ACTEMRA

Products Affected

- Actemra

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients already started on tocilizumab for a Covered Use.
Exclusion Criteria	Concurrent Use with a Biologic Disease-Modifying Antirheumatic Drug (DMARD) or Targeted Synthetic DMARD.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	RA, SJIA, PJIA - Prescribed by or in consultation with a rheumatologist.
Coverage Duration	RA/SJIA 3 mos, 4 mos PJIA. Cont - RA, SJIA, PJIA - 3 years.
Other Criteria	RA, approve for patients who have tried one DMARD (brand or generic, oral or injectable, traditional or synthetic). Systemic-onset JIA, approve for patients who have tried. one other systemic agent for SJIA (eg, a corticosteroid [oral, IV], a conventional synthetic DMARD [eg, MTX, leflunomide, sulfasalazine], or a biologic DMARD [eg, Kineret, a TNF inhibitor such as Enbrel, Humira or Remicade, or Ilaris (canakinumab for SC injection)], or a 1-month trial of a nonsteroidal anti-inflammatory drug [NSAID]). PJIA, approve if the patient has tried two of the following: etanercept, adalimumb, abatacept IV, or infliximab, unless the patient has CHF or a previously treated lymphoproliferative disease. If the patient has not tried two of these drugs, the patient must have a trial with etanercept or adalimumab. Cont tx - pt must have had a response (e.g., less joint pain, morning stiffness, or fatigue, improved function or ADLs, decreased soft tissue swelling in joints or tendon sheaths, improved lab values, reduced dosage of corticosteroids), as determined by the prescriber. The patient may not have a full response, but there should have been a recent or past response to Actemra IV or SC.

ACTEMRA SQ

Products Affected

- Actemra

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrent use with a Biologic DMARD or Targeted Synthetic DMARD.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	RA - Prescribed by or in consultation with a rheumatologist.
Coverage Duration	3 months intitial, 3 years cont.
Other Criteria	RA - The pt had a trial with one DMARD (brand or generic, oral or injectable, traditional or biologic) for at least 3 months. Cont tx - pt must have had a response (e.g., less joint pain, morning stiffness, or fatigue, improved function or ADLs, decreased soft tissue swelling in joints or tendon sheaths, improved lab values, reduced dosage of corticosteroids), as determined by the prescriber. The patient may not have a full response, but there should have been a recent or past response to Actemra IV or SC.

ADEMPAS

Products Affected

- Adempas

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PAH and CTEPH- must be precribed by or in consultation with a cardiologist or a pulmonologist.
Coverage Duration	3 years
Other Criteria	For PAH - must have PAH (WHO Group 1) and had a right heart catheterization to confirm the diagnosis of PAH (WHO Group 1). Right heart cathererization is not required in pts who are currently receiving Adempas or another agent indicated for WHO group 1.

AFINITOR

Products Affected

- Afinitor Disperz
- Afinitor oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients already taking Afinitor for a Covered Use. Advanced, unresectable neuroendocrine tumors. Perivascular Epitheloid Cell Tumors (PEComa), Recurrent Angiomyolipoma, Lymphangioleiomyomatosis, relapsed or refractory classical Hodgkin lymphoma, Waldenstrom's Macroglobulinemia/Lymphoplasmacytic Lymphoma (WM/LPL).
Exclusion Criteria	N/A
Required Medical Information	HER2 status. Advanced HER2-negative breast cancer, hormone receptor (HR) status.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.

Other Criteria	Advanced HER2-negative breast cancer, approve if the patient is a postmenopausal woman and has HR+ disease and Afinitor will be used in combination with exemestane or tamoxifen and the patient has tried letrozole or anastrozole. Renal cell carcinoma (RCC), approve if patient meets one of the following: 1) patient has advanced RCC with predominant clear cell histology AND the patient has tried Inlyta, Votrient, Sutent, or Nexavar OR 2) patient has relapsed or medically unresectable RCC with non-clear cell histology.Tuberous sclerosis complex (TSC) for the treatment of subependymal giant cell astrocytoma (SEGA), approve if the patient requires therapeutic intervention but cannot be curatively resected. NET-approve. Renal angiomyolipoma with TSC-approve. WM/LPL - approve if 1. patient has progressive or relapsed disease OR 2. patient has not responded to primary therapy (e.g., Velcade+/- Rituxan, Velcade with dexamethasone +/-Rituxan, Kyprolis with Rituxan and dexamethasone, cyclophosp/doxorubicin/vincristine/pred/Rituxan, Imbruvica, Rituxan, Rituxan with cyclophosphamide and dexamethasone, Thalomid+/- Rituxan

ALECENSA

Products Affected

- Alecensa

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	metastatic NSCLC - is anaplastic lymphoma kinase (ALK)-positive AND has either progressed on or is intolerant to Xalkori.

AMPYRA

Products Affected

- Ampyra

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patient already started on dalfampridine extended-release for Multiple Sclerosis (MS).
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	MS. If prescribed by, or in consultation with, a neurologist or MS specialist.
Coverage Duration	Authorization will be for 3 years.
Other Criteria	N/A

ANABOLIC STEROIDS

Products Affected

- Anadrol-50
- oxandrolone

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Girls w/Turner's Syndrome or Ullrich-Turner Syndrome (oxandrolone only), management of protein catabolism w/burns or burn injury (oxandrolone only), AIDS wasting and cachexia.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	N/A

ARANESP

Products Affected

- Aranesp (in polysorbate) injection solution 100 mcg/mL, 200 mcg/mL, 25 mcg/mL, 300 mcg/mL, 40 mcg/mL, 60 mcg/mL
- Aranesp (in polysorbate) injection syringe

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D worded as anemia associated with chronic renal failure (CRF), including patients on dialysis and not on dialysis, and worded as anemia secondary to myelosuppressive anticancer chemotherapy in solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia. Anemia due to myelodysplastic syndrome (MDS).
Exclusion Criteria	N/A
Required Medical Information	Pt is currently receiving iron therapy or confirmation of adequate iron stores (eg, prescribing information recommends supplemental iron therapy when serum ferritin is less than 100 mcg/L or when serum transferrin saturation is less than 20%).Anemia w/CRF on and not on dialysis.A hemoglobin (Hb) of less than 10.0 g/dL for adults and less than or equal to 11 g/dL for children required for start,Hb has to be less than or equal 11.5 g/dL adults or less than or equal to 12 g/dL in children if previously receiving epoetin alfa (EA) or Aranesp. Anemia due to myelosuppressive chemotx,Hb is 10.0 g/dL or less to start or less than or equal to 12.0 g/dL if previously on EA or Aranesp AND currently receiving myelosuppressive chemo. MDS, approve tx if Hb is 10 g/dL or less or serum erythropoietin level is 500 mU/mL or less to start. If the pt has previously been receiving Aranesp or EA, approve only if Hb is 12.0 g/dL or less. All conds, deny if Hb exceeds 12.0 g/dL.
Age Restrictions	MDS anemia = 18 years of age and older.
Prescriber Restrictions	MDS anemia, prescribed by or in consultation with, a hematologist or oncologist.
Coverage Duration	Anemia w/myelosuppressive = 4 mos, Other=6 mos.

Other Criteria	Part B versus Part D determination will be made at time of prior authorization review per CMS guidance to establish if the drug prescribed is to be used for an end-stage renal disease (ESRD)-related condition. For all covered uses, the patient is required to try Procrit first line.

ARCALYST

Products Affected

- Arcalyst

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patient already started on rilonacept for Muckle Wells Syndrome (MWS) or Familial Cold Autoinflammatory Syndrome (FCAS).
Exclusion Criteria	Concurrent biologic therapy
Required Medical Information	N/A
Age Restrictions	Initial tx CAPS-Greater than or equal to 12 years of age.
Prescriber Restrictions	Initial tx CAPS-prescribed by, or in consultation with, a rheumatologist, geneticist, allergist/immunologist, or dermatologist.
Coverage Duration	3 mos initial, 3 years cont
Other Criteria	CAPS renewal - approve if they have had a response and are continuing therapy to maintain response/remission.

AUBAGIO

Products Affected

- Aubagio

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrent use of Aubagio with other disease-modifying agents used for multiple sclerosis (MS)
Required Medical Information	MS, patient must have a relapsing form of MS (RRMS, SPMS with relapses, or PRMS). MS, previous MS therapies tried.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or MS specialist.
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Relapsing form of MS initial, approve if: 1) Patient is currently taking teriflunomide (Aubagio), OR 2) Patient has tried one of the following injectables: interferon beta-1a intramuscular (Avonex), interferon beta-1a subcutaneous (Rebif), interferon beta-1b (Betaseron or Extavia), glatiramer acetate (Copaxone/Glatopa), or Plegridy. Exceptions to having tried an injectable product can be made if the patient is unable to administer injections due to dexterity issues or visual impairment.

AVONEX

Products Affected

- Avonex (with albumin)
- Avonex intramuscular pen injector kit
- Avonex intramuscular syringe kit

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrent use of other disease-modifying agent used for multiple sclerosis (ie, interferon beta-1a, interferon beta-1b, glatiramer, natalizumab, fingolimod, teriflunomide, dimethyl fumarate DR)
Required Medical Information	Multiple Sclerosis (MS) diagnosis worded or described as patients with a diagnosis of MS or have experienced an attack and who are at risk of MS.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or after consultation with a neurologist or an MS specialist.
Coverage Duration	Authorization will be for 3 years.
Other Criteria	N/A

BETASERON/EXTAVIA

Products Affected

- Betaseron subcutaneous kit
- Extavia subcutaneous kit

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrent use with other disease-modifying agent used for multiple scelorosis (ie, interferon beta-1a, glatiramer, natalizumab, fingolimod, teriflunomide, dimethyl fumerate ER)
Required Medical Information	Multiple Sclerosis (MS) diagnosis worded or described as patients with a diagnosis of MS or have experienced an attack and who are at risk of MS.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or after consultation with a neurologist or an MS specialist.
Coverage Duration	Authorization will be for 3 years.
Other Criteria	For patients requesting Extavia, approve if the patient has tried two of the following: interferon beta-1a intramuscular (Avonex), interferon beta-1a subcutaneous (Rebif), interferon beta-1b (Betaseron), pegylated interferon beta-1a (Plegridy) or glatiramer acetate (Copaxone).

BONIVA INJECTION

Products Affected

- ibandronate intravenous solution

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Hypercalcemia of malignancy. Treatment of bone metastases in patients with solid tumor (eg, breast cancer, prostate cancer). Osteoporosis disorder related to organ transplantation.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.

Other Criteria	Part B versus Part D determination will be made at time of prior authorization review per CMS guidance to establish if the drug prescribed is to be used for an end-stage renal disease (ESRD)-related condition. Treatment of postmenopausal osteoporosis, must meet ONE of the following 1. T-score (current or at any time in the past) at or below -2.5 at the lumbar spine, femoral neck, or total hip, 2. has had osteoporotic fracture, 3. had a T-score (current or at any time in the past) at or below -2.0 at the lumbar spine, femoral neck, or total hip and the physician believes the patient is at high risk for fracture AND has had an inadequate response to oral bisphosphonate therapy after a trial duration of 12 months as determined by the prescribing physician (e.g., ongoing and significant loss of bone mineral density (BMD), lack of BMD increase), had an osteoporotic fracture while receiving oral bisphosphonate therapy, or experienced intolerability to an oral bisphosphonate (e.g., severe GI-related adverse effects) OR pt cannot take an oral bisphosphonate because the pt cannot swallow or has difficulty swallowing or the pt cannot remain in an upright position post oral bisphosphonate administration or pt has a pre-existing GI medical condition (eg, patient with esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]), OR pt has tried an IV bisphosphonate (ibandronate or zoledronic acid).

BOSULIF

Products Affected

- Bosulif oral tablet 100 mg, 500 mg

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D. Plus patients already started on Bosulif for a Covered Use. Plus patients with Phildelphia chromosome positive Acute Lymphoblastic Leukemia.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis. For CML/ALL, the Philadelphia chromosome (Ph) status of the leukemia must be reported. For CML/ALL, prior therapies tried
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	For CML, patient must have Ph-positive CML and must have tried one other TKI indicated for use in CML (e.g., Gleevec, Sprycel, or Tasigna). For ALL, patient must have Ph-positive ALL and have tried two other tyrosine kinase inhibitors that are used for Philadelphia chromosome positive ALL (e.g., Gleevec, Sprycel, etc).

BOTOX

Products Affected

- Botox

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus Achalasia. Anal Fissure. BPH. Chronic facial pain/pain associated with TMJ dysfunction. Chronic low back pain. Headache (chronic tension HA, whiplash, chronic daily HA). Palmar hyperhidrosis. Myofascial pain. Salivary hypersecretion. Spasticity (eg, due to cerebral palsy, stroke, brain injury, spinal cord injury, MS, hemifacial spasm). Essential tremor. Dystonia other than cervical (eg, focal dystonias, tardive dystonia, anismus). Frey's syndrome (gustatory sweating). Ophthalmic disorders (eg, esotropia, exotropia, nystagmus, facial nerve paresis). Speech/voice disorders (eg, dysphonias). Tourette's syndrome.
Exclusion Criteria	Use in the management of cosmetic uses (eg, facial rhytides, frown lines, glabellar wrinkling, horizontal neck rhytides, mid and lower face and neck rejuvenation, platsymal bands, rejuvenation of the peri-orbital region), allergic rhinitis, gait freezing in Parkinsons disease, vaginismus, interstitial cystitis, trigeminal neuralgia, or Crocodile tears syndrome.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Headache and chronic migraine - if prescribed by, or after consultation with, a neurologist or HA specialist.
Coverage Duration	Authorization will be for 12 months

Other Criteria	Primary axillary and Palmar hyperhydrosis after trial with at least 1 topical agent (eg, aluminum chloride). BPH after trial with at least 2 other therapies (eg, alpha1-blocker, 5 alpha-reductase inhibitor, TURP, transurethral microwave heat treatment, TUNA, interstitial laser therapy, stents, various forms of surgery). Chronic low back pain after trial with at least 2 other pharmacologic therapies (eg, NSAID, antispasmodics, muscle relaxants, opioids, antidepressants) and if being used as part of a multimodal therapeutic pain management program. Headache (eg,chronic tension headache, whiplash, chronic daily headache) after a trial with at least 2 other pharmacologic therapies (eg, anticonvulsants, antidepressants, beta-blockers, calcium channel blockers, non-steroidal anti-inflammatory drugs). Essential tremor after a trial with at least 1 other pharmacologic therapy (eg, primidone, propranolol, benzodiazepines, gabapentin, topiramate). Tourette's syndrome if after a trial with at least 1 more commonly used pharmacologic therapy (eg, neuroleptics, clonidine, SSRIs, psychostimulants). Chronic migraine-must have 15 or more migraine headache days per month with headache lasting 4 hours per day or longer AND have tried at least two other prophylactic pharmacologic therapies, each from a different pharmacologic class (eg, beta-blocker, anticonvulsant, tricyclic antidepressant). OAB and urinary incontinence associated with a neurological condition (eg, spinal cord injury, multiple sclerosis), approve after a trial with at least one other pharmacologic therapy (eg, anticholinergic medication).

BUPRENORPHINE/NALOXONE

Products Affected

- buprenorphine-naloxone sublingual tablet 2-0.5 mg, 8-2 mg
- Suboxone sublingual film 12-3 mg, 2-0.5 mg, 4-1 mg, 8-2 mg

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	N/A

C1 ESTERASE INHIBITORS

Products Affected

- Cinryze

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients already started on the prescribed drug for a covered use.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	prescribed by or in consultation with an allergist/immunologist or a physician that specializes in the treatment of HAE or related disorders
Coverage Duration	3 years
Other Criteria	N/A

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. Plus Differentiated (i.e., papillary, follicular, and Hurthle) Thyroid Carcinoma.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	MTC - patient has symptomatic or progressive MTC AND has unresectable locally advanced or metastatic disease. DTC - clinically progressive or symptomatic metastatic disease AND has nonradioiodine-responsive tumors at sites other than central nervous system.

