INTRAVENOUS IMMUNE GLOBULIN

Products Affected

- Bivigam
- Carimune NF
- Flebogamma DIF
- GamaSTAN S/D
- Gammagard
- Gammagard S/D Less IgA
- Gammaked
- Gammaplex
- Gamunex-C
- Octagam
- Privigen

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage not approved for progressive MS

PA Criteria	Criteria Details
Required Medical Information	Documented diagnosis of one of the following: Primary humoral immunodeficiency (Congenital agammaglobulinemia, Common variable immunodeficiency, Wiskott-Aldrich syndrome, X-linked agammaglobulinemia, or Severe combined immunodeficiency). Recurrent severe infection and documented severe deficiency or absence of IgG subclass. Clinically significant functional deficiency of humoral immunity as evidenced by documented failure to produce antibodies to specific antigens and a history of recurrent infections. Immune thrombocytopenic purpura (ITP) (Acute and Chronic refractory ITP). Chronic Lymphocytic Leukemia with associated hypogammaglobulinemia. Symptomatic Human Immunodeficiency Virus (HIV) in patients less than 13 years of age, who are immunologically abnormal. Bone marrow transplantation. Solid organ transplantation. Kawasaki disease (mucocutaneous lymph node syndrome). Acute and chronic inflammatory demyelinating polyradiculoneuropathy. Guillain-Barre syndrome. Myasthenia gravis. Immune thrombocytopenic purpura in pregnancy. Multifocal motor neuropathy (MMN) and dermatomyositis. Autoimmune mucocutaneous blistering diseases (Pemphigus vulgaris, Bullous pemphigoid, Mucous membrane pemphigoid [a.k.a., cicatrical pemphigoid], or Epidermolysis bullosa Acquisita). Scleromyxedema is covered for patients whose treatment with more traditional measures has failed. Humoral or vascular allograft rejection. Hemolytic anemia. Polymyositis and Dermatomyositis. Sensitized renal transplant recipients. Sepsis. Kidney disease. CMV infection. von Willebrand disorder. Uveitis. Toxic shock syndrome. RSV infection. HIV-associated thrombocytopenia and treatment of post-transfusion Purpura. Chronic inflammatory demyelinating polyneuropathy. Hepatitis A, Measles (Rubeola). Rubella. Varicella in immunosuppressed patients when varicella zoster immunoglobulin is not available.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Six (6) months upon initial approval
Other Criteria	None

IRESSA

Products Affected

- Iressa

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of metastatic non-small cell lung cancer (NSCLC) in tumors that have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations as detected by an FDA-approved test.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

ITRACONAZOLE

Products Affected

- *itraconazole*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of onychomycosis of the fingernails or toenails, or tinea capitis, and the requesting physician has documented that the member has had an inadequate response, contraindication, or inability to tolerate terbinafine tablets or Lamisil oral granules, or the requesting physician has documented that the member has a case of one of the following fungal infections: Aspergillosis, Blastomycosis, Cryptococcus neoformans, Histoplasmosis, or Tinea (corporis, pedis) resistant to aggressive topical therapy.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

JAKAFI

Products Affected

- Jakafi

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Myelofibrosis: The member must have a documented diagnosis of intermediate or high-risk myelofibrosis. Polycythemia Vera: The member must have a documented diagnosis of polycythemia vera with an inadequate response, contraindication, or inability to tolerate hydroxyurea.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Initial authorization is for six (6) months. Subsequent authorization is for Life of Plan.
Other Criteria	Subsequent authorization requires documentation of spleen size reduction or symptomatic improvement.

JUXTAPID

Products Affected

- Juxtapid

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a laboratory-confirmed documented diagnosis of homozygous familial hypercholesterolemia (HoFH) based on one of the following tests: a) LDLR DNA Sequence Analysis. b) LDLR Deletion/Duplication Analysis for large gene rearrangement testing (only if the Sequence Analysis is negative). c) APOB and PCSK9 testing if both of the above tests are negative but a strong clinical picture exists. The member must be concurrently taking lipid-lowering medications or has a documented contraindication to lipid-lowering medications and has had a documented inadequate response to an appropriate trial with or a contraindication to Repatha (evolocumab).
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

KADCYLA

Products Affected

- Kadcyla

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of human epidermal growth factor receptor 2 (HER2)-positive, metastatic breast cancer and has previously received Herceptin (trastuzumab) and a taxane, separately or in combination. Patients should have either received prior therapy for metastatic disease or developed disease recurrence during or within 6 months of completing adjuvant therapy.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

KALYDECO

Products Affected

- Kalydeco

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Kalydeco is not effective in patients with cystic fibrosis who are homozygous for the F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene.
Required Medical Information	The member must have a documented diagnosis of cystic fibrosis (CF) and have one mutation in the CFTR gene that is responsive to Kalydeco based on clinical and/or in vitro assay data. If the patient's genotype is unknown, an FDA-cleared cystic fibrosis mutation test should be used to detect the presence of a CFTR mutation followed by verification with bidirectional sequencing when recommended by the mutation test instructions for use.
Age Restrictions	Granules: The member must be twelve (12) months to five (5) years of age. Tablets: The member must be six (6) years of age or older.
Prescriber Restrictions	None
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

KANUMA

Products Affected

- Kanuma

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of Lysosomal Acid Lipase (LAL) deficiency and the diagnosis has been confirmed by a Dried Blood Spot (DBS) test, genetic testing or leucocyte testing.
Age Restrictions	None
Prescriber Restrictions	The prescriber must be a specialist in genetics and metabolism.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

KEVEYIS

Products Affected

- Keveyis

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of primary hyperkalemic periodic paralysis, primary hypokalemic periodic paralysis, and related variants.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

KEVZARA

Products Affected

- Kevzara

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of moderately-to-severely active rheumatoid arthritis (RA) and a documented inadequate response or inability to tolerate at least one tumor necrosis factor antagonist: Cimzia (certolizumab), Enbrel (etanercept), Humira (adalimumab), Remicade (infliximab), Simponi/Simponi Aria (golimumab).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a rheumatologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

KINERET

Products Affected

- Kineret

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Neonatal-Onset Multisystem Inflammatory Disease (NOMID): The member must have a documented diagnosis of NOMID. Rheumatoid Arthritis (RA): The member must have a documented diagnosis of moderately-to-severely active RA and has a documented inadequate response after three (3) months at optimal doses or an inability to take methotrexate.
Age Restrictions	RA: The member must be 18 years of age or older.
Prescriber Restrictions	The prescribing physician must be a pediatrician or rheumatologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

KISQALI

Products Affected

- Kisqali 200 Dose
- Kisqali 400 Dose
- Kisqali 600 Dose
- Kisqali Femara 200 Dose
- Kisqali Femara 400 Dose
- Kisqali Femara 600 Dose

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Advanced or Metastatic Breast Cancer: The member must be a post-menopausal woman with a documented diagnosis of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer and Kisqali is being used as initial endocrine-based therapy in combination with an aromatase inhibitor.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

KORLYM

Products Affected

- Korlym

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of hyperglycemia secondary to hypercortisolism with endogenous Cushing's syndrome and type 2 diabetes mellitus OR glucose intolerance AND have failed surgery OR is not a candidate for surgery.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

KUVAN

Products Affected

- Kuvan

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of hyperphenylalaninemia (HPA) due to tetrahydrobiopterin (BH4)-responsive phenylketonuria (PKU).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a specialist in metabolic diseases or a geneticist.
Coverage Duration	Initial approval is for eight (8) weeks. Subsequent approval is for Life of Plan.
Other Criteria	Coverage may be authorized for continuing therapy if the member has demonstrated at least a 30% reduction in phenylalanine levels compared to baseline.

