Prior Authorization Criteria
2017 MMP
Effective Date: 11/01/2017
Approval Date: 11/01/2017

ADCIRCA

Products Affected

- Adcirca

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patients taking nitrates (e.g., Nitrodur, Nitrostat, nitroglycerin, isosorbide) or a guanylate cyclase stimulator such as riociguat (Adempas)
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year
Other Criteria	N/A

ADEMPAS

Products Affected

- Adempas

PA Criteria	Criteria Details
Covered Uses	Adempas is approved for all FDA-approved indications not otherwise excluded under Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	For PAH and CTEPH, must be prescribed by or in consultation with a cardiologist or a pulmonologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	For PAH - must have PAH (WHO Group 1) and had a right heart catheterization or 2D ECHO to confirm the diagnosis of PAH (WHO Group 1).

AFINITOR

Products Affected

- Afinitor
- Afinitor Disperz

PA Criteria	Criteria Details
Covered Uses	Afinitor is approved for 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	Prescriber must be an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	For use in patients with advanced renal cell carcinoma. The patient must have a documented treatment failure, consistent with pharmacy claims data, with an adequate trial with Sutent or Nexavar.

ALECENSA

Products Affected

- Alecensa

PA Criteria	Criteria Details
Covered Uses	ALECENSA is approved for 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 Oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	For metastatic NSCLC - patient is anaplastic lymphoma kinase (ALK)-positive AND has either progressed on or is intolerant to Xalkori.

ALUNBRIG

Products Affected

- Alunbrig

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Disease is ALK-positive and either metastatic or recurrent. For Continuation of Therapy: Patient is responding positively.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	Failure of or clinically significant adverse effects to crizotinib (Xalkori) or ceritinib (Zykadia).

AMPYRA

Products Affected

- Ampyra

PA Criteria	Criteria Details
Covered Uses	Ampyra is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist or MS specialist
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

ANESTHETICS

Products Affected

- Lidocaine PTCH

PA Criteria	Criteria Details
Covered Uses	Lidocaine patches are approved for 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	Through the end of the Plan contract year
Other Criteria	N/A

ANTIBACTERIALS - BETA LACTAM, OTHER

Products Affected

- Cayston

PA Criteria	Criteria Details
Covered Uses	Cayston is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	For use in patients 7 years and older
Prescriber Restrictions	N/A
Coverage Duration	28 days
Other Criteria	N/A

AUBAGIO

Products Affected

- Aubagio

PA Criteria	Criteria Details
Covered Uses	Aubagio is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient must not have severe hepatic impairment, be on concurrent treatment with leflunomide, or be pregnant.
Required Medical Information	Patient must have relapsing form of MS with MRI features consistent with MS.
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescriber must be a neurologist or MS specialist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	Patient must have failed or have an intolerance to interferon Beta-1a, Copaxone, or Gilenya.

AVASTIN

Products Affected

- Avastin

PA Criteria	Criteria Details
Covered Uses	Avastin is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Metastatic colorectal cancer. For non-squamous non-small cell lung cancer, use in combination with carboplatin and paclitaxel for first line treatment of unresectable, locally advanced, recurrent or metastatic disease. For Glioblastoma, patient has progressive disease. For metastatic renal cell carcinoma, used in combination with interferon alfa.
Age Restrictions	Patients must be 18 years old or older.
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

AVONEX

Products Affected

- Avonex
- Avonex Pen

PA Criteria	Criteria Details
Covered Uses	Avonex is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient must not have a hypersensitivity to human albumin or interferon. Concurrent use with other disease-modifying agents in the treatment of MS.
Required Medical Information	Patient must have a relapsing form of MS or have experienced a first clinical episode of MS and have an MRI with features consistent with MS.
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescriber must be a neurologist or MS specialist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

BAVENCIO

Products Affected

- Bavencio

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	Through the end of the Plan contract year.
Other Criteria	Urothelial carcinoma: disease progression during or following platinum-containing chemotherapy OR disease progression within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy.

BELEODAQ

Products Affected

- Beleodaq

PA Criteria	Criteria Details
Covered Uses	Beleodaq is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patients must be 18 years old or older.
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

BENLYSTA

Products Affected

- Benlysta

PA Criteria	Criteria Details
Covered Uses	Benlysta is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Previous anaphylaxis to Benlysta. Documentation that the patient does not have severe active lupus nephritis or severe active central nervous system lupus.
Required Medical Information	N/A
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	Documented diagnosis of systemic lupus erythematosus (SLE) and an active, autoantibody-positive test who are receiving standard therapy comprising any of the following: anti-malarials, corticosteroids, immunosuppressives, and non-steroidal anti-inflammatory drugs.