CHENODAL

Products Affected

- Chenodal

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	For the treatment of gallstones, approve if the patient has tried or is currently using an ursodiol product.

CHORIONIC GONADOTROPINS (HCG)

Products Affected

- chorionic gonadotropin, human
- Novarel

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

CIALIS

Products Affected

- Cialis oral tablet 2.5 mg, 5 mg

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Indication for which tadalafil is being prescribed.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 mos.
Other Criteria	Benign prostatic hyperplasia (BPH), after confirmation that tadalafil is being prescribed as once daily dosing, to treat the signs and symptoms of BPH and not for the treatment of erectile dysfunction (ED).

CIMZIA

Products Affected

- Cimzia
- Cimzia Powder for Reconst

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D plus patients already started on certolizumab pegol for Covered use.
Exclusion Criteria	Concurrent use with a Biologic DMARD or Targeted Synthetic DMARD
Required Medical Information	N/A
Age Restrictions	Adults for CD.
Prescriber Restrictions	RA/AS, prescribed by or in consultation with a rheumatologist. Crohn's disease, prescribed by or in consultation with a gastroenterologist.PsA prescribed by or in consultation with a rheumatologist or dermatologist
Coverage Duration	3 months initial, 3 years cont.
Other Criteria	Initial PsA/AS, approve if the patient has tried Enbrel and Humira. Initial RA, approve if the patient has tried two of the following: Enbrel, Humira, Orencia, or Xeljanz. CD, approve if patient has previously tried Humira. Cont tx - approve if the patient has had a response to therapy, as according to the prescribing physician

COMETRIQ

Products Affected

- Cometriq

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D. Plus Renal Cell Carcinoma, Non-Small Cell Lung Cancer with RET Gene Rearrangements, and patients already started on Cometriq for a Covered Use.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	MTC - must have symptomatic or progressive MTC AND have unresectable locally advanced or metastatic disease. RCC - have relapsed or Stage IV and surgically unresectable, predominant clear-cell histology RCC AND has progressed on one of the first-line tyrosine kinase inhibitor therapies such as Sutent, Votrient, Inlyta, or Nexavar. Non-Small Cell Lung Cancer with RET Gene Rearrangements - approve.

COPAXONE

Products Affected

- Copaxone subcutaneous syringe 40 mg/mL
- Glatopa

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Concurrent use with other disease-modifying agent used for multiple scelorosis (ie, interferon beta-1a, interferon beta-1b, natalizumab, fingolimod, teriflunomide, dimethyl fumerate ER)
Required Medical Information	Multiple Sclerosis (MS) diagnosis worded or described as patients with a diagnosis of MS or have experienced an attack and who are at risk of MS.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or after consultation with a neurologist or an MS specialist.
Coverage Duration	Authorization will be for 3 years.
Other Criteria	N/A

CORLANOR

Products Affected

- Corlanor

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Previous use of a Beta-blocker, LVEF, sinus rhythm, and resting HR
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	HF in pts not currently receiving Corlanor - must all of the following 1. have LVEF of less than or equal 35 percent, 2. have sinus rhythm and a resting HR of greater than or equal to 70 BPM, AND 3. tried or is currently receiving a Beta-blocker for HF (e.g., metoprolol succinate sustained-release, carvedilol, bisoprolol, carvedilol ER) unless the patient has a contraindication to the use of beta blocker therapy (e.g., bronchospastic disease such as COPD and asthma, severe hypotension or bradycardia). HF in pts currently receiving Corlanor - had a LVEF of less than or equal to 35 percent prior to initiation of Corlanor therapy AND has tried or is currently receiving a Beta-blocker for HF unless the patient has a contraindication to the use of beta blocker therapy.

COSENTYX

Products Affected

- Cosentyx
- Cosentyx Pen

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrent Use with other Biologics or Targeted Synthetic Disease-Modifying Antirheumatic Drugs (DMARDs)
Required Medical Information	Diagnosis and previous medications use
Age Restrictions	PP initial - 18 years of age and older
Prescriber Restrictions	PP initial - Prescribed by or in consultation with a dermatologist
Coverage Duration	PP - initial tx 3 mos, cont tx 3 years
Other Criteria	PP initial - Patient must 1. have tried at least one of the following agents for at least 3 months for plaque psoriasis - an oral therapy for psoriasis (e.g., MTX, cyclosporine, acitretin tablets), oral methoxsalen plus ultraviolet A light (PUVA), or a biologic agent (e.g., Enbrel, Humira, Remicade, or Stelara), 2. experienced an intolerance to a trial of at least one oral or biologic therapy for plaque psoriasis (e.g., MTX, cyclosporine, acitretin, Enbrel, Humira, Remicade, or Stelara), OR 3. have a contraindication to one oral agent for psoriasis such as MTX, as determined by the prescribing physician. PP cont - patient must have responded, as determined by the prescriber. The patient may not have a full response, but there should have been a recent or past response to Cosentyx.

COTELLIC

Products Affected

- Cotellic

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Melanoma initial - must have BRAF V600 mutation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Melanoma - being prescribed in combination with Zelboraf.

CRINONE GEL

Products Affected

- Crinone vaginal gel 8 %

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus, secondary amenorrhea, support of an established pregnancy.
Exclusion Criteria	Use in patients to supplement or replace progesterone in the management of infertility.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Secondary amenorrhea, 12 months.Support of an established pregnancy, 9 months.
Other Criteria	N/A

DAKLINZA

Products Affected

- Daklinza

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus HCV genotypes 1a, 1b, 2, and 4, and recurrent HCV posttransplant in genotypes 1a, 1b, 2, 3, and 4. Plus patients already started on Daklinza for a covered use.
Exclusion Criteria	Combination use with Direct Acting Antivirals (DAAs) other than Sovaldi or ribavirin.
Required Medical Information	Hep C genotype, concurrent medications, medication history
Age Restrictions	18 years of age and older.
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician, or a liver transplant physician
Coverage Duration	Authorization will be for 12 weeks or 24 weeks, as specified in "other criteira".
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance.

DALIRESP

Products Affected

- Daliresp

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Chronic Obstructive Pulmonary Disease (COPD), medications tried.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	COPD, approve in patients who meet all of the following conditions: Patients has severe COPD or very severe COPD, AND Patient has chronic bronchitis, AND Patient has a history of exacerbations, AND Patient has tried a medication from two of the three following drug categories: long-acting beta2-agonist (LABA) [eg, salmeterol, formoterol], long-acting anticholinergic (eg, tiotropium), inhaled corticosteroid (eg, fluticasone).

ENBREL

Products Affected

- Enbrel subcutaneous recon soln
- Enbrel subcutaneous syringe 25 mg/0.5mL (0.51), 50 mg/mL (0.98 mL)
- Enbrel SureClick

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D plus patient already on etanercept for a Covered Use. Graft versus host disease (GVHD). Behcet's disease. Mucous membrane pemphigoid [cicatricial pemphigoid]. Uveitis
Exclusion Criteria	Concurrent use with biologic therapy or targeted synthetic DMARD
Required Medical Information	N/A
Age Restrictions	For use in rheumatoid arthritis (RA), approve for adults.
Prescriber Restrictions	RA/Ankylosing spondylitis/JIA/JRA,prescribed by or in consult w/ rheumatologist. Psoriatic arthritis, prescribed by or in consultation w/ rheumatologist or dermatologist.Plaque psoriasis (PP)/Cic Pemphigoid, prescribed by or in consult w/ dermatologist.GVHD,prescribed by or in consult w/ oncologist,hematologist,or physician affiliated w/ transplant center.Behcet's disease,prescribed by or in consult w/ rheumatologist,dermatologist,ophthalmologist,gastroenterologist,or neurologist.
Coverage Duration	FDA approved indications - 3 months initial, 3 years cont, others 12 months.

Other Criteria	RA initial, Tried 1 DMARD for 3 mos or is also receiving MTX, has a contraindication or intolerance to MTX and leflunomide, or has early RA (defined as disease duration of less than 6 months) with at least one of the following features of poor prognosis: functional limitation, extraarticular disease such as rheumatoid nodules, RA vasculitis, or Felty's syndrome, positive rheumatoid factor or anti-CCP antibodies, or bony erosions by radiograph. JIA/JRA, approve if the pt has aggressive disease or the pt has tried one other agent for this condition (eg, MTX, sulfasalazine, leflunomide, NSAID, biologic DMARD or the pt will be started on Enbrel concurrently with MTX, sulfasalazine, or leflunomide or the pt has an absolute contraindication to MTX (eg, pregnancy, breast feeding, alcoholic liver disease, immunodeficiency syndrome, blood dyscrasias), sulfasalazine, or leflunomide.Plaque psoriasis (PP) initial. Approve if the patient has tried at least one of the following agents for at least 3 months for plaque psoriasis: an oral therapy for psoriasis (eg, MTX, cyclosporine, Soriatane), oral methoxsalen plus PUVA, or a biologic agent OR the patient had intolerance to a trial of at least one oral or biologic therapy for plaque psoriasis OR the patient has a contraindication to one oral agent for psoriasis such as MTX. GVHD. Tried or currently is receiving with etanercept 1 conventional GVHD tx (high-dose SC, CSA, tacrolimus, MM, thalidomide, antithymocyte globulin, etc.). Behcet's. Have not responded to at least 1 conventional tx (eg, CS, immunosuppressant, interferon alfa, MM, etc) or adalimumab or infliximab. Cic Pemp Tried 2 conventional txs (eg, systemic corticosteroids, azathioprine, cyclophosphamide, dapsone, MTX, cyclosporine, mycophenolate mofetil). RA/AS/JIA/PP/PsA Cont - must have a response to tx.

ENTRESTO

Products Affected

- Entresto

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Combination therapy with an ACE inhibitor/ACE inhibitor containing product, an ARB/ARB containing product, or Tekturna (aliskiren tablets) or a Tekturna-Containing Product in patients with diabetes
Required Medical Information	Must have LVEF less than or equal to 40 percent prior to initiation with Entresto
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a cardiologist
Coverage Duration	12 months
Other Criteria	N/A

EPOETIN/PROCRIT

Products Affected

- Epogen injection solution 2,000 unit/mL, 20,000 unit/2 mL, 20,000 unit/mL, 3,000 unit/mL, 4,000 unit/mL
- Procrit injection solution 10,000 unit/mL, 2,000 unit/mL, 20,000 unit/mL, 3,000 unit/mL, 4,000 unit/mL, 40,000 unit/mL

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D worded as anemia associated with chronic renal failure (CRF), including patients on dialysis and not on dialysis, and worded as anemia secondary to myelosuppressive anticancer chemotherapy in solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia, . Plus anemia in patients with HIV who are receiving zidovudine. Anemic patients (Hb of 13.0 g/dL or less) at high risk for perioperative transfusions (secondary to significant, anticipated blood loss and are scheduled to undergo elective, noncardiac, nonvascular surgery to reduce the need for allogeneic blood transfusions). Additional off-label coverage is provided for Anemia due to myelodysplastic syndrome (MDS), Anemia associated with use of ribavirin therapy for hepatitis C (in combination with interferon or pegylated interferon alfa 2a/2b products with or without the direct-acting antiviral agents Victrelis or Incivek), and Anemia in HIV-infected patients.
Exclusion Criteria	N/A

Required Medical Information	Pt is currently receiving iron therapy or confirmation of adequate iron stores (eg, prescribing information recommends supplemental iron therapy when serum ferritin is less than 100 mcg/L or when serum transferrin saturation is less than 20%).CRF anemia in patients on and not on dialysis.Hemoglobin (Hb) of less than 10.0 g/dL for adults or less than or equal to 11 g/dL for children to start.Hb less than or equal to 11.5 g/dL for adults or 12 g/dL or less for children if previously on epoetin alfa or Aranesp.Anemia w/myelosuppressive chemotx.pt must be currently receiving myelosuppressive chemo and Hb 10.0 g/dL or less to start.Hb less than or equal to 12.0 g/dL if previously on epoetin alfa or Aranesp.MDS, approve if Hb is 10 g/dL or less or serum erythropoietin level is 500 mU/mL or less to start.Previously receiving Aranesp or EA, approve if Hb is 12.0 g/dL or less. Anemia in HIV (with or without zidovudine), Hb is 10.0 g/dL or less or endogenous erythropoetin levels are 500 munits/mL or less at tx start.Previously on EA approve if Hb is 12.0 g/dL or less.Anemia due to ribavirin for Hep C, pt is receiving tx for HepC (e.g. RBV in combo with INF, PegINF, with or w/o direct acting antiviral agents and Hb is 10.0 g/dL or less at tx start. Previously on EA or Aranesp approve if Hb is 12.0 g/dL or less. Surgical pts to reduce RBC transfusions - pt is unwilling or unable to donate autologous blood prior to surgery
Age Restrictions	MDS anemia/HepC anemia = 18 years of age and older
Prescriber Restrictions	MDS anemia, prescribed by or in consultation with, a hematologist or oncologist. Hep C anemia, prescribed by or in consultation with hepatologist, gastroenterologist or infectious disease physician who specializes in the management of hepatitis C.
Coverage Duration	Anemia w/myelosuppressive = 4 mos.Transfus=1 mo.Other=6mo. HIV + zidovudine = 4 mo
Other Criteria	Part B versus Part D determination will be made at time of prior authorization review per CMS guidance to establish if the drug prescribed is to be used for an end-stage renal disease (ESRD)-related condition. For all covered uses, if the request is for Epogen, then the patient is required to try Procrit first line.

ERIVEDGE

Products Affected

- Erivedge

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus, patient already started on Erivedge for a covered use.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months
Other Criteria	Locally advanced basal cell carcinoma (LABCC), approve if 1. the patient's BCC has recurred following surgery or radiation, OR 2. the patient is not a candidate for surgery and radiation therapy.

ESBRIET

Products Affected

- Esbriet

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Combination use with nintedanib
Required Medical Information	N/A
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist
Coverage Duration	3 years
Other Criteria	IPF baseline - must have FVC greater than or equal to 50 percent of the predicted value AND IPF must be diagnosed with either findings on high-resolution computed tomography (HRCT) indicating usual interstitial pneumonia (UIP) or surgical lung biopsy demonstrating UIP.

FARYDAK

Products Affected

- Farydak oral capsule 10 mg, 15 mg, 20 mg

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	MM - must be used in combination with Velcade and dexamethasone AND previously tried Velcade and one immunomodulatory drug (i.e., Thalomid, Revlimid, or Pomalyst).

FIRAZYR

Products Affected

- Firazyr

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an allergist/immunologist or a physican that specializes in the treatment of HAE or related disorders.
Coverage Duration	Authorization will be for 3 years.
Other Criteria	N/A

FLECTOR

Products Affected

- Flector

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 mos.
Other Criteria	Patients must try a generic oral NSAID or Voltaren gel.

FORTEO

Products Affected

- Forteo

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concomitant use with other medications for osteoporosis (eg, denosumab [Prolia], bisphosphonates, raloxifene, calcitonin nasal spray [Miacalcin, Fortical]), except calcium and Vitamin D.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 2 years.
Other Criteria	Treatment of PMO, approve if pt has tried one oral bisphosphonate OR pt cannot take an oral bisphosphonate because the pt cannot swallow or has difficulty swallowing or the pt cannot remain in an upright position post oral bisphosphonate administration or pt has a pre-existing GI medical condition (eg, patient with esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]), OR pt has tried an IV bisphosphonate (ibandronate or zoledronic acid), OR pt has severe renal impairment (creatinine clearance less than 35 mL/min) or CKD or pt has had multiple osteoporotic fractures. Increase bone mass in men with primary or hypogondal osteoporosis/Treatment of men and women with GIO, approve if pt tried one oral bisphosphonate OR pt cannot take an oral bisphosphonate because the patient cannot swallow or has difficulty swallowing or the patient cannot remain in an upright position post oral bisphosphonate administration or has a pre-existing GI medical condition (eg, patient with esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]), OR pt has tried zoledronic acid (Reclast), OR pt has severe renal impairment (CrCL less than 35 mL/min) or has CKD or has had multiple osteoporotic fractures.