KYNAMRO

Products Affected

- Kynamro

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a laboratory-confirmed documented diagnosis of homozygous familial hypercholesterolemia (HoFH) based on one of the following tests: a) LDLR DNA Sequence Analysis. b) LDLR Deletion/Duplication Analysis for large gene rearrangement testing (only if the Sequence Analysis is negative). c) APOB and PCSK9 testing if both of the above tests are negative but a strong clinical picture exists. The member must be concurrently taking lipid-lowering medications or has a documented contraindication to lipid-lowering medications and has had a documented inadequate response to an appropriate trial with or a contraindication to Repatha (evolocumab).
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

LENVIMA

Products Affected

- Lenvima 10 MG Daily Dose
- Lenvima 14 MG Daily Dose
- Lenvima 18 MG Daily Dose
- Lenvima 20 MG Daily Dose
- Lenvima 24 MG Daily Dose
- Lenvima 8 MG Daily Dose

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Advanced Renal Cell Carcinoma (ARCC): The member must have a documented diagnosis of ARCC and has had one (1) prior anti-angiogenictherapy and is being used in combination with Afinitor (everolimus). Hepatocellular carcinoma (HCC): The member must have a documented diagnosis of unresectable hepatocellular carcinoma. Thyroid Cancer: The member must have a documented diagnosis of locally recurrent or metastatic, progressive, radioactive iodine-refractory differentiated thyroid cancer.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

LIDOCAINE TRANSDERMAL PATCHES

Products Affected

- *lidocaine external patch*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	For Postherpetic Neuralgia or Diabetic Neuropathy, the member must have had a failure, adverse reaction, or contraindication to gabapentin. Lidocaine transdermal patches may be approved for members who are not candidates for opioid or other oral pain management therapy.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	Coverage will be authorized for new members if their pain is currently well-controlled on lidocaine transdermal patches.

LONSURF

Products Affected

- Lonsurf

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of metastatic colorectal cancer (mCRC) and has been previously treated with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy, an anti-vascular endothelial growth factor (VEGF) biological therapy, and if rat sarcoma viral oncogene (RAS) wild-type, an anti-epidermal growth factor receptor (EGFR) therapy.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

LYNPARZA

Products Affected

- Lynparza

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Breast Cancer: The member must have a documented diagnosis of deleterious or suspected deleterious germline BRCA-mutated (as detected by an FDA-approved test), HER2-negative metastatic breast cancer and has been treated with chemotherapy in the neoadjuvant, adjuvant, or metastatic setting. If hormone receptor-positive the member should have documented prior endocrine therapy or contraindication to or inability to tolerate endocrine therapy. Advanced Ovarian Cancer: The member must have a documented diagnosis of deleterious or suspected deleterious germline BRCA-mutated (as detected by an approved test) advanced ovarian cancer and has been treated with at least three (3) prior lines of chemotherapy. Recurrent Ovarian Cancer: The member must have a documented diagnosis of recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer in patients who are in a complete or partial response to platinum-based chemotherapy.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

MAKENA

Products Affected

- *hydroxyprogesterone caproate*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Hydroxyprogesterone caproate ONLY: Generic hydroxyprogesterone caproate may be approved for non-pregnant women with a documented diagnosis of advanced (stage III or IV) uterine adenocarcinoma, for the management of amenorrhea (primary and secondary) and abnormal uterine bleeding due to hormonal imbalance in the absence of organic pathology (eg, submucous fibroids or uterine cancer), or as a test for endogenous estrogen production, and for the production of secretory endometrium and desquamation.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration.
Other Criteria	None

MAVYRET

Products Affected

- Mavyret

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Criteria will be applied consistent with current AASLD-IDSA guidance.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a gastroenterologist, hepatologist, or an infectious disease specialist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

MEDICATIONS FOR THE TREATMENT OF PULMONARY HYPERTENSION

Products Affected

- Adcirca
- Adempas
- Letairis
- Opsumit
- Orenitram
- Remodulin
- REVATIO ORAL SOLUTION
- *sildenafil citrate*
- Tracleer
- Uptravi Oral Tablet
- Uptravi Oral Tablet Therapy Pack
- Ventavis

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a definitive diagnosis of pulmonary arterial hypertension (WHO group I: see below) as confirmed by right heart catheterization. World Health Organization (WHO) Classification of Pulmonary Hypertension - Group 1: a) Idiopathic PAH (primary pulmonary hypertension). b) Heritable PAH. c) Drug- and toxin-induced PAH. d) PAH associated with other diseases and conditions (APAH), such as: i) Connective tissue diseases ii) HIV infection iii) Portal hypertension iv) Congenital heart disease v) Schistosomiasis vi) Chronic hemolytic anemia. e) Persistent pulmonary hypertension of the newborn AND the pulmonary hypertension has progressed despite surgical treatment and/or maximal medical treatment of the underlying condition AND the medication used for treatment is consistent with its FDA-approved functional class (see Other Criteria).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a cardiologist or pulmonologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	Adcirca-NYHA Class II-IV: Adempas-WHO Class II-IV (Pulmonary Arterial Hypertension): Letairis-WHO Class II-IV: Opsumit-WHO Class II-IV: Orenitram-WHO Class II-IV: Remodulin-NYHA Class-II-IV: sildenafil-NYHA Class II-IV: Tracleer-NYHA Class II-IV: Uptravi - WHO Group I: Ventavis-NYHA Class III and IV

MEKINIST

Products Affected

- Mekinist

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	If Mekinist (trametinib) is being used as a single agent it will not be approved for members who have received prior BRAF-inhibitor therapy.
Required Medical Information	Single Agent: The member must have a documented diagnosis of unresectable ormetastatic melanoma with a BRAF V600E mutation as confirmed by an FDA-approved test. In combination with Tafinlar, the member must have one of the following documented diagnoses as detected by an FDA-approved test: Unresectable or metastatic melanoma with a BRAF V600E or V600K mutation, or as adjuvant treatment of melanoma with a BRAF V600E or V600K mutation and involvement of lymph node(s) following complete resection, or metastatic non-small cell lung cancer (NSCLC) with a BRAF V600E mutation, or locally advanced or metastatic anaplastic thyroid cancer (ATC) with BRAF V600E mutation and with no satisfactory locoregional treatment options.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

MISCELLANEOUS INJECTABLES

Products Affected

- Abelcet
- *acyclovir sodium*
- AmBisome
- *amphotericin b*
- *bleomycin sulfate*
- *cladribine*
- *cytarabine*
- *cytarabine (pf)*
- *fluorouracil intravenous*
- *ganciclovir sodium*
- HP Acthar
- *vinblastine sulfate*
- *vincasar pfs*
- *vincristine sulfate*