BETASERON

Products Affected

- Betaseron

PA Criteria	Criteria Details
Covered Uses	Betaseron is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patients with a hypersensitivity to human albumin or natural or recombinant interferon. Concurrent use with other disease-modifying agents in the treatment of MS.
Required Medical Information	Patient must have a relapsing form of MS or experienced a first clinical episode of MS and must have an MRI with features consistent with MS.
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescriber must be a neurologist or MS specialist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

BLOOD GLUCOSE REGULATORS - AMYLINOMIMETICS

Products Affected

- Symlinpen 120
- Symlinpen 60

PA Criteria	Criteria Details
Covered Uses	Symlin is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Submission of current HbA1c level greater than 7.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year
Other Criteria	Standard first line therapy for Diabetes type 2 includes trials on either metformin with a sulfonylurea or metformin with a thiazolodinedione, unless contraindicated. Standard first line therapy for Diabetes type 1 includes short-acting insulin in combination with basal insulin.

BLOOD PRODUCTS/MODIFIERS/ VOLUME EXPANDERS

Products Affected

- Aranesp Albumin Free INJ 100MCG/0.5ML, 100MCG/ML, 10MCG/0.4ML, 150MCG/0.3ML, 200MCG/0.4ML, 200MCG/ML, 25MCG/0.42ML, 25MCG/ML, 300MCG/0.6ML, 300MCG/ML, 40MCG/0.4ML, 40MCG/ML, 500MCG/ML, 60MCG/0.3ML, 60MCG/ML
- Epogen INJ 10000UNIT/ML, 20000UNIT/ML, 2000UNIT/ML, 3000UNIT/ML, 4000UNIT/ML
- Procrit

PA Criteria	Criteria Details
Covered Uses	Aranesp, Epogen and Procrit are approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Hemoglobin levels less than 10 grams per deciliter
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year
Other Criteria	For ongoing therapy in end stage renal disease and cancer patients, maintenance of hemoglobin and dose reduction or interruption if hemoglobin exceeds 10 g/dL (CKD not on dialysis-adult, cancer), 11 g/dL (CKD on dialysis), 12 g/dL (pediatric CKD).

BLOOD PRODUCTS/MODIFIERS/ VOLUME EXPANDERS - CINRYZE

Products Affected

- Cinryze

PA Criteria	Criteria Details
Covered Uses	Cinryze is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis for use. For hereditary angioedema: Documented failure of danazol.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial approval : 6 months. Extended approval: Annual review will be based on response to therapy
Other Criteria	N/A

BLOOD PRODUCTS/MODIFIERS/ VOLUME EXPANDERS - PROMACTA

Products Affected

- Promacta TABS 25MG, 50MG

PA Criteria	Criteria Details
Covered Uses	Promacta is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For Chronic Immune (Idiopathic) Thrombocytopenia, submission of platelet counts of less than 50,000 per microliter following standard treatment with corticosteroids, immunoglobulins, or after splenectomy. Platelet counts not required for chronic hepatitis C induced thrombocytopenia treatment to allow for interferon therapy initiation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year
Other Criteria	N/A

BOSULIF

Products Affected

- Bosulif

PA Criteria	Criteria Details
Covered Uses	Bosulif is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient must not have a hypersensitivity to bosutinib.
Required Medical Information	N/A
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	Patient must have a documented diagnosis of chronic, accelerated or blast phase Philadelphia chromosome positive (Ph+) chronic myelogenous leukemia AND documentation of resistance or intolerance to at least one prior therapy (e.g. imatinib, dasatinib, or nilotinib).

CABOMETYX

Products Affected

- Cabometyx

PA Criteria	Criteria Details
Covered Uses	Cabometyx is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis for use, medication history
Age Restrictions	Patient must be 18 years old or older
Prescriber Restrictions	Prescriber must be an oncologist
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	For Advanced Renal Cell Carcinoma prior treatment with one tyrosine kinase inhibitor therapy (e.g., Sutent, Votrient, Inlyta, Nexavar).