GILENYA

Products Affected

- Gilenya

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrent use of Gilenya with other disease-modifying agents used for multiple sclerosis (MS).
Required Medical Information	For use in MS, patient has a relapsing form of MS.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist or an MS specialist.
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Relapsing form of MS initial, approve if patient meets one of the following: 1) Patient has tried Avonex, Rebif, Betaseron, Extavia, Copaxone/Glatopa, or Plegridy, OR 2) Patient is unable to administer injections due to dexterity issues or visual impairment.

GILOTRIF

Products Affected

- Gilotrif oral tablet 20 mg, 30 mg, 40 mg

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Additional coverage is provide fro NSCLC - squamous cell carcinoma and NSCLC - HER2 positive.
Exclusion Criteria	N/A
Required Medical Information	For NSCLC - EGFR exon deletions or mutations HER2 status, or if NSCLC is squamous cell type
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	NSCLC EGFR pos - For the treatment of metastatic non small cell lung cancer (NSCLC) must be used in tumors with epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations. NSCLC squamous cell must have disease progression with first line treatment with platinum based chemotherapy. NSCLC HER2 pos - if HER2 positive NSCLC approve.

GLEEVEC

Products Affected

- Gleevec oral tablet 100 mg, 400 mg
- imatinib oral tablet 100 mg, 400 mg

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D. Plus chordoma, advanced or unresectable fibromatosis (desmoid tumors), cKit positive advanced/recurrent or metastatic melamona, and pigmented Villonodular Synovitis/Tenosynovial Giant Cell Tumor. Plus patients already started on Gleevec for a Covered Use.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis. For indications of CML and ALL, the Philadelphia chromosome (Ph) status of the leukemia must be reported.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	For ALL/CML, new patient must have Ph-positive for approval of Gleevec.

GLUCAGON-LIKE PEPTIDE-1 AGONISTS

Products Affected

- Bydureon
- Byetta subcutaneous pen injector 10 mcg/dose(250 mcg/mL) 2.4 mL, 5 mcg/dose (250 mcg/mL) 1.2 mL
- Victoza 3-Pak

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	N/A

GRALISE/HORIZANT

Products Affected

- Gralise
- Gralise 30-Day Starter Pack

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	Authorize use if the patient has tried gabapentin for their current condition. Patients with Restless Legs Syndrome, authorize use of Horizant without a trial of gabapentin.

GRASTEK

Products Affected

- Grastek

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	The patient is NOT currently receiving SC allergen immunotherapy
Required Medical Information	Diagnosis
Age Restrictions	5 years through 65 years of age
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	The diagnosis of grass pollen-induced AR must be confirmed by either 1. positive skin test response to a grass pollen from the Pooideae subfamily of grasses (this includes, but is not limited to sweet vernal, Kentucky blue grass, Timothy grass, orchard, or perennial rye grass), or 2. positive in vitro test (i.e., a blood test for allergen-specific IgE antibodies) for a grass in the Pooideae subfamily of grasses. Therapy must be initiated 12 weeks prior to the expected onset of the grass pollen season or therapy is being dosed daily continuously for consecutive grass pollen seasons.

GROWTH HORMONES

Products Affected

- Norditropin FlexPro
- Omnitrope

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Somatropin products are all covered for Growth hormone deficiency (GHD), idiopathic short stature (ISS), Chronic Kidney disease (CKD) in children or adolescents, Noonan Syndrome in children/adolescents, Prader-Willi Syndrome (PW), SHOX deficiency in children/adolescents, Children born small for gestational age (SGA), urner's Syndrome (TS) in girls, and Short Bowel Syndrome (SBS).
Exclusion Criteria	N/A
Required Medical Information	GHD in children/adoles initial must meet ONE of the following - 1. had hypophysectomy, 2. has congenital hypopituitarism AND had growth hormone response to one preferred GH test of less than 10 ng/mL (preferred tests are levodopa, insulin-induced hypoglycemia, arginine, clonidine, or glucagon), 3. has panhypopituitarism AND had growth hormone response to one preferred GH test of less than 10 ng/mL, has 3 or more pituitary hormone deficiencies (ACTH, TSH, LH/FSH, or prolactin), or pituitary stalk agenesis, empty sella, sellar or supra-sellar mass lesion, or ectopic posterior "bright spot" on MRI or CT, 4. pt had brain radiation, had growth hormone response to one preferred GH test of less than 10 ng/mL, AND meets one of these a. pretreatment growth rate (GR) is less than 7 cm/yr in children younger than 3 or b. GR is less than 4 cm/yr in 3 y/o or older, c. or if 18 y/o or younger with growth velocity that is less than 10th percentile for age/gender on last 6 months of data, OR 5. had growth hormone response to one preferred GH test of less than 10 ng/mL, ht less than the 10th percentile for age/gender, AND meets one of these a. pretreatment growth rate (GR) is less than 7 cm/yr in children younger than 3 or b. GR is less than 4 cm/yr in 3 y/o or older, c. or if 18 y/o or younger with growth velocity that is less than 10th percentile for age/gender on last 6 months of data. Cont 12 yr and younger ht increase 4 or more cm/yr. Additionally, pts older than 12 must also have open epiphyeses and pts older than 18 must also not attained midparental ht.
Age Restrictions	ISS 5 y/o or older, SGA 2 y/o or older, SBS and HIV wasting/cachexia 18 y/o or older

Prescriber Restrictions	GHD (Initial tx children or adolescents w/o hypophysectomy), GHD adults or transitional adolescents, Noonan (initial), Prader Willi (initial for child/adult and cont tx in adults), SHOX (initial), SGA (initial) - prescribed by or in consultation with an endocrinologist. CKD (initial) endocrinologist or nephrologist.
Coverage Duration	ISS - 6 mos intial, 12 months cont tx, SBS 4 weeks, others 12 mos

Other Criteria	GHD initial in adults and adoles 1. endocrin must certify not being prescribed for anti-aging or to enhance athletic performance, 2. has either childhood onset or adult onset resulting from GHD alone, multiple hormone deficiency from pituitary dx, hypothalmic dz, pituitary surgery, cranial radiation tx, tumor treatment, TBI or subarachnoid hemorrhage, AND 3. meets one of the following - A. childhood onset has known mutations, embryonic lesions, congential defects or irreversible structural hypothalmic pituitary lesion/damage, B. 3 or more pituitary hormone def (ACTH, TSH, LH/FSH, or prolactin, IGF1 less than 84 mcg/L (Esoterix RIA), AND other causes of low serum IGF-1 have been excluded, C. Neg response to ONE preferred GH stim test (insulin peak response less than or equal to 5 mcg/L, Glucagon peak less than or equal to 3 mcg/L, if insulin and glucagon contraindicated then Arginine alone test with peak of less than or equal to 0.4 mcg/L, GHRH plus arginine peak of less than or equal to 11 mcg/L if BMI is less than 25, peak less than 8 mcg/L if BMI is more than 25 but less than 30, or peak less than 4 mcg/L if BMI if more than 30) AND if a transitional adoles must be off tx for at least one month before retesting. Cont tx - endocrin must certify not being prescribed for anti-aging or to enhance athletic performance. ISS initial - baseline ht less than the 3rd percentile for age and gender, open epiphyses, does not have CDGP and height velocity is either growth rate (GR) is a. less than 4 cm/yr for pts older than 5 or b. growth velocity is less than 10th percentile for age/gender. Cont tx - 1. 5 y/o old or older doubled annualized GR or 2. ht increase by 4 or more cm/yr. Additionally, pts older than 12 must also have open epiphyeses and pts older than 18 must also have not attained midparental height. CKD initial - CKD defined by abnormal CrCl. Noonan initial - baseline height less than 5th percentile. PW cont tx in adults or adolesents who don't meet child requir - physician certifies not being used for anti-aging or to enhance athletic performance. SHOX initial - SHOX def by chromo analysis, open epiphyses, height less than 3rd percentile for age/gender. SGA initial -baseline ht less than 5th percentile for age/gender and born SGA (birth weight/length that is more than 2 SD below mean for gestational age/gender and didn't have sufficient catch up growth by 2-4 y/o). Cont tx - ht increase by 4 or more cm/yr. Additionally, pts older than 12 must also have open epiphyeses and pts older than 18 must also have not attained midparental height. Cont Tx for CKD, Noonan, PW in child/adoles, SHOX, and TS in girls - ht increased by 2.5 cm/yr or more and epiphyeses open. SBS initial pt receiving specialized nutritional support. Cont tx - 2nd course if pt responded to tx with a decrease in the requirement for specialized nutritional support.

HARVONI

Products Affected

- Harvoni

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients with recurrent HCV post-liver transplant. Plus patients started on Harvoni for a covered use
Exclusion Criteria	Combination use with other direct acting antivirals, excluding ribavirin
Required Medical Information	Genotype 1 - a. approve for 12 weeks if treatment naive OR pt does not have cirrhosis and is treatment experienced, b. as per Harvoni product labeling, approve for 24 weeks if treatment experienced in pts with compensated cirrhosis. Recurrent HCV Post-Liver Transplantation genotypes 1 and 4 - a. approve for 12 weeks ifpt does not have cirrhosis or has compensated cirrhosis and will be taken with RBV, OR b. approve for 24 weeks if pt is RBV intolerant or ineligible and has compensated cirrhosis. Genotypes 4, 5 or 6 - as per labeling and AASLD guidelines, approve for 12 weeks. HCV RNA (pre-treatment).
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by or in consultation w/ GI, hepatologist, ID, or a liver transplant MD
Coverage Duration	24wks or 12 wks see "REQ_MEDINFO" for details due to space limitations
Other Criteria	N/A

HETLIOZ

Products Affected

- Hetlioz

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	patient is totally blind with no perception of light
Age Restrictions	18 years or older
Prescriber Restrictions	prescribed by, or in consultation with, a physician who specializes in the treatment of sleep disorders
Coverage Duration	6 mos initial, 12 mos cont
Other Criteria	Initial - dx of Non-24 is confirmed by either assessment of one physiologic circadian phase marker (e.g., measurement of urinary melatonin levels, dim light melatonin onset, assessment of core body temperature), or if assessment of physiologic circadian phase marker cannot be done, the diagnosis must be confirmed by actigraphy performed for at least 1 week plus evaluation of sleep logs recorded for at least 1 month. Cont - Approve if pt has received at least 6 months of continuous therapy (i.e., 6 consecutive months of daily treatment) with Hetlioz under the guidance of a physician who specializes in the treatment of sleep disorders AND has achieved adequate results with Hetlioz therapy according to the prescribing physician (e.g., entrainment, clinically meaningful or significant increases in nighttime sleep, clinically meaningful or significant decreases in daytime sleep).

HIGH RISK MEDICATIONS - BENZODIAZEPINES

Products Affected

- clonazepam
- clorazepate dipotassium
- Diazepam Intensol
- diazepam oral solution 5 mg/5 mL (1 mg/mL)
- diazepam oral tablet
- diazepam rectal
- Lorazepam Intensol
- lorazepam oral tablet
- Onfi oral suspension
- Onfi oral tablet 10 mg, 20 mg
- oxazepam
- temazepam

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
Prescriber Restrictions	N/A
Coverage Duration	Procedure-related sedation = 1mo. All other conditions = 12 months.
Other Criteria	All medically accepted indications other than Restless Leg Syndrome and insomnia, authorize use. Restless Leg Syndrome, approve clonazepam if the patient has tried one other agent for this condition (eg, ropinirole, pramipexole, carbidopa-levodopa [immediate-release or extended-release]). Insomnia, approve lorazepam, oxazepam, or temazepam if the patient has had a trial with two of the following: ramelteon, trazodone, doxepin 3mg or 6 mg, eszopiclone, zolpidem, or zaleplon. Prior to approval, the physician must have assessed risk versus benefit in prescribing the requested HRM for the patient and must confirm that he/she would still like to initiate/continue therapy.

HIGH RISK MEDICATIONS - FIRST GENERATION ANTIHISTAMINES

Products Affected

- diphenhydramine HCl oral elixir
- hydroxyzine HCl oral tablet
- promethazine oral

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	For hydroxyzine hydrochloride, authorize use without a previous drug trial for all FDA-approved indications other than anxiety. Approve hydroxyzine hydrochloride if the patient has tried at least two other FDA-approved products for the management of anxiety. Prior to approval, the physician must have assessed risk versus benefit in prescribing the requested HRM for the patient and must confirm that he/she would still like to initiate/continue therapy.

HIGH RISK MEDICATIONS - TERTIARY TRICYCLIC ANTIDEPRESSANTS

Products Affected

- amitriptyline
- clomipramine
- doxepin oral
- imipramine HCl
- imipramine pamoate
- Surmontil
- trimipramine

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.

Other Criteria	For the treatment of depression, approve if the patient has tried at least two of the following agents (brand or generic): citalopram, escitalopram, fluoxetine, paroxetine, sertraline, venlafaxine, desvenlafaxine, duloxetine, bupropion, mirtazapine, nortriptyline, desipramine, or trazodone. For the treatment of pain, may approve amitriptyline (single-entity only, not amitriptyline combination products) or imipramine (brand or generic) if the patient has tried at least two of the following agents: duloxetine, pregabalin, gabapentin, venlafaxine, venlafaxine Er, desipramine, or notriptyline. For the mangement of insomnia, may approve amitriptyline (single-entity only, not amitriptyline combination products), doxepin greater than 6 mg, or imipramine (brand or generic) if the patient has tried at least two of the following medications: ramelteon, trazodone, or doxepin 3 mg or 6 mg. For the treatment of obessessive compulsive disorder (OCD), may approve clomipramine (brand or generic) if the patient has tried at least two of the following medications: fluoxetine, fluvoxamine, paroxetine, sertraline, citalopram, escitalopram, or venlafaxine. Prior to approval, the physician must have assessed risk versus benefit in prescribing the requested HRM for the patient and must confirm that he/she would still like to initiate/continue therapy.

HUMIRA

Products Affected

- Humira Pediatric Crohn's Start subcutaneous syringe kit 40 mg/0.8 mL, 40 mg/0.8 mL (6 pack)
- Humira Pen
- Humira Pen Crohn's-UC-HS Start
- Humira subcutaneous syringe kit 10 mg/0.2 mL, 20 mg/0.4 mL, 40 mg/0.8 mL

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D plus patients already started on adalimumab for a Covered Use. Hidradenitis Suppurativa
Exclusion Criteria	Concurrent use with another biologic DMARD or targeted synthetic DMARD
Required Medical Information	N/A
Age Restrictions	Crohn's disease (CD), 6 or older. Ulcerative colitis (UC), adults.
Prescriber Restrictions	RA/JIA/JRA/Ankylosing spondylitis, prescribed by or in consultation with rheumatologist. Psoriatic arthritis (PsA), prescribed by or in consultation with a rheumatologist or dermatologist. Plaque psoriasis (PP), prescribed by or in consultation with a dermatologist. UC/ CD, prescribed by or in consultation with a gastroenterologist. HS - dermatologist
Coverage Duration	FDA indication initial 3 months, cont tx 3 years, others 12 months.