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Diagnosis of an FDA-approved indication not otherwise excluded from Part D.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

MYTESI

Products Affected

- Mytesi

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of noninfectious diarrhea associated with HIV or AIDS and be on antiretroviral therapy.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

NATPARA

Products Affected

- Natpara

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Natpara will not be approved for members who are well-controlled on calcium supplements and active forms of vitamin D alone, or for members with hypoparathyroidism caused by calcium-sensing receptor mutations or acute postsurgical hypoparathyroidism.
Required Medical Information	The member must have a documented diagnosis of hypocalcemia secondary to hypoparathyroidism. Before starting Natpara, the prescriber must confirm sufficient 25-hydroxyvitamin D stores and that serum calcium is above 7.5 mg/dL.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an endocrinologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

NERLYNX

Products Affected

- Nerlynx

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of early stage human epidermal growth receptor type 2 (HER2) overexpressed/amplified breast cancer and has had previous adjuvant treatment with Herceptin-based therapy.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

NEXAVAR

Products Affected

- NexAVAR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Advanced Renal Cell Carcinoma (ARCC): The member must have a documented diagnosis of ARCC. Hepatocellular Carcinoma (HCC): The member must have a documented diagnosis of biopsy-proven, unresectable HCC. Thyroid Carcinoma (TC): The member must have a documented diagnosis of locally recurrent or metastatic, progressive, differentiated TC refractory to radioactive iodine treatment.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a nephrologist, oncologist, or urologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

NINLARO

Products Affected

- Ninlaro

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of multiple myeloma and Ninlaro is being used in combination with Revlimid (lenalidomide) and dexamethasone in patients who have received at least one (1) prior therapy.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

NORTHERA

Products Affected

- Northera

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of neurogenic orthostatic hypotension (NOH).
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

NUCALA

Products Affected

- Nucala

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of severe asthma with an eosinophilic phenotype and documentation that underlying conditions or triggers for asthma or pulmonary disease are being maximally managed.Eosinophilic granulomatosis with polyangiitis: The member must have a documented diagnosis of eosinophilic granulomatosis with polyangiitis and has had an inadequate response to an appropriate trial with at least one of the following immunosuppressants: azathioprine, cyclophosphamide, or methotrexate.
Age Restrictions	The member must be 12 years of age or older.
Prescriber Restrictions	The prescriber must be an asthma specialist (e.g., allergist, immunologist, pulmonologist).
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

NUEDEXTA

Products Affected

- Nuedexta

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of pseudobulbar affect (PBA).
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

NUPLAZID

Products Affected

- Nuplazid

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of Parkinson's disease and have hallucinations and delusions associated with Parkinson's disease psychosis.
Age Restrictions	None
Prescriber Restrictions	The medication is being prescribed by or in consultation with a neurologist or psychiatrist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

OCALIVA

Products Affected

- Ocaliva

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Ocaliva will not be authorized for the treatment of non-alcoholic steatohepatitis.
Required Medical Information	The member must have a documented diagnosis of primary biliary cholangitis (PBC) and Ocaliva is being used in combination with ursodiol (ursodeoxycholic acid) in adults with an inadequate response to ursodiol, or as monotherapy in adults unable to tolerate ursodiol.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

ODOMZO

Products Affected

- Odomzo

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of locally advanced basal cell carcinoma and one of the following: a) Documentation of disease recurrence following surgery or radiation therapy or b) Documentation that the member is not a candidate for surgery or radiation therapy.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

OFEV

Products Affected

- Ofev

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of idiopathic pulmonary fibrosis (IPF) and is not currently taking Esbriet (pirfenidone).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a pulmonologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

ORENCIA

Products Affected

- Orencia ClickJect
- Orencia Intravenous
- Orencia Subcutaneous

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage of Orencia will not be approved if administered concomitantly with another tumor necrosis factor antagonist or Kineret (anakinra).
Required Medical Information	Juvenile Idiopathic Arthritis (JIA): The member must have a documented diagnosis of JIA and has a documented inadequate response or inability to tolerate Enbrel (etanercept) or Humira (adalimumab). Psoriatic Arthritis: The member must have a documented diagnosis of psoriatic arthritis and has had an inadequate response or inability to take methotrexate or sulfasalazine at maximal doses for three (3) months. Rheumatoid Arthritis (RA): The member must have a documented diagnosis of RA and a documented inadequate response or inability to tolerate at least one tumor necrosis factor antagonist: Cimzia (certolizumab), Enbrel (etanercept), Humira (adalimumab), Remicade (infliximab), Simponi/Simponi Aria (golimumab).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a rheumatologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

ORFADIN

Products Affected

- Orfadin

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of genetic (hereditary) tyrosinemia Type-1.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

ORKAMBI

Products Affected

- Orkambi

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Orkambi will not be covered for individuals that are not homozygous for the F508del mutation.
Required Medical Information	The member must have a documented diagnosis of cystic fibrosis (CF) and have documentation from an FDA-approved CF mutation test that the member has the F508del mutation on both alleles of the CFTR gene.
Age Restrictions	The member must be 6 years of age or older.
Prescriber Restrictions	None
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

OTEZLA

Products Affected

- Otezla

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Plaque Psoriasis: The member must have a documented diagnosis of moderate-to-severe chronic plaque psoriasis. Psoriatic Arthritis: The member must have a documented diagnosis of psoriatic arthritis and has had an inadequate response or inability to tolerate methotrexate or sulfasalazine at maximal doses for three (3) months.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a dermatologist or rheumatologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

PALYNZIQ

Products Affected

- Palynziq

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of phenylketonuria (PKU) and has uncontrolled blood phenylalanine concentrations greater than 600 micromol per liter on existing management.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a specialist in metabolic diseases or a geneticist.
Coverage Duration	Initial approval is for sixteen (16) weeks. Subsequent approval is for Life of Plan.
Other Criteria	Coverage may be authorized for continuing therapy if the member has demonstrated at least a 30% reduction in phenylalanine levels compared to baseline.

PERJETA

Products Affected

- Perjeta

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Metastatic Breast Cancer: The member must have a documented history of human epidermal growth factor receptor 2 (HER2)-positive metastatic breast cancer (in combination with docetaxel and Herceptin) and has not received prior anti-HER2 therapy or chemotherapy for metastatic disease. Neoadjuvant Treatment of Breast Cancer: The member has a documented history of HER2-positive, locally advanced, inflammatory, or early stage breast cancer (either greater than 2 cm in diameter or node positive).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

POMALYST

Products Affected

- Pomalyst

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of multiple myeloma and has received at least two (2) prior therapies including Revlimid (lenalidomide) and a proteasome inhibitor (Kyprolis, Ninlaro, or Velcade) and has demonstrated disease progression on or within 60 days of completion of the last therapy.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

PREVYMIS

Products Affected

- Prevymis

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have documentation of having had, or is scheduled to receive, an allogeneic hematopoietic stem cell transplant (HSCT) and the member is at high risk of cytomegalovirus (CMV) infection.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