Other Criteria	RA initial, Tried 1 DMARD (brand or generic, oral or injectable) for 3 mos (this includes patients who have tried other biologic DMARDs for 3 mos), or pt is concurrently receiving methotrexate (MTX), or pt has a contraindication or inolerance to MTX and leflunomide, as determined by prescribing physician, or pt has early RA (defined as disease duration of less than 6 months) with at least one of the following features of poor prognosis: functional limitation, extraarticular disease such as rheumatoid nodules, RA vasculitis, or Felty's syndrome, positive rheumatoid factor or anti-cyclic citrullinated protein antibodies, or bony erosions by radiograph. JIA/JRA initial. Tried another agent (e.g MTX, sulfasalazine, leflunomide, NSAID, or biologic DMARD (eg, etanercept, abatacept, infliximab, anakinra, tocilizumab) or will be starting on adalimumab concurrently with MTX, sulfasalazine, or leflunomide. Approve without trying another agent if pt has absolute contraindication to MTX, sulfasalazine, or leflunomide or if pt has aggressive disease. PP initial. Pt has tried a systemic therapy (eg, MTX, CSA, acritretin, etanercept, infliximab, or ustekinumab) for 3 mos or PUVA) for 3 months , or pt experienced an intolerance to a trial of at least one systemic therapy (oral or biologic therapy), or pt has a contraindication to one oral agent for psoriasis such as MTX, as determined by the prescribing physician. CD initial. Tried corticosteroids (CSs) or if CSs are contraindicated or if pt currently on CSs or patient has tried one other agent for CD (eg, azathioprine, 6-mercaptopurine, MTX, certolizumab, infliximab, or vedolizumab) OR pt had ilecolonic resection OR enterocutaneous (perianal or abdominal) or rectovaginal fistulas. UC initial. Pt has tried a systemic therapy (eg, 6-mercaptopurine, azathioprine, CSA, tacrolimus, infliximab, or a corticosteroid such as prednisone or methylprednisolone) for 2 months or was intolerant to one of these agents, or the pt has pouchitis and has tried therapy with an antibiotic, probiotic, corticosteroid enema, or mesalamine (Rowasa) enema. FDA approve indications cont tx - must respond to tx as determined by prescriber. HS - tried ONE other therapy (e.g., intralesional or oral corticosteroids, systemic antibiotics, isotretinoin)

IBRANCE

Products Affected

- Ibrance

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Breast cancer - approve advanced (metastatic) ER positive disease, and HER2-negative breast cancer when the pt meets ONE of the following 1. Pt is postmenopausal woman and Ibrance will be used as first line therapy in combination with anastrozole, ememestane, or letrozole 2, pt is premonopausal or perimenopausal woman and is receiving ovarian suppression/abaltation with LHRH agonists, surgical bilateral oophorectomy, or ovarian irradiation AND it will be used as first line endocrine therapy in combination with anastrozole, exemestane, or letrozole, 3. pt is a man who is receiving LHRH agonist AND Ibrance with be used as first line endocrine therapy in combination with anastrozole, exemestane or letrozole, 4. Pt is postmenopausal and has relapsed or progressed during endocrine therapy (e.g. anastrozole, exemestance, letrozole, tamoxifen) AND has not previously taken Ibrance in combination with letrozole, anastrozole, or exemestance AND will be used in combination with Faslodex, 5. Pt is premenopausal or perimenopausal and is receiving ovarian suppression/ablation with LHRH agonist, surgical bilateral oophorectomy, or ovarian irradiation, relapsed or progressed on prior endocrine therapy, has not previously taken Ibrance in combination with letrozole, anastrozole, or exemestane AND will be used in combination with Faslodex.

ICLUSIG

Products Affected

- Iclusig oral tablet 15 mg, 45 mg

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D. Plus patients already started on Iclusig for a Covered Use.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis the Philadelphia chromosome (Ph) status of the leukemia must be reported. T315I status
Age Restrictions	CML/ALL - Adults
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	CML Ph+, T315I-positive or has tried TWO other TKIs indicated for use in Philadelphia chromosome positive CML (e.g., Gleevec, Sprycel, Tasigna). ALL Ph+, T315I-posistive or has tried TWO other TKIs indicated for use in Ph+ ALL (e.g. Gleevec, Sprycel.)

ILARIS

Products Affected

- Ilaris (PF)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	When used in combination with concurrent biologic therapy (e.g.TNF antagonists, etanercept, adalimumab, certolizumab pegol, golimumab, infliximab), anakinra, or rilonacept.
Required Medical Information	N/A
Age Restrictions	CAPS-4 years of age and older. SJIA-2 years of age and older.
Prescriber Restrictions	CAPS/MWS/FCAS initial- Prescribed by or in consultation with a rheumatologist, geneticist, allergist/immunologist, or dermatologist. SJIA initial- prescribed by or in consultation with a rheumatologist
Coverage Duration	3 mos initial, 3 years cont
Other Criteria	For renewal of CAPS/MWS/FCAS - after pt had been started on Ilaris, approve if the pt had a response to therapy as determined by prescribing physician and the pt is continuing therapy to maintain a response/remission. For treatment of SJIA, initial therapy approve if the pt meets one of the following 1. has tried at least 2 other biologics for SJIA (tocilizumab, abatacet, TNF antagonists (e.g. etanercept, adalimumab, infliximab) OR 2. pt has features of poor prognosis (e.g. arthritis of the hip, radiographic damage, 6-month duration of significant active systemic diease, defined by fever, elevated inflammatory markers, or requirement for treatment with systemic glucocorticoids AND tried Actemra or Kineret. SJIA renewal approve if it patient was already started on Ilaris and the pt had a response (e.g. resolution of fever, improvement in limitions of motion, less joint pain or tenderness, decreased duration of morning stiffness or fatigue, improved function or ADLs, reduced dosage of CS) and the pt is continuing therapy to maintain response/remission.

IMBRUVICA

Products Affected

- Imbruvica

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients already taking Imbruvica for a Covered Use.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	N/A

INLYTA

Products Affected

- Inlyta oral tablet 1 mg, 5 mg

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus, Differentiated (i.e., papillary, follicular, and Hurthle) Thyroid Carcinoma. Plus, patients already started on Inlyta for a Covered Use.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Advanced renal cell carcinoma, approve. Differientiated thyroid cancer approve if patient has clinically progressive or symptomatic metastatic disease AND has nonradioiodine-responsive tumors at sites other than central nervous system.

IRESSA

Products Affected

- Iressa

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Metastatic NSCLC - The patient has epidermal growth factor receptor (EGFR) exon 19 deletions OR has exon 21 (L858R) substitution mutations as detected by an FDA-approved test.

IVIG

Products Affected

- Privigen

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	Part B versus D determination per CMS guidance to establish if drug used for PID in pt's home.

JAKAFI

Products Affected

- Jakafi oral tablet 10 mg, 15 mg, 20 mg, 25 mg, 5 mg

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus, patients already started on Jakafi for a Covered Use.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	For polycythemia vera patients must have tried hydroxyurea

KALYDECO

Products Affected

- Kalydeco oral granules in packet
- Kalydeco oral tablet

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	CF - must have one of the following mutations in the cystic fibrosis transmembrane conductance regulator (CFTR) gene G551D, G178R, S549N, S549R, G551S, G1244E, S1251N, S1255P, G1349D, OR R117H AND must NOT be Homozygous for the F508del Mutation in the CFTR Gene or have unknown CFTR gene mutations.

LENVIMA

Products Affected

- Lenvima

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	DTC - must be locally recurrent or metastatic, progressive refractory to radioactive iodine treatment for approval.

LETAIRIS/TRACLEER

Products Affected

- Letairis
- Tracleer

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Chronic thromboembolic pulmonary hypertension (CTEPH) (Tracleer).
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) WHO Group 1 patients not currently on Letairis or Tracleer or another agent indicated for WHO Group 1 PAH are required to have had a right-heart catheterization to confirm the diagnosis of PAH to ensure appropriate medical assessment. PAH WHO Group 1 patients currently on Letairis or Tracleer or another agent indicated for WHO Group 1 PAH may continue therapy without confirmation of a right-heart catheterization.
Age Restrictions	N/A
Prescriber Restrictions	For treatment of pulmonary arterial hypertension, Letairis or Tracleer must be prescribed by or in consultation with a cardiologist or a pulmonologist.CTEPH-prescribed by or in consultation with a cardiologist or pulmonologist
Coverage Duration	Authorization will be for 3 years.
Other Criteria	CTEPH - pt must have tried Adempas, has a contraindication to Adepmas, or is currently receiving Tracleer for CTEPH.

LEUPROLIDE (LONG ACTING)

Products Affected

- Lupron Depot
- Lupron Depot (3 Month)
- Lupron Depot (4 Month)
- Lupron Depot (6 Month)
- Lupron Depot-Ped intramuscular kit 11.25 mg, 15 mg

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D but specific to the following drugs as follows: Prostate cancer (Lupron Depot), Endometriosis (Lupon Depot), Uterine leiomyomata (Lupon Depot), Treatment of central precocious puberty (Lupron Depot Ped). Ovarian cancer (Lupron Depot, Lupron Depot Ped). Breast cancer (Lupron Depot, Lupron Depot Ped). Prophylaxis or treatment of uterine bleeding in premenopausal women with hematologic malignancy or prior to bone marrow/stem cell transplantation (BMT/SCT) (Lupron Depot, Lupron Depot Ped). Abnormal uterine bleeding (Lupron Depot, Lupron Depot Ped).
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	For abnrml uterine bleeding,uterine leiomyomata,endometriosis-6 mo.All other=12 mo
Other Criteria	N/A

LIDODERM

Products Affected

- lidocaine topical adhesive patch,medicated

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

LONSURF

Products Affected

- Lonsurf

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Metastatic CRC - As per labeling, the patient has been previously treated with a fluoropyrimidine (e.g., capecitabine, 5-FU) AND oxaliplatin AND irinotecan AND if the tumor or metastases are wild-type KRAS and/or NRAS (that is, the tumors or metastases are KRAS and/or NRAS mutation negative) Erbitux or Vectibix has been tried.

LYNPARZA

Products Affected

- Lynparza

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients already started on Lynparza.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Ovarian cancer approve if the patient has a germline BRCA mutation AND as per product labeling, has progressed on three or more prior lines of chemotherapy.

LYRICA/NEURONTIN

Products Affected

- Lyrica

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D. Plus, patients already started on Lyrica for a Covered Use.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	Authorize use if the patient has tried gabapentin (brand or generic) for the current condition. Authorize a Lyrica without a trial of gabapentin if the patient has tried Horizant or Gralise, has a seizure disorder, fibromyalgia, neuropathic pain associated with a spinal cord injury, diabetic neuropathy, or symptoms of GAD if the patient had tried at least TWO drugs from the following classes - TAC, SSRI, SNRI, or buspirone.

MEKINIST

Products Affected

- Mekinist oral tablet 0.5 mg, 2 mg

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients already started on Mekinist for a Covered Use.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis for which Mekinist is being used. For unresectable or metastatic melanoma must have documentation of BRAF V600 mutations
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	For unresectable or metastatic melanoma must be used in patients with BRAF V600 mutations, not being used in combination with Zelboraf, and either 1. be used in combination with Tafinlar per product labeling or 2. be used as monotherapy in a patient who has not experienced disease progression on a BRAF Inhibitor for Melanoma (i.e., Tafinlar or Zelboraf)

MYALEPT

Products Affected

- Myalept

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, an endocrinologist or a geneticist physician specialist
Coverage Duration	Authorization will be for 3 years.
Other Criteria	N/A

NAMENDA

Products Affected

- memantine oral solution
- memantine oral tablet
- Namenda oral solution
- Namenda XR
- Namzaric

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D. Plus patients with mild to moderate vascular dementia.
Exclusion Criteria	N/A
Required Medical Information	Indication for which memantine is being prescribed.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	N/A

NATPARA

Products Affected

- Natpara

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist.
Coverage Duration	12 months
Other Criteria	Chronic hypoparathyroidism - Before starting Natpara, serum calcium concentration is greater than 7.5 mg/dL and 25-hydroxyvitamin D stores are sufficient per the prescribing physician AND as per product labeling, patient cannot be well-controlled on calcium supplements and active forms of vitamin D alone

NEULASTA

Products Affected

- Neulasta subcutaneous syringe

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D but worded more broadly as cancer patients receiving myelosuppressive chemotherapy. Plus patients undergoing PBPC collection and therapy
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Cancer patients receiving chemotherapy, if prescribed by or in consultation with an oncologist or hematologist.PBPC-prescribed by or in consultation with an oncologist, hematologist, or physician that specializes in tranplantation
Coverage Duration	Cancer pts receiving chemo -Authorization will be for 6 months. PBPC - 1 month
Other Criteria	Cancer patients receiving chemotherapy, approve if the patient is receiving myelosuppressive anti-cancer medications that are associated with a high risk of febrile neutropenia (the risk is at least 20% based on the chemotherapy regimen), OR the patient is receiving myelosuppressive anti-cancer medications that are associated with a risk of febrile neutropenia but the risk is less than 20% based on the chemotherapy regimen and the patient has one or more risk factors for febrile neutropenia (eg, older patient [aged greater than or equal to 65 years]), history of previous chemotherapy or radiation therapy, pre-existing neutropenia, open wounds or active infection, poor performance status, OR the patient has had a neutropenic complication from prior chemotherapy and did not receive prophylaxis with a colony stimulating factor and a reduced dose or frequency of chemotherapy may compromise treatment.

NEUPOGEN

Products Affected

- Neupogen

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D worded more broadly as cancer patients receiving myelosuppressive chemotherapy, patients with acute myeloid leukemia (AML) receiving chemotherapy, cancer patients receiving bone marrow transplantation (BMT), patients undergoing peripheral blood progenitor cell (PBPC) collection and therapy, and patients with severe chronic neutropenia [SCN] (e.g., congenital neutropenia, cyclic neutropenia, idiopathic neutropenia). Neutropenia associated with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS). Treatment of myelodysplastic syndromes (MDS). Drug induced agranulocytosis or neutropenia. Aplastic anemia (AA). Acute lymphocytic leukemia (ALL).
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	AML, HIV/AIDS, MDS - adults. Other uses - no age requirements.
Prescriber Restrictions	Cancer/AML, MDS, ALL, oncologist or a hematologist. Cancer patients receiving BMT and PBPC, prescribed by or in consultation with an oncologist, hematologist, or a physician who specializes in transplantation. SCN, AA - hematologist. HIV/AIDS neutropenia, infectious disease (ID) physician (MD), hematologist, or MD specializing in HIV/AIDS.
Coverage Duration	chemo/SCN/AML-6 mo.HIV/AIDS-4 mo.MDS-3 mo.PBPC,Drug induce A/N,AA,ALL,BMT-1 mo.All other=12mo.

Other Criteria	Cancer patients receiving chemotherapy, approve if the patient meets one of the following conditions: patient is receiving myelosuppressive anti-cancer medications that are associated with a high risk of febrile neutropenia (the risk is at least 20% based on the chemotherapy regimen), patient is receiving myelosuppressive anti-cancer medications that are associated with a risk of febrile neutropenia but the risk is less than 20% based on the chemotherapy regimen and the patient has one or more risk factors for febrile neutropenia (eg, older patient [aged greater than or equal to 65 years], history of previous chemotherapy or radiation therapy, pre-existing neutropenia, open wounds or active infection, poor performance status), patient has had a neutropenic complication from prior chemotherapy and did not receive prophylaxis with a colony stimulating factor (eg, Leukine, Neulasta, Neupogen) and a reduced dose or frequency of chemotherapy may compromise treatment, patient has received chemotherapy has febrile neutropenia and has at least one risk factor (eg, sepsis syndrome, aged greater than 65 years, severe neutropenia [absolute neutrophil account less than 100 cells/mm3], neutropenia expected to be greater than 10 days in duration, invasive fungal infection).

NEXAVAR

Products Affected

- Nexavar

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus , patients already started on Nexavar for a covered use, osteosarcoma, angiosarcoma, advanced or unresectable desmoids tumors, gastrointestinal stromal tumors (GIST), medullary thyroid carcinoma, Acute Myeloid Leukemia.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Osteosarcoma, approve if the patient has tried standard chemoterhapy and have relapsed/refractory or metastatic disease. GIST, approve if the patient has tried TWO of the following: imatinib mesylate (Gleevec), sunitinib (Sutent), or regorafenib (Stivarga). Differentiated (ie, papillary, follicular, Hurthle) thyroid carcinoma (DTC), approve if the patient has locally recurrent or metastatic, progressive DTC and the patient is refractory to radioactive iodine treatment. Medullary thyroid carcinoma, approve if the patient has disseminated symptomatic disease and the patient has tried vandetanib (Caprelsa) or cabozantinib (Cometriq). AML - Approve if the patient has relapsed or refractory disease AND FLT3-ITD mutation positive disease AND Nexavar will be used in combination with azacitidine injection (intravenous or subcutaneous) or decitabine IV injection.

NINLARO

Products Affected

- Ninlaro oral capsule 2.3 mg, 3 mg, 4 mg

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus , patients already started on Ninlaro.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	MM - be used in combination with Revlimid and dexamethasone AND pt had received at least ONE previous therapy for multiple myeloma (e.g., Velcade, Kyprolis, Thalomid, Revlimid, Pomalyst, Alkeran, dexamethasone, prednisone).

NUCALA

Products Affected

- Nucala

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrent use with Xolair
Required Medical Information	N/A
Age Restrictions	12 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an allergist, immunologist, or pulmonologist
Coverage Duration	Authorization will be for 6 months initial, 12 months continuation.

Other Criteria	Initial - must have peripheral blood eosinophil count of greater than or equal to 150 cells per microliter within the previous 6 weeks (prior to treatment with Nucala) AND Patient has received at least 3 consecutive months of combination therapy with an inhaled corticosteroid AND one of the following A. inhaled LABA, B. inhaled long-acting muscarinic antagonist, C. Leukotriene receptor antagonist, or D. Theophylline. Patient's asthma continues to be uncontrolled as defined by ONE of the following - patient experienced two or more asthma exacerbations requiring treatment with systemic corticosteroids in the previous year, patient experienced one or more asthma exacerbation requiring hospitalization or an Emergency Department (ED) visit in the previous year, patient has a FEV1 less than 80 percent predicted, Patient has an FEV1/FVC less than 0.80, or Patient's asthma worsens upon tapering of oral corticosteroid therapy. Continuation - The patient has responded to Nucala therapy as determined by the prescribing physician (e.g., decreased asthma exacerbations, decreased asthma symptoms, decreased hospitalizations, emergency department (ED)/urgent care, or physician visits due to asthma, decreased requirement for oral corticosteroid therapy) AND Patient continues to receive therapy with BOTH an inhaled corticosteroid AND one of the following inhaled LABA, inhaled long-acting muscarinic antagonist, leukotriene receptor antagonist, or Theophylline.

NUVIGIL/PROVIGIL

Products Affected

- modafinil

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Fatigue associated with multiple sclerosis (MS) - modafinil only. Excessive daytime sleepiness (EDS) due to myotonic dystrophy - modafinil only. Adjunctive/augmentation for treatment of depression in adults - modafinil only. Idiopathic hypersomnolence - modafanil only
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patients must be greater than or equal to 17 years of age.
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	Excessive sleepiness due to SWSD if the patient is working at least 5 overnight shifts per month. Adjunctive/augmentation treatment for depression in adults if the patient is concurrently receiving other medication therapy for depression. Idiopathic hypersomnolence is covered diagnosis is confirmed by a sleep specialist physician or at an institution that specializes in sleep disorders (i.e., sleep center).

ODOMZO

Products Affected

- Odomzo

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus metastatic BCC.
Exclusion Criteria	N/A
Required Medical Information	BCC - Must not have had disease progression while on Erivedge (vismodegib).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Locally advanced BCC approve ifthe BCC has recurred following surgery/radiation therapy or if the patient is not a candidate for surgery AND the patient is not a candidate for radiation therapy, according to the prescribing physician. Metatastic BCC - approve.

OFEV

Products Affected

- Ofev

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Combination use with pirfenidone
Required Medical Information	N/A
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist
Coverage Duration	3 years
Other Criteria	IPF baseline - must have FVC greater than or equal to 50 percent of the predicted value AND IPF must be diagnosed with either findings on high-resolution computed tomography (HRCT) indicating usual interstitial pneumonia (UIP) or surgical lung biopsy demonstrating UIP.

OLYSIO

Products Affected

- Olysio

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D. Plus patients already started on Olysio for a covered use. Plus Recurrent HCV post liver transplant genotype 1.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by or in consultation with a GI, hepatologist, ID, or a liver transplant MD
Coverage Duration	12 weeks others, 24 wks w Sovaldi in cirrhosis with geno 1
Other Criteria	Has not failed therapy with Olysio or another NS3/4A Protease Inhibitor for HCV (i.e., Incivek or Victrelis). Pts with genotype 1a must NOT have the Q80K polymorphism (unknown Q80K status is not covered). Genotype 1 - prescribed in combination with PegINF and RBV in accordance with product labeling or in combination with Sovaldi. Recurrent HCV post liver transplant genotype 1 - Prescribed in combination with Sovaldi.

OPSUMIT

Products Affected

- Opsumit

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	PAH WHO group, right heart catherization
Age Restrictions	N/A
Prescriber Restrictions	PAH - must be prescribed by or in consultation with a cardiologist or a pulmonologist.
Coverage Duration	Authorization will be for 3 years
Other Criteria	Pulmonary arterial hypertension (PAH) WHO Group 1 patients not currently on Opsumit or another agent indicated for WHO Group 1 PAH are required to have had a right-heart catheterization to confirm the diagnosis of PAH to ensure appropriate medical assessment. PAH WHO Group 1 patients currently on Opsumit or another agent indicated for WHO Group 1 PAH may continue therapy without confirmation of a right-heart catheterization.

ORENCIA

Products Affected

- Orencia
- Orencia (with maltose)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients who have already been started on abatacept for a covered use.
Exclusion Criteria	Concurrent use with a Biologic DMARD or Targeted Synthetic DMARD
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	RA and JIA/JRA prescribed by or in consultation with a rheumatologist.
Coverage Duration	3 mos initial, 3 years cont
Other Criteria	RA Initial, approve if the patient has tried one DMARD (brand or generic, oral or injectable, traditional or biologic) for at least 3 months. Juvenile idiopathic arthritis (JIA) [or Juvenile Rheumatoid Arthritis (JRA)] initial, approve Orencia IV only if the patient has tried adalimumab or etanercept (Orencia SC is not FDA-approved for the treatment of JIA/JRA). Cont x - responded to therapy as per the prescriber.

ORKAMBI

Products Affected

- Orkambi

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Combination use with Kalydeco
Required Medical Information	N/A
Age Restrictions	12 years of age and older
Prescriber Restrictions	prescribed by or inconsultation with a pulmonologist or a physician who specializes in CF
Coverage Duration	3 years
Other Criteria	CF - homozygous for the Phe508del (F508del) mutation in the CFTR gene (meaning the patient has two copies of the Phe508del mutation)

OTEZLA

Products Affected

- Otezla
- Otezla Starter

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Must not be used combination in with a biologic DMARD or targeted synthetic DMARD.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PsA - Prescribed by or in consultation with a dermatologist or rheumatologist. PP - prescribed by or in consultation with a dermatologist.
Coverage Duration	4 months initial, 1 years cont
Other Criteria	PsA initial, must have tried ONE biologic DMARD (eg, Cimzia, Humira, Enbrel, Simponi, Remicade, or Stelara) for at least 3 months or cannot take a TNF because of hepatitis B, hepatitis C, demyelinating disease, or malignancy, congestive heart failure (CHF), being on chronic systemic corticosteroid therapy (e.g., prednisone, dexamethasone), chronic infection or is at high risk of infection (e.g., HIV, malignancy, neutropenia, DM), as determined by the prescribing physician, OR history of recurrent infections, as determined by the prescribing physician. PP initial- approve if pt has meets one of the following a. tried ONE biologic (e.g., Cosentyx, Humira, Enbrel, Remicade, or Stelara) for at least 3 months, unless intolerant, OR b. cannot take a TNF because of the reasons listed above. PsA/PP cont - pt has received 4 months of therapy and had a response, as determined by the prescribing physician.

PHOSPHODIESTERASE-5 INHIBITORS FOR PAH

Products Affected

- Adcirca
- sildenafil intravenous
- sildenafil oral

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Pulmonary arterial hypertension (PAH) WHO Group 1, patients not currently taking an agent indication for WHO Group 1 PAH are required to have had a right-heart catheterization to confirm diagnosis of PAH to ensure appropriate medical assessment. PAH WHO Group 1patients currently receiving an agent indicated for WHO Group 1 PAH may continue therapy without confirmation of a right-heart catheterization.
Age Restrictions	N/A
Prescriber Restrictions	For PAH, if prescribed by, or in consultation with, a cardiologist or a pulmonologist.
Coverage Duration	Authorization will be for 3 years.
Other Criteria	For approval of sildenafil injection, patient must be unable to take an oral PDE-5 inhibitor.

PLEGRIDY

Products Affected

- Plegridy subcutaneous pen injector 125 mcg/0.5 mL, 63 mcg/0.5 mL- 94 mcg/0.5 mL
- Plegridy subcutaneous syringe 125 mcg/0.5 mL, 63 mcg/0.5 mL- 94 mcg/0.5 mL

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrent use of with other disease-modifying agents used for multiple sclerosis (MS).
Required Medical Information	For use in MS, patient has a relapsing form of MS.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist or an MS specialist.
Coverage Duration	Authorization will be for 3 years.
Other Criteria	N/A

PRALUENT

Products Affected

- Praluent Pen subcutaneous pen injector 150 mg/mL, 75 mg/mL
- Praluent Syringe subcutaneous syringe 150 mg/mL, 75 mg/mL

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrent use of Juxtapid or Kynamro.
Required Medical Information	LDL-C and response to other agents, prior therapies tried, medication adverse event history, medical history
Age Restrictions	18 years of age and older.
Prescriber Restrictions	Prescribed by, or in consultation with, a cardiologist, endocrinologist, or a physician who focuses in the treatment of CV risk management and/or lipid disorders
Coverage Duration	Authorization will be for 12 months.

Other Criteria	Hyperlipidemia in patients with HeFH without ASCVD -approve if meets all of the following 1. Pt has been diagnosed with HeFH AND 2. tried ONE high intensity statin (i.e. atorvastatin greater than or equal to 40 mg daily or Crestor greater than or equal to 20 mg daily) AND 3. LDL-C remains greater than or equal to 70 mg/dL unless is determined to be statin intolerant defined by experiencing statin related rhabdomyolysis or experienced skeletal-related muscle symptoms while receiving separate trials of atorvastatin and Crestor and during both trials the skeletal-related symptoms resolved during d/c. Hyperlipidemia Pt with Clinical ASCVD with or without HeFH -approve if meets all of the following has an LDL-C greater than or equal to 70 mg/dL (after treatment with antihyperlipidemic agents but prior to PCSK9 therapy), AND has one of the following conditions prior MI, h/o ACS, diagnosis of angina, h/o CVA or TIA, PAD, undergone a coronary or other arterial revascularization procedure, AND tried ONE high intensity statin (as defined above) AND LDL-C remains greater than or equal to 70 mg/dL unless the pt is determined to be statin intolerant defined by experiencing statin related rhabdomyolysis or pt experienced skeletal-related muscle symptoms while receiving separate trials of atorvastatin and Crestor and during both trials the skeletal-related symptoms resolved during d/c.

PROLIA

Products Affected

- Prolia

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concomitant use with other medications for osteoporosis (eg, denosumab [Prolia], bisphosphonates, raloxifene, calcitonin nasal spray [Miacalcin, Fortical]), except calcium and Vitamin D.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Treatment of postmenopausal osteoporosis/Treatment of osteoporosis in men (to increase bone mass), approve if the patient has meets one 1. has had inadequate response after 12 months of therapy with an oral bisphosphonate, had osteoporotic fracture while receiving an oral bisphosphonate, or intolerability to an oral bisphospohate, 2. OR pt has tried an IV bisphosphonate (ibandronate or zoledronic acid), 3. OR the patient has severe renal impairment (eg, creatinine clearance less than 35 mL/min) or chronic kidney disease, or if the patient has multiple osteoporotic fractures. Treatment of bone loss in men at high risk for fracture receiving ADT for nonmetastatic prostate cancer, approve if the patient has prostate cancer that is not metastatic to the bone and the patient is receiving ADT (eg, leuprolide, triptorelin, goserelin) or the patient has undergone a bilateral orchiectomy. Treatment of bone loss (to increase bone mass) in patients at high risk for fracture receiving adjuvant AI therapy for breast cancer, approve if the patient has breast cancer that is not metastatic to the bone and in receiving concurrent AI therapy (eg, anastrozole, letrozole, exemestane).

PROMACTA

Products Affected

- Promacta

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Thrombocytopenia due to hepatitis C virus (HCV)-related cirrhosis.
Exclusion Criteria	Use in the management of thrombocytopenia in myelodysplastic syndrome (MDS).
Required Medical Information	Cause of thrombocytopenia. Thrombocytopenia due to HCV-related cirrhosis, platelet counts.
Age Restrictions	N/A
Prescriber Restrictions	Thrombocytopenia due to chronic ITP or Aplastic Anemia, approve if prescribed by, or after consultation with, a hematologist. Thrombocytopenia due to HCV-related cirrhosis, approve if prescribed by, or after consultation with, either a gastroenterologist, a hepatologist, or a physician who specializes in infectious disease.
Coverage Duration	Chronic ITP - 3 years, others 12 months.
Other Criteria	Thrombocytopenia in patients with chronic immune (idiopathic) thrombocytopenia purpura, approve if the patient has tried corticosteroids or IVIG or has undergone a splenectomy. Treatment of thrombocytopenia due to HCV-related cirrhosis, approve to allow for initiation of antiviral therapy if the patient has low platelet counts (eg, less than 75,000 mm3) and the patient has chronic HCV infection and is a candidate for hepatitis C therapy (eg, Pegasys or PegIntron plus ribavirin, with or without direct-acting antiviral agents [boceprevir, telaprevir]). Aplastic anemia - has low platelet counts at baseline/pretreatment (e.g., less than 30,000 mm3) AND tried one immunosuppressant therapy (e.g., cyclosporine, mycophenolate moefetil, sirolimus, Atgam)

REBIF

Products Affected

- Rebif (with albumin)
- Rebif Rebidose subcutaneous pen injector 22 mcg/0.5 mL, 44 mcg/0.5 mL, 8.8mcg/0.2mL-22 mcg/0.5mL (6)
- Rebif Titration Pack

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients who expereinced an attack and are at risk for multiple sclerosis.
Exclusion Criteria	Concurrent use with other disease-modifying agent used for multiple sclerosis (ie, interferon beta-1a, interferon beta-1b, glatiramer, natalizumab, fingolimod, terflunomide, dimethyl fumarate).
Required Medical Information	Diagnosis of MS includes the following patient types: patients with actual diagnosis of MS, patients who have experienced an MS attack, and patients who are at risk for developing MS.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or after consultation with a neurologist or an MS specialist.
Coverage Duration	Authorization will be for 3 years.
Other Criteria	N/A

RECLAST

Products Affected

- zoledronic acid-mannitol-water intravenous solution

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrent Use with Other Medications for Osteoporosis (e.g., other bisphosphonates, Prolia, Forteo, Evista, calcitonin nasal spray), except calcium and Vitamin D.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Paget's 1 month. Others 12 months.