PROLIA AND XGEVA

Products Affected

- Prolia
- Xgeva

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Coverage of Prolia (denosumab) for the treatment of osteoporosis in men and postmenopausal women may be authorized when the following criteria are met: The member is at high risk of fracture defined as a history of osteoporotic fracture or multiple risk factors for fracture and a T score less than or equal to -2.0 as evidenced via bone density scan or the member has had an inadequate response to, or is unable to tolerate therapy with at least one of the traditional osteoporosis treatments [alendronate (Fosamax), calcitonin (Miacalcin), ibandronate (Boniva), raloxifene (Evista), risedronate (Actonel), zoledronic acid (Reclast)] or the member is a female at high risk for fracture receiving adjuvant aromatase inhibitor therapy for breast cancer and is using Prolia (desosumab) as a treatment to increase bone mass. Coverage of Prolia may be authorized for men at high risk of fracture who are receiving androgen deprivation therapy for nonmetastatic prostate cancer. Coverage for Xgeva (denosumab) may be authorized for prevention of skeletal-related events in patients with bone metastases from solid tumors only or the member is being treated for unresectable giant cell tumor of bone (GCTB) or surgical resection of GCTB is likely to result in severe morbidity, or for the treatment of hypercalcemia of malignancy refractory to bisphosphonate therapy.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

PROMACTA

Products Affected

- Promacta

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of Chronic Immune (idiopathic) Thrombocytopenic purpura (ITP) and has had an insufficient response or intolerance to corticosteroids, immunoglobulins, or splenectomy. Coverage may also be authorized for the treatment of thrombocytopenia in patients with chronic hepatitis C infection. Coverage may be authorized for the treatment of severe aplastic anemia in patients who have had an insufficient response to immunosuppressive therapy.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

RADICAVA

Products Affected

- Radicava

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of amyotrophic lateral sclerosis (ALS).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a neurologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

RAVICTI

Products Affected

- Ravicti

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of a urea cycle disorder.
Age Restrictions	The member must be 2 months of age or older.
Prescriber Restrictions	None
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

REMICADE

Products Affected

- Remicade

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Ankylosing Spondylitis: The member must have a documented diagnosis of active ankylosing spondylitis. Crohn's Disease, Pediatric Ulcerative Colitis, or Ulcerative Colitis (UC): The member must have a documented diagnosis of one of the aforementioned diseases and an inadequate response to an appropriate trial with two (2) or more of the following agents: a) Corticosteroids (e.g., methylprednisolone, prednisolone, prednisone). b) 5-Aminosalicylates (e.g. balsalazide (Colazal), Dipentum, mesalamine (Asacol), Pentasa, Rowasa, sulfasalazine (Azulfidine)). c) 6-mercaptopurine (6-MP, Purinethol) or azathioprine. d) Methotrexate. Plaque Psoriasis: The member must have a documented diagnosis of severe chronic plaque psoriasis and has failed to respond to, or has been unable to tolerate treatment with one (1) of the following medications: cyclosporine, methotrexate, or acitretin (Soriatane). Psoriatic Arthritis: The member must have a documented diagnosis of psoriatic arthritis and has had an inadequate response or inability to take methotrexate or sulfasalazine at maximal doses for three (3) months. Rheumatoid Arthritis (RA): The member must have a documented diagnosis of RA and has documented inadequate response after three (3) months at optimal doses or an inability to take methotrexate.
Age Restrictions	The member must be 18 years of age or older. For pediatric Crohn's Disease and Ulcerative Colitis, the member must be 6 years of age or older.
Prescriber Restrictions	None
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

RENFLEXIS

Products Affected

- Renflexis

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Ankylosing Spondylitis: The member must have a documented diagnosis of active ankylosing spondylitis. Crohn's Disease and Ulcerative Colitis(UC): The member must have a documented diagnosis of either disease and an inadequate response to an appropriate trial with two (2) or more of the following agents: a) Corticosteroids (e.g., methylprednisolone, prednisolone, prednisone). b) 5-Aminosalicylates (e.g. Asacol, azulfidine,Colazal, Dipentum, Pentasa, Rowasa, sulfasalazine). c) 6-mercaptopurine(6-MP, Purinethol) or azathioprine. d) Methotrexate OR the member has demonstrated failure or intolerance to Remicade. Plaque Psoriasis: The member must have a documented diagnosis of moderate-to-severe chronic plaque psoriasis and has failed to respond to, or has been unable to tolerate treatment with one (1) of the following medications: acitretin, cyclosporine, or methotrexate. Psoriatic Arthritis: The member must have a documented diagnosis of psoriatic arthritis and has had an inadequate response or inability to take methotrexate or sulfasalazine at maximal doses for three (3) months. Rheumatoid Arthritis(RA): The member must have a documented diagnosis of RA and has a documented inadequate response after three (3) months at optimal doses or an inability to take methotrexate.
Age Restrictions	The member must be 18 years of age or older. For Crohn's Disease and Ulcerative Colitis, the member must be 6 years of age or older.
Prescriber Restrictions	The prescribing physician must be a dermatologist, gastroenterologist, ophthalmologist, or rheumatologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

REPATHA

Products Affected

- Repatha
- Repatha Pushtronex System
- Repatha SureClick

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Coverage may be authorized when ALL of the criteria are met: FOR ALL REQUESTS: INITIAL AUTHORIZATION: 1) Value and date of baseline LDL cholesterol. 2) Documented lipid-lowering treatments and responses. REAUTHORIZATION: 1) Pretreatment and current LDL cholesterol. INITIAL AUTHORIZATION: Clinical atherosclerotic CV disease (ASCVD): The member has a history of ASCVD or CV event (Provide documentation of the event/diagnosis. ASCVD is defined as a diagnosis of: Acute coronary syndromes, history of MI, angina, arterial revascularization procedure, stroke of atherosclerotic origin, transient ischemic attack, peripheral arterial disease of atherosclerotic origin OR ASCVD from CT angiogram or catheterization) AND current LDL-C level of greater than or equal to 70 mg/dL after treatment with a high-potency statin (See below), OR a contraindication/intolerance to statin therapy. Familial Hypercholesterolemia (FH): 1. Documented diagnosis by one of the following: a) Genetic test b) Meets Simon-Broome or WHO/Dutch Lipid Clinic Network Criteria. One of the previous AND one of the following: 1) Has concurrent ASCVD (See above) 2) Homozygous FH (HoFH): Current LDL-C level of greater than or equal to 100 mg/dL after treatment with a high-potency statin (See below) AND ezetimibe, OR a contraindication/intolerance to statin therapy AND is taking ezetimibe, OR a contraindication to BOTH statin therapy and ezetimibe. Heterozyous FH (HeFH): Current LDL-C level of greater than or equal to 100 mg/dL after treatment with a high-potency statin (See below), OR a contraindication/intolerance to statin therapy.
Age Restrictions	None
Prescriber Restrictions	The medication is being prescribed by or in consultation with a cardiologist, endocrinologist, lipidologist, or neurologist.
Coverage Duration	Initial: Six (6) months. Reauthorization: Twelve (12) months.