Other Criteria	Treatment of osteoporosis in post menopausal women or osteoporosis in men, must meet ONE of the following patient had an inadequate response after a trial duration of 12 months (eg, ongoing and significant loss of BMD, lack of BMD increase) or patient had an osteoporotic fracture while receiving therapy or patient experienced intolerability (eg, severe GI-related adverse effects, severe musculoskeletal-related side effects, a femoral fracture), OR pt cannot take an oral bisphosphonate because the pt cannot swallow or has difficulty swallowing or the pt cannot remain in an upright position post oral bisphosphonate administration or pt has a pre-existing GI medical condition (eg, patient with esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]), OR pt has tried IV Reclast. Treatment of PMO may have also tried IV Boniva for approval. Prevention or treatment of glucocorticoid induced osteoporosis (GIO), approve if: pt is initiating or continuing therapy with systemic glucocorticoids, AND has had an inadequate response after a trial duration of 12 months (eg, ongoing and significant loss of BMD, lack of BMD increase) or patient had an osteoporotic fracture while receiving therapy or patient experienced intolerability (eg, severe GI-related adverse effects, severe musculoskeletal-related side effects, a femoral fracture), OR pt cannot take an oral bisphosphonate because the pt cannot swallow or has difficulty swallowing or the pt cannot remain in an upright position post oral bisphosphonate administration or pt has a pre-existing GI medical condition (eg, patient with esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]), or has tried Reclast. Treatment of Paget's disease, approve if patient has elevations in serum alkaline phosphatase of two times higher than the upper limit of the age-specific normal reference range, OR patient is symptomatic (eg, bone pain, hearing loss, osteoarthritis), OR patient is at risk for complications from their disease (eg, immobilization, bone deformity, fractures, nerve compression syndrome). Preventions of PMO - meets one of the following had an inadequate response after a trial duration of 12 months (eg, ongoing and significant loss of BMD, lack of BMD increase) or patient had an osteoporotic fracture while receiving therapy or patient experienced intolerability (eg, severe GI-related adverse effects, severe musculoskeletal-related side effects, a femoral fracture), OR pt cannot take an oral bisphosphonate because the pt cannot swallow or has difficulty swallowing or the pt cannot remain in an upright position post oral bisphosphonate administration or pt has a pre-existing GI medical condition (eg, patient with esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]), OR pt has tried Reclast.

REMICADE

Products Affected

- Remicade

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D plus patients already started on infliximab for non-Crohn's disease covered uses. Behcet's disease (BD). Still's disease (SD). Uveitis (UV). Undifferentiated spondylarthroplasty, Pyoderma gangrenosum (PG). Hidradenitis suppurativa (HS). Graft-versus-host disease (GVHD). Juvenile Idiopathic Arthritis (JIA). Sarcoidosis
Exclusion Criteria	Concurrent use with Biologic DMARD or Targeted Synthetic DMARD
Required Medical Information	N/A
Age Restrictions	CD and UC, Pts aged 6 years or more.
Prescriber Restrictions	Prescribed by or in consult w/:RA/AS/Still's/Undifferent spondyl/JIA-rheumatol.Plaque Psor/Pyoderma gangrenosum/HS dermatol.Psoriatic Arthritis-rheumatol or dermatol.CD/UC-gastroenterol.Uveitis-ophthalmol.GVHD-transplant center, oncol, or hematol.Behcet's-rheumatol, dermatol,ophthalmol, gastroenterol, or neurol.Sarco-pulmonol, ophthalmol, or dermatol.
Coverage Duration	FDA ind/JIA initial - 3 mos, cont 3 years, others 12 mo

Other Criteria	Approve for RA if pt will be taking Remicade in combination with MTX or one other traditional DMARD (eg, leflunomide, sulfasalazine, hydroxychloroquine) unless the pt has a contraindication or intolerance to MTX and leflunomide, AND pt has tried one of etanercept, adalimumab, certolizumab, or golimumab SC OR if the patient has not tried one of these drugs, the patient must have a trial with etanercept or adalimumab. Ankylosing Spondylitis and PsA. Pt has tried one of etanercept, adalimumab, certolizumab, or golimumab SC OR if the patient has not tried one of these drugs, the patient must have a trial with etanercept or adalimumab. CD in patients aged greater than 6 years but less than 18 years, approve if the pt has tried corticosteroid (CS) or if CSs contraindicated or if currently on CS or if the patient has tried one other agent for CD (eg, azathioprine, 6-MP, MTX, certolizumab, adalimumab, Entyvio) OR the patient has enterocutaneous (perianal or abdominal) or rectovaginal fistulas OR the patient has had ileocolonic resection. CD in patients 18 years or more, approve if the patient has tried adalimumab or certolizumab. Plaque psoriasis (PP).Pt tried etanercept, adalimumab, or ustekinumab for 3 mos or or the pt experienced an intolerance.Ulcerative colitis (UC).Tried 2-mo trial of systemic CS, 6-MP, AZA, CSA or tacrolimus or was intolerant to one of these agents OR the patient has pouchitis AND has tried therapy with an antibiotic, probiotic, corticosteroid enema, or mesalamine enema. Behcet's.Pt has tried at least one conventional tx (eg, systemic CSs, immunosuppressants [e.g., AZA, MTX, MM, CSA, tacrolimus, chlorambucil, cyclophosphamide] or interferon alfa), Enbrel or Humira OR has ophthalmic manifestations. SD.Tried CS AND 1 non-biologic DMARD (eg, MTX) for 2 mos, or was intolerant.UV.Tried periocular/intraocular CS, systemic CS, immunosuppressant (eg, MTX, MM, CSA, AZA, CPM), etanercept, adalimumab.Sarc.Tried CS and immunosuppressant (eg, MTX, AZA, CSA, chlorambucil), or chloroquine, or thalidomide.Pyoderma gangrenosum (PG).Tried one systemic CS or immunosuppressant (eg, mycophenolate, CSA) for 2 mos. Hidradenitis suppurativa (HS).Tried 1 tx (eg, intralesional/oral CS, systemic antibiotic, isotretinoin).GVHD.Tried 1 tx (eg, high-dose CS, antithymocyte globulin, CSA, thalidomide, tacrolimus, MM, etc.) or receiving IFB concurrently. JIA (regardless of type of onset) approve if Remicade started in combination with MTX or one other traditional DMARD (eg, leflunomide, sulfasalazine) AND the pt has tried 1 other agent for this condition (eg, MTX, sulfasalazine, or leflunomide, an NSAID, or one biologic DMARD [eg, Humira, Orencia, Enbrel, Kineret, Actemra]) or the pt has aggressive disease. FDA approved indications cont tx - approve if patient has had a response, as determined by the prescriber.

REMODULIN

Products Affected

- Remodulin

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	PAH WHO group, right heart catherization results, WHO functional status, previous drugs tried
Age Restrictions	N/A
Prescriber Restrictions	PAH WHO Group 1, prescribed by or in consultation with a cardiologist or a pulmonologist.
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Part B versus Part D determination will be made at time of prior authorization review per CMS guidance. PAH WHO Group 1, patients not currently on Remodulin pt required to have had a right-heart catheterization to confirm the diagnosis of PAH (mPAP greater than 25 mm Hg at rest, PCWP equal to or less than 15 mm Hg, and PVR greater than 3 Wood units) AND have Class II, III, or IV WHO functional status AND if the pt has idiopathic PAH, they must have one of the following: 1. had an acute response to vasodilator testing that occured during the right heart cath (defined as decrease in mPAPof at least 10 mm Hg to an absolute mPAP of less than 40 mm Hg without a decrease in cardiac output) AND has tried an oral CCB or 2. pt did not have an acute response to vasodilator testing or 3. cannot undergo vasodilator test or cannot take CCB due to extreme right HF (e.g. hypotension, cardiac index less than 1.5, or right atrial pressure greater than 20, or 4. has tried a CCB without vasodilator testing. PAH WHO Group1, patients currently on Remodulin- pt must have had a right heart catherization to confirm the diagnosis of PAH.

REPATHA

Products Affected

- Repatha SureClick
- Repatha Syringe

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrent use of Juxtapid, Kynamro, or Praluent.
Required Medical Information	LDL-C and response to other agents, prior therapies tried, medication adverse event history, medical history
Age Restrictions	ASCVD/HeFH - 18 yo and older, HoFH 13 yo and older.
Prescriber Restrictions	Prescribed by, or in consultation with, a cardiologist, endocrinologist, or a physician who focuses in the treatment of CV risk management and/or lipid disorders
Coverage Duration	Authorization will be for 12 months.

Other Criteria	Hyperlipidemia in patients with HeFH without ASCVD -approve if meets all of the following 1. Pt has been diagnosed with HeFH AND 2. tried ONE high intensity statin (i.e. atorvastatin greater than or equal to 40 mg daily or Crestor greater than or equal to 20 mg daily) AND 3. LDL-C remains greater than or equal to 70 mg/dL unless is determined to be statin intolerant defined by experiencing statin related rhabdomyolysis or experienced skeletal-related muscle symptoms while receiving separate trials of atorvastatin and Crestor and during both trials the skeletal-related symptoms resolved during d/c. Hyperlipidemia Pt with Clinical ASCVD with or without HeFH -approve if meets all of the following has an LDL-C greater than or equal to 70 mg/dL (after treatment with antihyperlipidemic agents but prior to PCSK9 therapy), AND has one of the following conditions prior MI, h/o ACS, diagnosis of angina, h/o CVA or TIA, PAD, undergone a coronary or other arterial revascularization procedure, AND tried ONE high intensity statin (as defined above) AND LDL-C remains greater than or equal to 70 mg/dL unless the pt is determined to be statin intolerant defined by experiencing statin related rhabdomyolysis or pt experienced skeletal-related muscle symptoms while receiving separate trials of atorvastatin and Crestor and during both trials the skeletal-related symptoms resolved during d/c. HoFH - approve if meets all of the following has one of the following genetic confirmation of two mutant alleles at the LDLR, APOB, PCSK9, or LDLRAP1 gene locus, OR untreated LDL-C greater than 500 mg/dL (prior to treatment with antihyperlipidemic agents), OR treated LDL-C greater than or equal to 300 mg/dL (after treatment with antihyperlipidemic agents but prior to agents such as Repatha, Kynamro or Juxtapid), OR have clinical manifestations of HoFH (e.g., cutaneous xanthomas, tendon xanthomas, arcus cornea, tuberous xanthomas or xanthelasma), AND tried ONE high intensity statin (as defined above) for greater than or equal to 8 weeks and LDL-C remains greater than or equal to 70 mg/dL unless is determined to be statin intolerant defined by experiencing statin related rhabdomyolysis or experienced skeletal-related muscle symptoms while receiving separate trials of atorvastatin and Crestor and during both trials the skeletal-related symptoms resolved during d/c.

REVLIMID

Products Affected

- Revlimid

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D. Plus patients already started on Revlimid for a Covered Use. Systemic Amyloidosis Light Chain, Diffuse Large B Cell Lymphoma (Non-Hodgkin's Lymphoma), Follicular Lymphoma (Non-Hodgkin's Lymphoma), Myelofibrosis.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis and previous therapies or drug regimens tried.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.

Other Criteria	MCL-approve if the patient meets one of the following 1) Pt has tried two prior therapies or therapeutic regimens (eg, Velcade, HyperCVAD [cyclophosphamide, vincristine, doxorubicin, and dexamethasone alternating with high-dose mextotrexate and cytarabine] + Rituxan [rituximab injection], the NORDIC regimen [dose-intensified induction immunochemotherapy with Rituxan + cyclophosphamide, vincristine, doxorubicin, prednisone alternating with Rituxan and high-dose cytarabine], RCHOP/RICE [Rituxan, cyclophosphamide, doxorubicin, vincristine, prednisone]/[Rituxan, Ifex (ifosafamide injection), carboplatin, etoposide], Treanda (bendamustine injection) plus Rituxan, Velcade (bortezomib injection) +/- Rituxan, cladribine + Rituxan, FC (fludarabine, cyclophosphamide) +/- Rituxan, PCR [pentostatin, cyclophosphamide, Rituxan]), or Imbruvica (ibrutinib capsules), OR 2) Pt has tried one prior therapy or therapeutic regimen (examples listed above) and cannot take Velcade according to the prescribing physician. MDS-approve if the patient meets one of the following: 1) Pt has symptomatic anemia, OR 2) Pt has transfusion-dependent anemia, OR 3) Pt has anemia that is not controlled with an erythroid stimulating agent (eg, Epogen, Procrit [epoetin alfa injection], Aranesp [darbepoetin alfa injection]). Diffuse, Large B Cell Lymphoma (Non-Hodgkin's Lymphoma)-approve if the pt has tried one other medication treatment regimen (eg, RCHOP, dose-adjusted EPOCH [etoposide, prednisone, vincristine, cyclophosphamide, doxorubicin] + Rituxan, RCEPP [Rituxan, cyclophosphamide, etoposide, prednisone, procarbazine], DHAP [dexamethasone, cisplatin, cytarabine] +/- Rituxan, ICE [Ifex, carboplatin, etoposide] +/- Rituxan, and Treanda +/- Rituxan). Myelofibrosis-approve if the pt has tried one other therapy (eg, Jakafi [ruxolitinib tablets], androgens [eg, nandrolone, oxymetholone], Epogen, Procrit, Aranesp, prednisone, danazol, Thalomid [thalidomide capsules], melphalan, Myleran [busulfan tablets], alpha interferons, and hydroxyurea).

RITUXAN

Products Affected

- Rituxan

PA Criteria	Criteria Details
Covered Uses	All medically-accepted indications not otherwise excluded from Part D. Patients already started on Rituxan for a Covered Use.
Exclusion Criteria	Concurrent use with a Biologic DMARD or Targeted Synthetic DMARD
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	RA (initial course). Prescribed by a rheumatologist or in consultation with a rheumatologist.
Coverage Duration	RA,1mo. Othr=12 mo.
Other Criteria	RA (initial course), approve if 1. Rituxan is prescribed in combination with methotrexate or another traditional DMARD (eg, leflunomide or sulfasalazine) unless the patient has been shown to be intolerant or has a contraindication to one or more traditional DMARDs AND 2. the patient has tried one of certolizumab pegol, etanercept, adalimumab, infliximab, golimumab (ie, a TNF antagonist), unless the patient has CHF or a lymphoproliferative disease OR if the patient has not yet tried a TNF antagonist, the patient must have a trial with etanercept or adalimumab.

SAMSCA

Products Affected

- Samsca

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Serum sodium less than 125 mEq/L at baseline or less marked hyponatremia, defined as serum sodium less than 135 mEq/L at baseline, that is symptomatic (eg, nausea, vomiting, headache, lethargy, confusion).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 30 days
Other Criteria	Hyponatremia - Pt must meet ONE of the following: 1. serum sodium less than 125 mEq/L at baseline, OR 2. marked hyponatremia, defined as less than 135 mEq/L at baseline, that is symptomatic (eg, nausea, vomiting, headache, lethargy, confusion), OR 3. patient has already been started on Samsca and has received less than 30 days of therapy.

SIMPONI

Products Affected

- Simponi

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D. Plus patients already started on golimumab for a covered use.
Exclusion Criteria	Concurrent use with a Biologic DMARD or Targeted Synthetic DMARD
Required Medical Information	N/A
Age Restrictions	UC adults.
Prescriber Restrictions	RA/Ankylosing spondylistis, prescribed by or in consultation with a rheumatologist. Psoriatic arthritis, prescribed by or in consultation with a rheumatologist or dermatologist. UC-prescribed by or in consultation with a gastroenterologist
Coverage Duration	3 mos initial, 3 years cont
Other Criteria	PsA/AS approve if the patient has tried Enbrel AND Humira. RA, approve if the patient has tried two of the following: Enbrel, Humira, Orencia, or Xeljanz. Ulcerative colitits initial - approve if the patient has had a trial with Humira. Cont tx - must have a response to therapy as according to prescriber

SIMPONI ARIA

Products Affected

- Simponi ARIA

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients already started on golimumab for a covered use.
Exclusion Criteria	Concurrent use with a Biologic DMARD or Targeted Synthetic DMARD
Required Medical Information	Diagnosis for which Simponi Aria is being prescribed, concurrent medications, previous therapies tried.
Age Restrictions	N/A
Prescriber Restrictions	RA - Prescribed by or in consultation with a rheumatologist
Coverage Duration	3 mos initial, 3 years cont
Other Criteria	For RA initial - in patients who have not been receiving Simponi or Simponi Aria, approve if they will be taking Simponi Aria in combination with MTX or one other traditional disease-modifying antirheumatic drug (DMARD) [e.g., leflunomide, sulfasalazine, hydroxychloroquine], unless intolerant or contraindicated AND patient has tried certolizumab, etanercept, adalimumab, or golimumab SC. If the patient has not tried one of these drugs, the patient must have a trial with etanercept or adalimumab. Cont tx - must have a response to therapy as according to prescriber

SOLARAZE

Products Affected

- diclofenac sodium topical gel 3 %

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 6 months.
Other Criteria	N/A

SOVALDI

Products Affected

- Sovaldi

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients already started on Sovaldi for a covered use. Plus Recurrent HCV Post-Liver Transplantation genotypes 1, 2, 3, and 4 and CHC Genotype 5 or 6.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by or in consultation w/ GI, hepatologist, ID, or a liver transplant MD
Coverage Duration	12 wks, 16 wks, 24 wks, or 48 wks as specified in Other Criteria.
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance.