PA Criteria	Criteria Details
Other Criteria	REAUTHORIZATION: Reauthorizations may be given in 12-month intervals, provided the following criteria are met: 1) The member has achieved or maintained a clinically significant LDL-C reduction. Include LDL-C value and date that LDL-C level was drawn. 2) The member is concurrently taking maximally-tolerated, high-potency statins unless otherwise contraindicated. Definitions: High-potency statin treatment: atorvastatin greater than or equal to 40 mg or rosuvastatin greater than or equal to 20 mg daily. Simon-Broome Diagnostic Criteria for definite FH: Total cholesterol greater than 290 mg/dL or LDL-C greater than 190 mg/dL and tendon xanthomas in the patient, first (parent, sibling or child) or second degree relative (grandparent, uncle or aunt). Dutch Lipid Clinical Network Criteria for definite FH: Total score greater than 8 points.

RETINOIDS FOR THE TOPICAL TREATMENT OF ACNE VULGARIS AND PSORIASIS

Products Affected

- *adapalene*
- *adapalene-benzoyl peroxide*
- Atralin
- *avita*
- Fabior
- Retin-A
- Retin-A Micro
- Retin-A Micro Pump
- *tazarotene*
- Tazorac
- *tretinoin external*
- *tretinoin microsphere*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage of topical acne products will not authorized for cosmetic purposes.
Required Medical Information	For all retinoids, the member must have a physician-documented diagnosis of acne vulgaris, comedones (white heads), or actinic keratosis. Tazorac may also be covered if the member has a physician-documented diagnosis of plaque psoriasis or documented diagnosis of skin cancer provided effective treatment with Tazorac is recognized for treatment of such indication in one of the standard reference compendia, or in the medical literature.
Age Restrictions	This criterion only applies to members age 26 or older. Authorization is not required for members 25 years of age or younger.
Prescriber Restrictions	None
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

REVLIMID

Products Affected

- Revlimid

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Mantle Cell Lymphoma (MLL): The member must have a documented diagnosis of MLL and the member's disease has relapsed or progressed after two (2) prior therapies, one of which included Velcade (bortezomib). Multiple Myeloma: The member must have a documented diagnosis of multiple myeloma and Revlimid is being used in combination with dexamethasone or as maintenance therapy in a member following autologous hematopoietic stem cell transplantation. Myelodysplastic Syndrome (MDS): The member must have a documented diagnosis of transfusion-dependent anemia due to MDS associated with the 5q-deletion cytogenetic abnormality.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a hematologist or oncologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

RITUXAN

Products Affected

- Rituxan

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Rheumatoid Arthritis (RA): The member must have a documented diagnosis of active RA and have a documented inadequate response to an appropriate trial with at least one (1) tumor necrosis factor (TNF) antagonist therapy, including Cimzia (certolizumab pegol), Enbrel (etanercept), Humira (adalimumab), Remicade (infliximab) or Simponi/Simponi Aria (golimumab), and Rituxan is being used in combination with methotrexate. Wegener's granulomatosis or microscopic polyangiitis: The member must have a documented diagnosis of either disease and the member is concurrently taking glucocorticoids (e.g., prednisone). Rituxan does not require prior authorization for members with a diagnosis of Non-Hodgkins Lymphoma or Chronic Lymphocytic Leukemia.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	Additional authorization for Wegener's granulomatosis or microscopic polyangiitis may be given if documentation of an objective measurable effect is provided indicating clinical improvement of condition. Subsequent authorizations may be given in 6-month intervals.

RUBRACA

Products Affected

- Rubraca

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Rubraca will not be approved for concurrent use with other chemotherapy agents.
Required Medical Information	Advanced Ovarian Cancer: Rubraca may be approved for the treatment (monotherapy) of deleterious germline and/or somatic BRCA mutation associated (as detected by an FDA-approved test) advanced ovarian cancer in patients who have been treated with two (2) or more prior lines of chemotherapy. Recurrent Ovarian Cancer (maintenance): The member must have a documented diagnosis of recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in a complete or partial response to platinum-based chemotherapy.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

RYDAPT

Products Affected

- Rydapt

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Rydapt is not indicated as a single-agent induction therapy for the treatment of patients with AML.
Required Medical Information	The member must have a newly-documented diagnosis of acute myeloid leukemia (AML) that is FLT3 mutation-positive as detected by an FDA-approved test, and is being used in combination with standard cytarabine and daunorubicin induction and cytarabine consolidation. Rydapt is covered for members with a documented diagnosis of aggressive systemic mastocytosis (ASM), systemic mastocytosis with associated hematological neoplasm (SM-AHN), or mast cell leukemia (MCL).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a hematologist or oncologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

SIGNIFOR

Products Affected

- Signifor

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of Cushing's disease and pituitary surgery is not an option or has not been curative.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an endocrinologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

SIGNIFOR LAR

Products Affected

- Signifor LAR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of acromegaly and has had a failure of, or is unable to tolerate, a treatment regimen that includes octreotide (Sandostatin/Sandostatin LAR Depot) OR lanreotide (Somatuline Depot), and the member is not a candidate for surgery and/or radiation, or has had an inadequate response to surgery and/or radiation.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an endocrinologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

SILIQ

Products Affected

- Siliq

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of moderate-to-severe chronic plaque psoriasis.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a dermatologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

SIMPONI

Products Affected

- Simponi Aria Syringe 100 MG/ML, 50 MG/0.5ML
- Simponi Subcutaneous Solution Auto-Injector 100 MG/ML, 50 MG/0.5ML
- Simponi Subcutaneous Solution Prefilled

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Ankylosing Spondylitis: The member must have a documented diagnosis of active ankylosing spondylitis. Psoriatic Arthritis: The member must have a documented diagnosis of psoriatic arthritis and has had an inadequate response or inability to take methotrexate or sulfasalazine at maximal doses for three (3) months. Rheumatoid Arthritis (RA): The member must have a documented diagnosis of RA and has documented inadequate response after three (3) months at optimal doses or an inability to take methotrexate. Ulcerative Colitis (UC): The member must have a documented diagnosis of moderate-to-severely active UC and has had an inadequate response to an appropriate trial with two (2) or more of the following agents: a) Corticosteroids (e.g., methylprednisolone, prednisolone, prednisone). b) 5-Aminosalicylates (e.g. balsalazide (Colazal), Dipentum, mesalamine (Asacol), Pentasa, Rowasa, sulfasalazine (Azulfidine)). c) 6-mercaptopurine (6-MP, Purinethol) or azathioprine. d) Methotrexate OR the member has demonstrated failure or intolerance to infliximab (Remicade).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a dermatologist, gastroenterologist or rheumatologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

SIRTURO

Products Affected

- Sirturo

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of pulmonary multi-drug resistant tuberculosis (MDR-TB) and Sirturo is being used in combination with at least three (3) other drugs to which the patient's MDR-TB isolate has been shown to be susceptible in vitro. If in vitro testing results are unavailable, treatment may be initiated with Sirturo in combination with at least four (4) other drugs to which the patient's MDR-TB isolate is likely to be susceptible.
Age Restrictions	The member must be 18 years of age or older.
Prescriber Restrictions	None
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

SOMAVERT

Products Affected

- Somavert

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of acromegaly and has had a failure of, or is unable to tolerate, a treatment regimen that includes octreotide, and the member is not a candidate for surgery and/or radiation, or has had an inadequate response to surgery and/or radiation.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an endocrinologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

SOVALDI

Products Affected

- Sovaldi

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Criteria will be applied consistent with current AASLD-IDSA guidance.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a gastroenterologist, hepatologist, or an infectious disease specialist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

SPRYCEL

Products Affected

- Sprycel Oral Tablet 100 MG, 140 MG, 20 MG, 50 MG, 70 MG, 80 MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Chronic Myeloid (or Myelogenous) Leukemia (CML): The member must have a documented diagnosis of accelerated, or myeloid or lymphoid blast phase Ph+ CML and documented resistance or intolerance to prior therapy, including imatinib mesylate (Gleevec). Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ALL): The member must have a documented diagnosis of Ph+ALL and documented resistance or intolerance to prior therapy, including imatinib mesylate (Gleevec). Philadelphia chromosome-positive chronic myeloid leukemia in chronic phase (Ph+ CP-CML): The member must have a documented diagnosis of Ph+ CP-CML.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist or hematologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

STELARA

Products Affected

- Stelara

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Crohn's Disease: The member must have a documented diagnosis of moderately-to-severely active Crohn's Disease and has had an inadequate response to an appropriate trial with two (2) or more of the following agents: a) Corticosteroids (e.g., methylprednisolone, prednisolone, prednisone). b) 5-Aminosalicylates (e.g. balsalazide (Colazal), Dipentum, mesalamine (Asacol), Pentasa, Rowasa, sulfasalazine (Azulfidine)). c) 6-mercaptopurine (6-MP, Purinethol) or azathioprine. d) Methotrexate OR the member has demonstrated failure or intolerance to infliximab (Remicade). Plaque Psoriasis: The member must have a documented diagnosis of moderate-to-severe chronic plaque psoriasis. Psoriatic Arthritis: The member must have a documented diagnosis of psoriatic arthritis and has had an inadequate response or inability to take methotrexate or sulfasalazine at maximal doses for three (3) months.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

STIVARGA

Products Affected

- Stivarga

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Gastrointestinal Stromal Tumors (GIST): The member must have a documented diagnosis of GIST and documented failure, contraindication, or intolerance to both imatinib mesylate (Gleevec) and Sutent (sunitinib malate). Hepatocellular Carcinoma: The member must have a documented diagnosis of hepatocellular carcinoma and had a documented failure, contraindication, or intolerance to Nexavar (sorafenib). Metastatic Colorectal Cancer (MCC): The member must have a documented diagnosis of MCC and has been previously treated with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy, an antivascular endothelial growth factor (VEGF) therapy, and, if KRAS wild type, an antiepidermal growth factor receptor (EGFR) therapy.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

STRENSIQ

Products Affected

- Strensiq

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of perinatal/infantile- or juvenile-onset hypophosphatasia (HPP) confirmed with both biochemical and molecular genetic testing.
Age Restrictions	The member is/was 18 years of age or younger at age of onset.
Prescriber Restrictions	None
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

SUBLINGUAL ALLERGY IMMUNOTHERAPY

Products Affected

- Oralair

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Oralair: The member must have documentation 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 five (5) grass species contained in this product in patients 10 to 65 years of age.
Age Restrictions	Oralair 10-65 years old Not FDA-approved for members over 65 years of age.
Prescriber Restrictions	The prescribing physician must be or has consulted with an allergist, immunologist, or pulmonologist.
Coverage Duration	One year
Other Criteria	None

SUTENT

Products Affected

- Sutent

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Advanced Renal Cell Carcinoma (ARCC): The member must have a documented diagnosis of ARCC. Gastrointestinal Stromal Tumor (GIST): The member must have a documented diagnosis of GIST and has a demonstrated disease progression or intolerance following an appropriate trial with imatinib mesylate (Gleevec). Progressive Neuroendocrine Tumors (PNET): The member must have a documented diagnosis of PNET located in the pancreas and the tumor cannot be removed by surgery or has spread to other parts of the body.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

SYLVANT

Products Affected

- Sylvant

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of multicentric Castleman's disease and is HIV negative and human herpesvirus-8 (HHV-8) negative.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a hematologist or oncologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

SYMDEKO

Products Affected

- Symdeko

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Symdeko is not indicated for the treatment of members with cystic fibrosis (CF) who are heterozygous for the F508del mutation in the CF transmembrane conductance regulator (CFTR) gene.
Required Medical Information	The member must have a documented diagnosis of cystic fibrosis (CF) and have one mutation in the CFTR gene that is responsive to Symdeko based on clinical and/or in vitro assay data. If the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of a CFTR mutation followed by verification with bidirectional sequencing when recommended by the mutation test instructions for use.
Age Restrictions	The member must be twelve (12) years of age or older.
Prescriber Restrictions	None
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

TAFINLAR

Products Affected

- Tafinlar

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Tafinlar is not indicated for the treatment of patients with wild-type BRAF melanoma.
Required Medical Information	Single Agent: The member must have a documented diagnosis of unresectable ormetastatic melanoma with a BRAF V600E mutation as confirmed by an FDA-approved test. In combination with Mekinist, the member must have one of the following documented diagnoses as detected by an FDA-approved test: Unresectable or metastatic melanoma with a BRAF V600E or V600K mutation, or as adjuvant treatment of melanoma with a BRAF V600E or V600K mutation and involvement of lymph node(s) following complete resection, or metastatic non-small cell lung cancer (NSCLC) with a BRAF V600E mutation, or locally-advanced or metastatic anaplastic thyroid cancer (ATC) with a BRAF V600E mutation with no satisfactory locoregional treatment options.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

TAGRISSO

Products Affected

- Tagrisso

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of metastatic non-small cell lung cancer (NSCLC) and epidermal growth factor receptor (EGFR) T790M mutation-positive as detected by an FDA-approved test, and a documented failure, contraindication, or intolerance to prior tyrosine kinase inhibitor therapy (e.g., Gilotrif, Iressa, Tarceva) OR EGFR exon 19 deletions or exon 21 L858R mutation positive disease as detected by an FDA-approved test.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

TALTZ

Products Affected

- Taltz

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Plaque Psoriasis: The member must have a documented diagnosis of moderate-to-severe chronic plaque psoriasis. Psoriatic Arthritis: The member must have a documented diagnosis of psoriatic arthritis and has had an inadequate response or inability to take methotrexate or sulfasalazine at maximal doses for three (3) months.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a dermatologist or rheumatologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

TASIGNA

Products Affected

- Tasigna

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Newly-diagnosed Philadelphia chromosome positive chronic myeloid leukemia (Ph+ CML): The member must have a documented diagnosis of Ph+ CML in chronic phase. Resistant or Intolerant Ph+ CML-CP and CML-AP: The member must have a documented diagnosis of Ph+ CML in chronic phase or in accelerated phase and documented resistance or intolerance to prior therapy, including imatinib mesylate (Gleevec).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