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. Plus GIST and patients already started on Sprycel for a Covered Use.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis for which Sprycel is being used. For indications of CML and ALL, the Philadelphia chromosome (Ph) status of the leukemia must be reported.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	For CML, new patient must have Ph-positive CML for approval of Sprycel. For ALL, new patient must have Ph-positive ALL for approval of Sprycel. GIST - has D842V mutation AND previously tried Sutent and Gleevec.

STELARA

Products Affected

- Stelara subcutaneous syringe

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Ustekinumab should not be given in combination with a Biologic DMARD or Targeted Synthetic DMARD
Required Medical Information	N/A
Age Restrictions	Adults
Prescriber Restrictions	Plaque psoriasis.Prescribed by or in consultation with a dermatologist. PsA - prescribed by or in consultation with a rheumatologist or dermatologist
Coverage Duration	PPInitial tx 3 mos, PsA intitial 4 months, cont tx 3 years.
Other Criteria	PP initial - patient must meet one of the following 1. try at least one of the following agents for at least 3 months - an oral therapy for psoriasis (e.g., MTX, cyclosporine, Soriatane), oral methoxsalen PUVA, or a biologic agent (e.g., Enbrel, Remicade, or Humira), 2. experienced an intolerance to a trial of at least one oral or biologic therapy for plaque psoriasis, OR 3. have a contraindication to one oral agent for psoriasis such as MTX, as determined by the prescribing physician. PsA initial - Patient has tried at least one biologic disease-modifying antirheumatic drug (DMARD) for PsA (e.g., Cimzia, Humira, Enbrel, Simponi, or Remicade) for at least 2 months, unless intolerant. PP/PsA cont - approve if according to the prescribing physician, the patient has responded to therapy.

STIVARGA

Products Affected

- Stivarga

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D. Plus patients already started on Stivarga for a Covered Use.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis for which Stivarga is being used. For metastatic colorectal cancer (CRC)and gastrointestinal stromal tumors (GIST), prior therapies tried. For metastatic CRC, KRAS/NRAS mutation status.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	For metastatic CRC with KRAS and/or NRAS mutation, patient must have previously been treated with each of the following for approval: a fluoropyrimidine (eg, Xeloda, 5-FU), oxaliplatin, and irinotecan. For metastatic CRC with no detected KRAS and/or NRAS mutations (ie, KRAS/NRAS wild-type), patient must have previously been treated with each of the following for approval: a fluoropyrimidine (eg, Xeloda, 5-FU), oxaliplatin, irinotecan, anti-EGFR therapy (eg, Eribitux, Vectibix). For GIST, patient must have previously been treated with imatinib (Gleevec) and sunitinib (Sutent).

SUTENT

Products Affected

- Sutent oral capsule 12.5 mg, 25 mg, 37.5 mg, 50 mg

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients already started on Sutent for a Covered Use. Advanced, unresectable neuroendocrine tumors, chordoma, angiosarcoma, solitary fibrous tumor/hemangiopericytoma, alveolar soft part sarcoma (ASPS), differentiated (ie, papillary, follicular, and Hurthle) thyroid carcinoma, medullary thyroid carcinoma, thymic carcinoma.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Gastrointestinal stromal tumors (GIST), approve if the patient has previously tried imatinib (Gleevec). Chordoma, approve if the patient has recurrent disease. Differentiated thyroid carcinoma, approve if the patient has clinically progressive or symptomatic metastatic disease and the patient has nonradioiodine-responsive tumors at sites other than the central nervous system. Medullary thyroid carcinoma, approve if the patient has progressive disease or symptomatic distant metastases and the patient has tried vandetanib (Caprelsa) or cabozantinib (Cometriq). Thymic carcinoma - has tried chemotherapy (e.g., carboplatin/paclitaxel) or radiation therapy.

SYMLIN

Products Affected

- SymlinPen 120
- SymlinPen 60

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D worded as patient has type 1 or 2 diabetes mellitus.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	N/A

TAFINLAR

Products Affected

- Tafinlar oral capsule 50 mg, 75 mg

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus NSCLC in patients with BRAF V600 E mutation. Plus patients already started on Tafinlar for a Covered Use.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis for which Tafinlar is being used. BRAF V600 mutations
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	For unresectable or metastatic melanoma with BRAF V600 mutation AND used as monotherapy or in combination with Mekinist. For NSCLC with BRAF V600E mutation - must have progressed following at least one line of anti-cancer therapy.

TAGRISSO

Products Affected

- Tagrisso oral tablet 40 mg, 80 mg

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	NSCLC - prior therapies and EGFR T790M mutation
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	NSCLC - Must have metastatic epidermal growth factor receptor (EGFR) T790M mutation-positive NSCLC as detected by an approved test AND hasprogressed on or after one of Tarceva, Iressa, or Gilotrif therapy.

TARCEVA

Products Affected

- Tarceva oral tablet 100 mg, 150 mg, 25 mg

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients already started on Tarceva for a Covered Use, renal cell carcinoma (RCC).
Exclusion Criteria	N/A
Required Medical Information	Advanced, recurrent, or metastatic non small cell lung cancer (NSCLC), EGFR mutation or gene amplification status.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Advanced, recurrent, or metastatic NSCLC, approve if the patient has EGFR exon 19 deletion or exon 21 (L858R) substitution. Locally advanced or metastatic NSCLC, approve if the patient has failed at least one prior chemotherapy regimen or the patient's disease has not progressed after four cycles of platinum-based first-line chemotherapy (switch-maintenance therapy). Pancreatic locally advanced, unresectable, or metastatic cancer, approve if Tarceva is being prescribed in combination with gemcitabine. RCC, approve if the patient has non-clear cell histology that is Stage IV OR relapsed disease.

TASIGNA

Products Affected

- Tasigna oral capsule 150 mg, 200 mg

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D. Plus patients already started on Tasigna for a Covered Use. Plus Philadelphia postitive Acute Lymphoblastic Leukemia (ALL) and Gastrointestinal Stromal Tumor (GIST).
Exclusion Criteria	N/A
Required Medical Information	Diagnosis for which Tasigna is being used. For indication of CML and ALL, the Philadelphia chromosome (Ph) status of the leukemia must be reported. For indication of gastrointestinal stromal tumor (GIST) and ALL, prior therapies tried.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	For CML, new patient must have Ph-positive CML for approval of Tasigna. For GIST, patient must have tried TWO of the following - sunitinib (Sutent), imatinib (Gleevec), or regorafenib (Strivarga). For ALL, Approve if the patient has tried two other tyrosine kinase inhibitors that are used for Philadelphia chromosome positive ALL (e.g., Gleevec, Sprycel, etc).

TAZORAC

Products Affected

- Tazorac

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Cosmetic uses
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	PP/acne vulgaris - 3 years, other - 12 months.
Other Criteria	Acne vulgaris after a trial with at least 1 other topical retinoid product (eg, tretinoin cream/gel/solution/microgel, adapalene).

TECFIDERA

Products Affected

- Tecfidera

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrent use with other disease-modifying agents used for multiple sclerosis (MS).
Required Medical Information	MS, patient must have a relapsing form of MS (RRMS, SPMS with relapses, or PRMS). MS, previous MS therapies tried.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or MS specialist.
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Relapsing form of MS initial, approve if patient meets one of the following: 1) Patient has tried Avonex, Rebif, Betaseron, Extavia, Copaxone/Glatopa, or Plegridy, OR 2) Patient is unable to administer injections due to dexterity issues or visual impairment.

TECHNIVIE

Products Affected

- Technivie

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D. Plus patients already started on Technivie for a Covered Use.
Exclusion Criteria	Combination use with Direct Acting Antivirals (DAAs) other than ribavirin.
Required Medical Information	Hep C genotype, concurrent medications, medication history
Age Restrictions	18 years of age and older.
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician, or a liver transplant physician
Coverage Duration	Authorization will be for 12 weeks.
Other Criteria	N/A

THALOMID

Products Affected

- Thalomid

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients already started on Thalomid for a Covered Use, Discoid lupus erythematosus or cutaneous lupus erythematosus, Myelofibrosis, Prurigo nodularis, Recurrent aphthous ulcers or aphthous stomatitis, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, Systemic Light Chain Amyloidosis.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Discoid lupus erythematosus or cutaneous lupus erythematosus, approve if the patient has tried two other therapies (eg, corticosteroids [oral, topical, intralesional], hydroxychloroquine, tacrolimus [Protopic], methotrexate, dapsone, acitretin [Soriatane]). Myelofibrosis, approve if the patient has tried one other therapy (eg, ruxolitinib [Jakafi], danazol, epoetin alfa [Epogen/Procrit], prednisone, lenalidomide [Revlimid], hydroxyurea). Prurigo nodularis, approve if the patient has tried two other therapies (eg, azathioprine, capsaicin, psoralen plus ultraviolet A [PUVA] therapy, ultraviolet B [UVB] therapy). Recurrent aphthous ulcers or aphthous stomatitis, approve if the patient has tried two other therapies (eg, topical or intralesional corticosteroids, systemic corticosteroids, topical anesthetics/analgesics [eg, benzocaine lozenges], antimicrobial mouthwashes [eg, tetracycline], acyclovir, colchicine).

TOPAMAX/ZONEGRAN

Products Affected

- topiramate oral capsule, sprinkle
- topiramate oral tablet
- zonisamide

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage is not provided for weight loss or smoking cessation.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	N/A

TOPICAL IMMUNOMODULATORS

Products Affected

- tacrolimus topical

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	Authorize use in patients who have tried a prescription strength topical corticosteroid (brand or generic) or generic tacrolimus 0.1 percent or 0.03 percent for the current condition. Dermatologic condition on or around the eyes, eyelids, axilla, or genitalia, authorize use without a trial of a prescription strength topical corticosteroid.

TOPICAL RETINOID PRODUCTS

Products Affected

- adapalene topical cream
- adapalene topical gel
- Avita topical cream
- tretinoin microspheres topical gel with pump
- tretinoin topical

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Coverage is not provided for cosmetic use.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months
Other Criteria	N/A

TOPICAL TESTOSTERONE PRODUCTS

Products Affected

- Androderm
- AndroGel transdermal gel in metered-dose pump 20.25 mg/1.25 gram (1.62 %)
- AndroGel transdermal gel in packet
- Axiron
- Fortesta
- Testim
- testosterone transdermal gel in packet 1 % (25 mg/2.5gram)

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of primary hypogonadism (congenital or acquired) in males. Diagnosis of secondary (hypogonadotropic) hypogonadism (congenital or acquired) in males. Hypogonadism (primary or secondary) in males, serum testosterone level.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months
Other Criteria	Hypogonadism (primary or secondary) in males, approve if hypogonadism has been confirmed by a low for age serum testosterone (total or free) level defined by the normal laboratory reference values. For patients requesting Androderm, Axiron, Fortesta, Striant, or Testim, approve if the patient has previously tried Androgel.

TRANSMUCOSAL FENTANYL DRUGS

Products Affected

- fentanyl citrate buccal lozenge on a handle 1,200 mcg, 1,600 mcg, 200 mcg, 400 mcg, 600 mcg, 800 mcg

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 12 months.
Other Criteria	For breakthrough pain in patients with cancer if patient is unable to swallow, has dysphagia, esophagitis, mucositis, or uncontrollable nausea/vomiting OR patient is unable to take 2 other short-acting narcotics (eg, oxycodone, morphine sulfate, hydromorphone, etc) secondary to allergy or severe adverse events AND patient is on or will be on a long-acting narcotic (eg, Duragesic), or the patient is on intravenous, subcutaneous, or spinal (intrathecal, epidural) narcotics (eg, morphine sulfate, hydromorphone, fentanyl citrate).

TYKERB

Products Affected

- Tykerb

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D. Plus patients already started on Tykerb for a Covered Use.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis for which Tykerb is being used. Metastatic breast cancer, HER2 status or hormone receptor (HR) status.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	HER2-positive advanced or metastatic breast cancer, approve if Tykerb will be used in combination with Xeloda or Herceptin and the patient has received prior therapy with Herceptin. HER2-positive HR positive metastatic breast cancer, approve if the patient is a man or a postmenopausal woman and Tykerb will be used in combination with an aromatase inhibitor, that is letrozole (Femara), anastrozole, or elemestane. HER-2 positive early breast cancer, approve if Tykerb will be used in combination with Herceptin.

TYSABRI

Products Affected

- Tysabri

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D. Plus patients already started on Tysabri for a Covered Use.
Exclusion Criteria	Concurrent use of another immunomodulator (eg, Rebif, Betaseron, Extavia, Copaxone or Avonex or Aubagio), Tecfidera, or fingolimod (Gilenya) or an immunosuppressant such as mitoxantrone, cyclophosphamide, rituximab (Rituxan), alemtuzumab (Campath), azathioprine, MTX, or mycophenolate mofetilin in multiple sclerosis (MS) patients. Concurrent use with immunosuppressants (eg, 6-mercaptopurine, azathioprine, cyclosporine, methotrexate) or tumor necrosis factor (TNF) alfa inhibitors (eg, infliximab, adalimumab, certolizumab pegol) in Crohn's disease (CD) patients. Per warning and precautions, coverage is not provided for immune compromised patients with MS or CD.
Required Medical Information	Adults with MS. Patient has a relapsing form of MS (relapsing forms of MS are relapsing remitting [RRMS], secondary progressive [SPMS] with relapses, and progressive relapsing [PRMS]). Adults with CD. Patient has moderately to severely active CD with evidence of inflammation (eg, elevated C-reactive protein).
Age Restrictions	Adults
Prescriber Restrictions	MS. Prescribed by, or in consultation with, a neurologist or physician who specializes in the treatment of MS.CD. Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	Authorization will be for 3 years.

Other Criteria	Adults with a relapsing form of MS. Patient has had an inadequate response to, or is unable to tolerate, therapy with at least one of the following MS medications: interferon beta-1a (Avonex, Rebif), interferon beta-1b (Betaseron, Extavia), glatiramer acetate (Copaxone/Glatopa), Plegridy, fingolimod (Gilenya), Tecfidera, Lemtrada, or Aubagio OR the patient has highly active or aggressive disease according to the prescribing physician. Adults with CD. Patient has moderately to severely active CD with evidence of inflammation (eg, elevated C-reactive protein) and patient has tried two TNF antagonists for CD for at least 2 months each, adalimumab, certolizumab pegol, or infliximab, and had an inadequate response or was intolerant to the TNF antagonists.

UPTRAVI

Products Affected

- Uptravi

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients currently taking Uptravi.
Exclusion Criteria	N/A
Required Medical Information	Confirmation of right heart catheterization (select populations), medication history.
Age Restrictions	N/A
Prescriber Restrictions	PAH must be prescribed by, or in consultation with, a cardiologist or a pulmonologist.
Coverage Duration	3 years
Other Criteria	Must have PAH (WHO Group 1) and had a right heart catheterization to confirm the diagnosis of PAH (WHO Group 1). Right heart cathererization is NOT required in pts who are currently receiving Uptravi or another agent indicated for PAH (WHO group 1). Patient must meet a) OR b): a) tried TWO or is currently taking TWO oral therapies for PAH (either alone or in combination) each for greater than or equal to 60 days: PDE5 inhibitor (eg, sildenafil, Adcirca, Revatio), endothelin receptor antagonist (ERA) [eg, Tracleer, Letairis or Opsumit], or Adempas, OR b) receiving or has received in the past one prostacyclin therapy for PAH (eg, Orenitram, Tyvaso, Ventavis, Remodulin, or epoprostenol injection).