TECFIDERA

Products Affected

- TECFIDERA ORAL STARTER PACK
- Tecfidera Oral Capsule Delayed Release

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a definitive diagnosis of a relapsing form of multiple sclerosis or the member has a documented failure, contraindication, or intolerance to at least one (1) of the following multiple sclerosis immunomodulator agents: Aubagio (teflunomide) or Gilenya (fingolimod).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a neurologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

TRANSMUCOSAL IMMEDIATE-RELEASE FENTANYL (TIRF)

Products Affected

- Abstral
- Actiq
- *fentanyl citrate*
- Fentora
- Lazanda Nasal Solution 100 MCG/ACT, 300 MCG/ACT, 400 MCG/ACT
- Subsys

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	The Transmucosal Immediate-Release Fentanyl (TIRF) products will not be covered for any non-cancer pain indication.
Required Medical Information	The Transmucosal Immediate-Release Fentanyl (TIRF) products may be covered for the management of breakthrough pain in adult cancer patients who are already receiving and who are tolerant to around-the-clock opioid therapy for their underlying persistent cancer pain.
Age Restrictions	None.
Prescriber Restrictions	The prescribing physician must be an oncologist or a pain management specialist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	Patients considered opioid tolerant are those who are taking around-the-clock medicine consisting of morphine oral 60 mg daily or more, fentanyl transdermal 25 mcg/hour or more, oxycodone oral 30 mg daily or more, hydromorphone oral 8 mg daily or more, or an equianalgesic dose of another opioid daily for a week or longer. Patients must remain on around-the-clock opioids when taking fentanyl transmucosal.

TREMFYA

Products Affected

- Tremfya

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of moderate-to-severe chronic plaque psoriasis.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a dermatologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

TYKERB

Products Affected

- Tykerb

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	For estrogen receptor (ER)-positive, human epidermal growth factor receptor-2 (HER-2) overexpressing advanced or metastatic breast cancer, the member must meet ALL of the following criteria: 1. Documented diagnosis of HER-2 overexpressing advanced or metastatic breast cancer. 2. The member has failed prior therapy with an anthracycline and a taxane chemotherapeutic agent. 3. The member has failed prior therapy with Herceptin (trastuzumab). 4. The member is concurrently treated with capecitabine (Xeloda). Hormone receptor positive metastatic breast cancer in post-menopausal women: The member must have a documented diagnosis of hormone receptor positive metastatic breast cancer that overexpresses the HER-2 receptor and is concurrently being treated with an aromatase inhibitor (e.g. anastrozole, exemestane, or letrozole).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

TYMLOS

Products Affected

- Tymlos

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage for Tymlos will not be authorized when cumulative use of it and/or other parathyroid hormone analogs is greater than 2 years.
Required Medical Information	Coverage of Tymlos may be authorized when the requesting physician has documented that the member is at high risk for fracture and has a T score less than or equal to -2.0 as evidenced via bone density scan or the requesting physician has documented that the member has had one or more osteoporotic fractures. For either condition previously listed, the member must also have had an inadequate response to, or is unable to tolerate therapy with at least one of the traditional osteoporosis treatments: alendronate (Fosamax), calcitonin (Miacalcin), denosumab (Prolia), ibandronate (Boniva), raloxifene (Evista), risedronate (Actonel) or zoledronic acid (Reclast).
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Coverage of Tymlos is limited to 24 months.
Other Criteria	None

TYSABRI

Products Affected

- Tysabri

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Tysabri will not be approved when used in conjunction with other medications for the treatment of progressive multiple sclerosis (Betaseron, Avonex, Rebif or Copaxone) or when used in conjunction with other medications (including immunosuppressants) for the treatment of Crohn's disease.
Required Medical Information	Crohn's Disease: The member must have a documented diagnosis of Crohn's disease and both of the following: 1. An inadequate response to an appropriate trial with two (2) or more of the following agents: a) Corticosteroids (e.g., methylprednisolone, prednisolone, prednisone). b) 5-Aminosalicylates (e.g. balsalazide (Colazal), Dipentum, mesalamine (Asacol), Pentasa, Rowasa, sulfasalazine (Azulfidine)). c) 6-mercaptopurine (6-MP, Purinethol) or azathioprine. d) Methotrexate. 2. The member has demonstrated an inadequate response to an appropriate trial with at least one TNF-inhibitor and/or biologic indicated for Crohn's Disease. Multiple Sclerosis (MS): The member must have a documented diagnosis of relapsing MS and has a documented inadequate response or inability to tolerate an appropriate trial with at least one of the following agents: Aubagio, Avonex, Betaseron, Copaxone, Extavia, Gilenya, Lemtrada, Plegridy, Rebif, Tecfidera or Zinbryta.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a gastroenterologist or neurologist.
Coverage Duration	Initial authorization: 6 months. Re-authorization may be given 12-month increments.
Other Criteria	None

VENCLEXTA

Products Affected

- Venclexta
- Venclexta Starting Pack

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of Chronic Lymphocytic Leukemia (CLL) or Small Lymphocytic Lymphoma (SLL) as detected by an FDA-approved test and has received at least one (1) prior therapy.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

VERZENIO

Products Affected

- Verzenio

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of advanced or metastatic breast cancer. For monotherapy, the member must have documented hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer with disease progression following endocrine therapy and prior chemotherapy. For combination therapy with Faslodex (fulvestrant), the member must have documented HR-positive, HER2-negative advanced or metastatic breast cancer with disease progression following endocrine therapy.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

VIMPAT

Products Affected

- Vimpat Oral Solution
- Vimpat Oral Tablet

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of partial-onset seizures and has had an insufficient response or intolerance to at least two (2) other medications indicated for adjunct partial seizures (e.g. Aptiom, Briviact, felbamate (Felbatol), Fycompa, gabapentin (Fanatrex, Gralise, Neurontin), lamotrigine (Lamictal, Lamictal XR, Lamictal ODT), Lyrica, levetiracetam (Keppra, Keppra XR, Roweepra, Spritam), oxcarbazepine (Oxtellar XR, Trileptal), tiagabine (Gabitril), topiramate (Topamax, Trokendi XR), Potiga, and/or zonisamide (Zonegran)).
Age Restrictions	The member must be 17 years of age or older.
Prescriber Restrictions	The prescribing physician must be a neurologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

VOSEVI

Products Affected

- Vosevi

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Criteria will be applied consistent with current AASLD-IDSA guidance.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a gastroenterologist, hepatologist, or an infectious disease specialist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

VOTRIENT

Products Affected

- Votrient

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Advanced Renal Cell Carcinoma (ARCC): The member must have a documented diagnosis of ARCC. Advanced Soft Tissue Sarcoma (ASTS): The member must have a documented diagnosis of ASTS and has received prior chemotherapy, including anthracycline treatment, or was unsuited for such therapy.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

VYZULTA

Products Affected

- Vyzulta

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of open-angle glaucoma and ocular hypertension.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an ophthalmologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

XALKORI

Products Affected

- Xalkori

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of locally advanced or metastatic non-small cell lung cancer (NSCLC) that is anaplastic lymphoma kinase (ALK)-positive as detected by a FDA-approved test or the member has documented ROS1-positive tumors.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

XELJANZ

Products Affected

- Xeljanz
- Xeljanz XR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Psoriatic Arthritis: The member must have a documented diagnosis of psoriatic arthritis and has had an inadequate response or inability to take methotrexate or sulfasalazine at maximal doses for three (3) months. Rheumatoid Arthritis (RA): The member must have a documented diagnosis of moderate-to-severely active RA and has a documented inadequate response after three (3) months at optimal doses or an inability to take methotrexate. Ulcerative Colitis (UC): The member must have a documented diagnosis of moderate-to-severely active UC and has had an inadequate response to an appropriate trial with two (2) or more of the following agents: a) Corticosteroids (e.g., methylprednisolone, prednisolone, prednisone). b) 5-Aminosalicylates (e.g. balsalazide (Colazal), Dipentum, mesalamine (Asacol), Pentasa, Rowasa, sulfasalazine (Azulfidine)). c) 6-mercaptopurine (6-MP, Purinethol) or azathioprine. d) Methotrexate OR the member has demonstrated failure or intolerance to infliximab (Remicade).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a gastroenterologist or rheumatologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

XERMELO

Products Affected

- Xermelo

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of carcinoid syndrome diarrhea that is inadequately controlled by somastatin analog (SSA) therapy alone and Xermelo is being used in combination with an SSA (e.g. Sandostatin LAR).
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a gastroenterologist, hematologist, or oncologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

XIFAXAN 550 MG

Products Affected

- Xifaxan Oral Tablet 550 MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage will not be authorized for treatment of Irritable Bowel Syndrome with constipation (IBS-C).
Required Medical Information	Hepatic Encephalopathy: The member must have a documented diagnosis of hepatic encephalopathy and has had an inadequate response or a contraindication to lactulose. Irritable Bowel Syndrome with Diarrhea (IBS-D): The member must have a documented diagnosis of IBS-D.
Age Restrictions	Hepatic Encephalopathy: The member must be 18 years of age or older.
Prescriber Restrictions	None
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	Xifaxan 200 mg tablets do not require authorization.

XOLAIR

Products Affected

- Xolair

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Coverage may be authorized when all of the following criteria are met: 1. The member has had a failure of a treatment regimen that included two (2) or more of the following medications: inhaled corticosteroids, oral corticosteroids, leukotriene modifiers and inhaled long-acting bronchodilators, or is unable to tolerate these medications. 2. The member shows a definitive sensitivity on allergy testing to one or more perennial allergens. 3. The member has a pre-treatment serum IgE level equal to or greater than 30 IU/mL and less than or equal to 700 IU/mL. Chronic Idiopathic Urticaria (CIU): The member must have a documented diagnosis of CIU for at least six (6) weeks and the physician has documented that the member remains symptomatic despite H1 antihistamine treatment.
Age Restrictions	Chronic Idiopathic Urticaria (CIU): Twelve (12) years of age or older. Moderate-to-severe persistent asthma: Six (6) years of age or older.
Prescriber Restrictions	The prescribing physician must be an allergist, dermatologist, immunologist or pulmonologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

XTANDI

Products Affected

- Xtandi

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of metastatic castration-resistant prostate cancer.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist or urologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

XURIDEN

Products Affected

- Xuriden

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of hereditary orotic aciduria.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

YONSA

Products Affected

- Yonsa

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of metastatic castration-resistant prostate cancer (mCRPC) and is being used in combination with methylprednisolone.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist or urologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

ZAVESCA

Products Affected

- *miglustat*
- Zavesca

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of mild-to-moderate type 1 Gaucher disease for whom enzyme replacement therapy (e.g. Cerezyme) is not a therapeutic option (e.g. allergy, hypersensitivity, poor venous access).
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

ZEJULA

Products Affected

- Zejula

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer and is experiencing complete or partial response to platinum-based chemotherapy.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

ZELBORAF

Products Affected

- Zelboraf

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Zelboraf is not indicated for treatment of patients with wild-type BRAF melanoma.
Required Medical Information	Erdheim-Chester Disease (ECD): The member must have a documented diagnosis of Erdheim-Chester disease (ECD) with a BRAF V600 mutation. Unresectable or Metastatic Melanoma: The member must have a documented diagnosis of unresectable or metastatic melanoma that is BRAF V600E mutation-positive as detected by an FDA-approved test.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

ZEPATIER

Products Affected

- Zepatier

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Criteria will be applied consistent with current AASLD-IDSA guidance.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a gastroenterologist, hepatologist, or an infectious disease specialist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

ZINPLAVA

Products Affected

- Zinplava

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Zinplava is not indicated for the treatment of Clostridium difficile infection (CDI). It will only be approved as adjunct therapy to antibacterial drug treatment of CDI.
Required Medical Information	The member must have a documented diagnosis of a Clostridium difficile infection (CDI), is concurrently receiving antibacterial drug treatment and documentation that the member is at high risk for recurrence based on one (1) or more of the following: a) History of CDI in the past six (6) months b) Age 65 years or older c) Member is immunocompromised d) Severe CDI at presentation e) CDI with hyper-virulent strain (e.g., ribotypes 027, 078, or 244).
Age Restrictions	The member must be 18 years of age or older.
Prescriber Restrictions	None
Coverage Duration	The plan will authorize one infusion per active CDI.
Other Criteria	Zinplava will not be approved for any repeat doses for recurrence of the same active infection.

ZOLINZA

Products Affected

- Zolinza

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of cutaneous T-cell lymphoma (Stage IIB and higher) and progressive, persistent or recurrent disease and documented current or prior treatment or treatment failure with at least two (2) systemic chemotherapeutic agents for cutaneous T-cell lymphoma.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

ZURAMPIC

Products Affected

- Zurampic

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of hyperuricemia associated with gout that has not reached target serum uric acid levels or contraindication to a xanthine oxidase inhibitor alone and Zurampic (lesinurad) will be used in combination with a xanthine oxidase inhibitor.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

ZYDELIG

Products Affected

- Zydelig

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Chronic Lymphocytic Leukemia (CLL): The member must have a documented diagnosis of relapsed CLL and Zydelig will be given in combination with Rituxan (rituximab). Follicular B-cell non-Hodgkin Lymphoma and Small Lymphocytic Lymphoma (SLL): The member must have a documented diagnosis of either disease and documented use of at least two (2) prior systemic therapies.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be a hematologist or oncologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

ZYKADIA

Products Affected

- Zykadia

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	The member must have a documented diagnosis of anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer (NSCLC) as detected by an FDA-approved test.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

ZYTIGA

Products Affected

- Zytiga Oral Tablet 250 MG, 500 MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	None
Required Medical Information	Metastatic Castration-Sensitive Prostate Cancer: The member must have a documented diagnosis of metastatic castration-sensitive prostate cancer. Metastatic High-Risk Castration-Resistant Prostate Cancer (CRPC): The member must have a documented diagnosis of metastatic high-risk CRPC and Zytiga is being used in combination with prednisone AND the member has a documented failure, contraindication, or intolerance to Xtandi.
Age Restrictions	None
Prescriber Restrictions	The prescribing physician must be an oncologist or urologist.
Coverage Duration	FDA-approved duration, balance of contract year or clinically appropriate duration
Other Criteria	None

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