VIEKIRA

Products Affected

- Viekira Pak

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients started on Viekira for a covered use
Exclusion Criteria	Previous failure of Viekira in patients with minimal liver disease. Combination use with other direct acting antivirals, excluding ribavirin
Required Medical Information	Genotype 1, Cirrhosis status and genotype 1 subtype
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by or in consultation w/ GI, hepatologist, ID, or a liver transplant MD, Recurrent HVC post liver transplant - prescribed by or in consultation with one of the following prescribers who is affiliated with a transplant center, GI, hepatologist, ID, or a liver transplant physician
Coverage Duration	24 wks G1a w cirrh, Rec HCV Post-Liver Trans, 12 wks others
Other Criteria	Prescribed in combination with RBV for Genotype 1a, and Recurrent HCV post liver transplant.

VOTRIENT

Products Affected

- Votrient

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus, patients already taking Votrient for a Covered Use. Differentiated (ie, papillary, follicular, Hurthle cell) thyroid carcinoma. Uterine sarcoma, Dermatofibrosarcoma Protuberans (DFSP), Epithelial Ovarian, Fallopian Tube, or Primary Peritoneal Cancer, Gastrointestinal Stromal Tumor (GIST).
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Soft tissue sarcoma (angiosarcoma, Pleomorphic rhabdomyosarcoma, retroperitoneal/intra-abdominal soft tissue sarcoma that is unresectable or progressive, soft tissue sarcoma of the extremity/superficial trunk, including synvovial sarcoma, or other non-lipogenic (non-adipocytic) soft tissue sarcoma) - approve. Differentiated (ie, papillary, follicular, Hurthle) thyroid carcinoma, approve if the patient has clinically progressive or symptomatic metastatic disease and the patient has nonradioiodine-responsive tumors at sites other than the central nervous system. Uterine sarcoma, approve if the patient has advanced or metastatic disease. Advanced RCC - approve. DFSP - approve if the patient has metastasis. Epithelial Ovarian, Fallopian Tube, or Primary Peritoneal Cancer - approve if the patient has received primary treatment with chemotherapy (e.g., carboplatin with paclitaxel) and/or surgery AND has complete clinical remission. GIST - approve if the patient has tried TWO of the following: Gleevec, Sutent, or Strivarga.

XALKORI

Products Affected

- Xalkori oral capsule 200 mg, 250 mg

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Additional coverage is provided for soft tissue sarcoma Inflammatory Myofibroblastic Tumor (IMT) with ALK translocation, NSCLC with ROS1 Rearrangement, and NSCLC with MET amplification. Plus patients already started on crizotinib for a Covered Use.
Exclusion Criteria	N/A
Required Medical Information	For the FDA-approved indication of NSCLC for patients new to therapy, ALK status and ROS1 rearrangement required. For soft tissue sarcoma IMT, ALK translocation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	NSCLC, patient new to therapy must be ALK-positive, have MET amplification, or have ROS1 rearrangement for approval.

XELJANZ

Products Affected

- Xeljanz
- Xeljanz XR

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients already started on Xeljanz for a Covered Use.
Exclusion Criteria	Concurrent use with a biologic for an inflammatory condition (eg, tocilizumab, anakinra, abatacept, rituximab) or a TNF inhibitor (eg, certolizumab pegol, etanercept, adalimumab, infliximab, golimumab). Concurrent use with potent immunosuppressants that are not methotrexate (MTX) [eg, azathioprine, tacrolimus, cyclosporine, mycophenolate mofetil].
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	RA, prescribed by or in consultation with a rheumatologist.
Coverage Duration	Authorization will be for 3 months initial, 3 years cont.
Other Criteria	RA - approve in patients who have had a trial with one DMARD (brand or generic, oral or injectable, traditional or biologic) for at least 3 months.

XENAZINE

Products Affected

- tetrabenazine
- Xenazine

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Tardive dyskinesia (TD). Tourette syndrome and related tic disorders. Hyperkinetic dystonia. Hemiballism.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	For treatment of chorea associated with Huntington's disease, Tourette syndrome or related tic disorders, hyperkinetic dystonia, or hemiballism, Xenazine or generic (tetrabenazine) must be prescribed by or after consultation with a neurologist. For TD, Xenazine or generic (tetrabenazine) must be prescribed by or after consultation with a neurologist or psychiatrist.
Coverage Duration	Authorization will be for 3 years.
Other Criteria	N/A

XOLAIR

Products Affected

- Xolair

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Seasonal or perennial allergic rhinitis (SAR or PAR).
Exclusion Criteria	N/A
Required Medical Information	Moderate to severe persistant asthma and SAR/PAR, baseline IgE level of at least 30 IU/mL. For asthma, patient has a positive skin test or in vitro testing (ie, a blood test for allergen-specific IgE antibodies such as an enzyme-linked immunoabsorbant assay (eg, immunoCAP, ELISA) or the RAST) for 1 or more perennial aeroallergens (eg, house dust mite, animal dander [dog, cat], cockroach, feathers, mold spores) and/or for 1 or more seasonal aeroallergens (grass, pollen, weeds). For SAR/PAR, patient has positive skin testing (eg, grass, tree, or weed pollen, mold spores, house dust mite, animal dander, cockroach) and/or positive in vitro testing (ie, a blood test for allergen-specific IgE antibodies) for one or more relevant allergens (eg, grass, tree, or weed pollen, mold spores, house dust mite, animal dander, cockroach). CIU - must have urticaria for more than 6 weeks, with symptoms present more than 3 days/wk despite daily non-sedating H1-antihistamine therapy (e.g., cetirizine, desloratadine, fexofenadine, levocetirizine, loratadine) AND must have tried therapy with a leukotriene modifier (e.g., montelukast) with a daily non-sedating H1 antihistamine
Age Restrictions	Patients aged 12 years and older.
Prescriber Restrictions	Moderate to severe persistent asthma/SAR/PAR if prescribed by, or in consultation with an allergist, immunologist, or pulmonologist. CIU if prescribed by or in consultation with an allergist, immunologist, or dermatologist.
Coverage Duration	Initial tx 4 months, continued tx 12 months

Other Criteria	Moderate to severe persistent asthma must meet all criteria patient's asthma symptoms have not been adequately controlled by concomitant use of at least 3 months of inhaled corticosteroid and a long-acting beta-agonist (LABA) or LABA alternative, if LABA contraindicated or pt has intolerance then alternatives include sustained-release theophylline or a leukotriene modifier (eg, montelukast), AND inadequate control demonstrated by hospitalization for asthma, requirement for systemic corticosteroids to control asthma exacerbation(s), or increasing need (eg, more than 4 times a day) for short-acting inhaled beta2 agonists for symptoms (excluding preventative use for exercise-induced asthma). For continued Tx for asthma - must meet specialist criteria and patient has responded to therapy (e.g., decreased asthma symptoms or exacerbations, decreased hospitalizations, emergency room, urgent care, or physician visits due to asthma, decreased reliever/rescue medication use, increased lung function parameters (FEV1, PEF)), as determined by the prescribing physician. SAR/PAR must meet the following criteria - pt has tried concurrent therapy with at least one drug from 2 of the following classes, a non-sedating or low-sedating anthistamine/nasal antihistamine, a nasal corticosteroid, or montelukast or pt has tried at least one drug from all 3 of these classes during one allergy season AND pt has had immunotherapy, is receiving immunotherapy, or will be receiving immunotherapy, AND for pts with allergies to animals, these animals must be removed from the patient's immediate environment (eg, work, home). For continued tx SAR/PAR - must meet specialist criteria and pt must have responded to therapy (e.g., decreased symptoms of sneezing, itchy nose, watery, red, or itchy eyes, itchy throat, nasal congestion) as determined by the prescribing physician. For CIU cont tx - must meet specialist criteria and have responded to therapy (e.g., decreases severity of itching, decreased number and/or size of hives) as determined by the prescribing physician.

XTANDI

Products Affected

- Xtandi

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus patients already started on Xtandi for a Covered Use.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis for which Xtandi is being used.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	For prostate cancer, patient must have metastatic, castration-resistant prostate cancer for approval.

ZARXIO

Products Affected

- Zarxio

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D worded more broadly as cancer patients receiving myelosuppressive chemotherapy, patients with acute myeloid leukemia (AML) receiving chemotherapy, cancer patients receiving bone marrow transplantation (BMT), patients undergoing peripheral blood progenitor cell (PBPC) collection and therapy, and patients with severe chronic neutropenia [SCN] (e.g., congenital neutropenia, cyclic neutropenia, idiopathic neutropenia). Neutropenia associated with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS). Treatment of myelodysplastic syndromes (MDS). Drug induced agranulocytosis or neutropenia. Aplastic anemia (AA). Acute lymphocytic leukemia (ALL).
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	AML, HIV/AIDS, MDS - adults
Prescriber Restrictions	Cancer/AML, MDS, ALL, oncologist or a hematologist. Cancer patients receiving BMT and PBPC, prescribed by or in consultation with an oncologist, hematologist, or a physician who specializes in transplantation. SCN, AA - hematologist. HIV/AIDS neutropenia, infectious disease (ID) physician (MD), hematologist, or MD specializing in HIV/AIDS.
Coverage Duration	chemo/SCN/AML-6 mo.HIV/AIDS-4 mo.MDS-3 mo.PBPC,Drug induce A/N,AA,ALL,BMT-1 mo.All other=12mo.

Other Criteria	Cancer patients receiving chemotherapy, approve if the patient meets one of the following conditions: patient is receiving myelosuppressive anti-cancer medications that are associated with a high risk of febrile neutropenia (the risk is at least 20% based on the chemotherapy regimen), patient is receiving myelosuppressive anti-cancer medications that are associated with a risk of febrile neutropenia but the risk is less than 20% based on the chemotherapy regimen and the patient has one or more risk factors for febrile neutropenia (eg, older patient [aged greater than or equal to 65 years], history of previous chemotherapy or radiation therapy, pre-existing neutropenia, open wounds or active infection, poor performance status), patient has had a neutropenic complication from prior chemotherapy and did not receive prophylaxis with a colony stimulating factor (eg, Leukine, Neulasta, Neupogen) and a reduced dose or frequency of chemotherapy may compromise treatment, patient has received chemotherapy has febrile neutropenia and has at least one risk factor (eg, sepsis syndrome, aged greater than 65 years, severe neutropenia [absolute neutrophil account less than 100 cells/mm3], neutropenia expected to be greater than 10 days in duration, invasive fungal infection).

ZELBORAF

Products Affected

- Zelboraf

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus, patients with Hairy Cell Leukemia, Non-Small Cell Lung Cancer (NSCLC) with BRAF V600E Mutation, and patients already started on vemurafenib for a Covered Use.
Exclusion Criteria	Concurrent use with Mekinist.
Required Medical Information	BRAFV600 mutation status required.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Melanoma, patient new to therapy must have BRAFV600 mutation for approval AND must not have experienced disease progression on Tafinlar. NSCLC - must have had progression following at least one line of anti-cancer therapy. HCL - must have relapsed or refractory disease AND tried at least two therapies for hairy cell leukemia (e.g., cladribine, Nipent, cladribine or Nipent with or without Rituxan).

ZYDELIG

Products Affected

- Zydelig

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Additional off-label coverage is provided for Marginal Zone Lymphoma and Lymphoplasmacytic Lymphoma (LPL) with or without Waldenstrom's Macroglobulinemia (WM).
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	N/A

ZYKADIA

Products Affected

- Zykadia

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Must have metastatic NSCLC that is anaplastic lymphoma kinase (ALK)-positive.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	The patient must have either been intolerant or progressed on therapy with Xalkori.

ZYTIGA

Products Affected

- Zytiga

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Plus, patients already started on Zytiga for a Covered Use.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Metastatic castration-resistance prostate cancer, approve if Zytiga is being used in combination with prednisone.

PART B VERSUS PART D

Products Affected

- Abelcet
- acetylcysteine
- acyclovir sodium intravenous solution
- Akynzeo
- albuterol sulfate inhalation solution for nebulization 0.63 mg/3 mL, 1.25 mg/3 mL, 2.5 mg /3 mL (0.083 %), 5 mg/mL
- AmBisome
- amino acids 15 %
- Aminosyn 7 % with electrolytes
- Aminosyn 8.5 %-electrolytes
- Aminosyn II 10 %
- Aminosyn II 15 %
- Aminosyn II 7 %
- Aminosyn II 8.5 %
- Aminosyn II 8.5 %-electrolytes
- Aminosyn M 3.5 %
- Aminosyn-HBC 7%
- Aminosyn-PF 10 %
- Aminosyn-PF 7 % (sulfite-free)
- Aminosyn-RF 5.2 %
- amiodarone intravenous solution
- amphotericin B
- azathioprine
- Bethkis
- budesonide inhalation
- Cancidas
- CellCept Intravenous
- CellCept oral suspension for reconstitution
- cidofovir
- Clinimix 5%/D15W Sulfite Free
- Clinimix 5%/D25W sulfite-free
- Clinimix 2.75%/D5W Sulfit Free
- Clinimix 4.25%/D10W Sulf Free
- Clinimix 4.25%/D5W Sulfit Free
- Clinimix 4.25%-D20W sulf-free
- Clinimix 4.25%-D25W sulf-free
- Clinimix 5%-D20W(sulfite-free)
- cromolyn inhalation
- cyclophosphamide oral capsule
- cyclosporine intravenous
- cyclosporine modified
- cyclosporine oral capsule
- Cyramza
- dronabinol
- Emend oral
- Empliciti
- Engerix-B (PF) intramuscular syringe
- Engerix-B Pediatric (PF)
- Freamine HBC 6.9 %
- Gengraf
- granisetron HCl oral
- Hepatamine 8%
- Intralipid intravenous emulsion 20 %
- Intralipid intravenous emulsion 30 %
- ipratropium bromide inhalation
- ipratropium-albuterol
- levalbuterol HCl inhalation solution for nebulization 0.31 mg/3 mL, 0.63 mg/3 mL, 1.25 mg/0.5 mL
- Lioresal
- methotrexate sodium (PF)
- methotrexate sodium oral
- methylprednisolone oral tablet
- Millipred oral tablet
- mycophenolate mofetil
- mycophenolate sodium
- Nebupent
- Neoral
- Nephramine 5.4 %
- nitroglycerin intravenous
- Nulojix
- ondansetron
- ondansetron HCl oral
- Perforomist
- prednisolone sodium phosphate oral tablet,disintegrating

Updated 06/2016. Please contact Amida Care Member Services at 1-888-963-7092 or, for TTY users, 711, from 8 a.m. to 8 p.m. Monday – Friday (everyday October through February) for the most recent list of drugs. http://www.amidacareny.org.

- Prednisone Intensol
- prednisone oral tablet
- Premasol 10 %
- Premasol 6 %
- Prograf intravenous
- Pulmicort inhalation suspension for nebulization 1 mg/2 mL
- Pulmozyme
- Rapamune oral solution
- Rapamune oral tablet 1 mg, 2 mg
- Recombivax HB (PF) intramuscular suspension 10 mcg/mL, 40 mcg/mL
- Recombivax HB (PF) intramuscular syringe
- Rheumatrex
- Sandimmune
- Simulect intravenous recon soln 20 mg
- sirolimus
- tacrolimus oral
- Thymoglobulin
- tobramycin in 0.225 % NaCl
- Travasol 10 %
- TrophAmine 10 %
- Trophamine 6%
- Tyvaso
- Varubi
- Vectibix intravenous solution 100 mg/5 mL (20 mg/mL)
- Zortress

Details

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

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