CAPRELSA

Products Affected

- Caprelsa

PA Criteria	Criteria Details
Covered Uses	Caprelsa is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Treatment of symptomatic or progressive medullary thyroid cancer in patients with unresectable locally advanced or metastatic disease.
Age Restrictions	Patients must be 18 years old or older.
Prescriber Restrictions	Prescriber must be an oncologist or endocrinologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

CARDIOVASCULAR AGENTS

Products Affected

- Ranexa

PA Criteria	Criteria Details
Covered Uses	Ranexa is approved for 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	Through the end of the Plan contract year
Other Criteria	Trial and failure of long-acting nitrate therapy.

CENTRAL NERVOUS SYSTEM AGENTS

Products Affected

- Modafinil TABS 200MG

PA Criteria	Criteria Details
Covered Uses	Modafinil is approved for 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	Through the end of the Plan contract year
Other Criteria	N/A

CEREZYME

Products Affected

- Cerezyme

PA Criteria	Criteria Details
Covered Uses	Cerezyme is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation the patient has a confirmed diagnosis of Type 1 Gaucher disease severe enough to result in one of the following conditions: moderate to severe anemia, thrombocytopenia with bleeding tendency, bone disease, or significant hepatomegaly or splenomegaly.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

CHORIONIC GONADOTROPIN

Products Affected

- Chorionic Gonadotropin INJ
- Pregnyl W/diluent Benzyl Alcohol/nacl

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Excluded if used to promote fertility.
Required Medical Information	Prepubertal Cryptorchidism: Diagnosis of prepubertal cryptorchidism not due to anatomical obstruction. Male Hypogonadotropic Hypogonadism (MHH): Diagnosis of male hypogonadism secondary to pituitary deficiency
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Prepubertal Cryptorchidism: 6 wks. MHH (initial, reauth): Through the end of the Plan contract year.
Other Criteria	MHH (Reauth): Documentation of positive clinical response to therapy.

COMETRIQ

Products Affected

- Cometriq

PA Criteria	Criteria Details
Covered Uses	Cometriq is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Treatment of patients with progressive, metastatic medullary thyroid cancer.
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

COPAXONE

Products Affected

- Glatopa

PA Criteria	Criteria Details
Covered Uses	Copaxone is approved for all FDA-approved used not otherwise excluded from Part D.
Exclusion Criteria	Patients with a hypersensitivity to glatiramer or mannitol. Concurrent use with other disease-modifying agents in the treatment of MS.
Required Medical Information	Patient must have relapsing MS or have experienced a first clinical episode of MS and must have an MRI with features consistent with MS.
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescriber must be a neurologist or MS specialist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

COTELLIC

Products Affected

- Cotellic

PA Criteria	Criteria Details
Covered Uses	COTELLIC is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	BRAF V600 mutations for diagnosis of Melanoma
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an Oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	For Melanoma used in combination with Zelboraf.

DERMATOLOGICAL AGENTS

Products Affected

- Elidel
- Tacrolimus OINT

PA Criteria	Criteria Details
Covered Uses	Elidel and Protopic are approved for 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	Through the end of the Plan contract year
Other Criteria	Trial and failure of at least two medium to high potency topical corticosteroids (eg, amcinonide, fluticasone propionate, triamcinolone acetonide, betamethasone valerate, fluocinolone acetonide, hydrocortisone butyrate, mometasone furoate, desoximetasone, fluocinonide or betamethasone dipropionate).

EMFLAZA

Products Affected

- Emflaza

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 Duchenne muscular dystrophy (DMD) confirmed by one of the following: Genetic testing (e.g., dystrophin deletion or duplication mutation found) OR if genetic studies are negative (i.e., no mutation identified), positive muscle biopsy (e.g., absence of dystrophin protein). CONTINUATION OF THERAPY: Maintained on therapy with positive response (e.g., improvement in muscle strength tests, pulmonary function tests, walk tests).
Age Restrictions	5 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	Failure of prednisone, unless contraindicated or clinically significant adverse effects are experienced.

ENZYME REPLACEMENTS/ MODIFIERS - KUVAN

Products Affected

- Kuvan

PA Criteria	Criteria Details
Covered Uses	Kuvan is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Reduction of blood phenylalanine levels from baseline to demonstrate BH4 responsive phenylketonuria
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Approve 2 months for initiation, then through the end of the Plan contract year if PKU responsive
Other Criteria	N/A

ESBRIET

Products Affected

- Esbriet

PA Criteria	Criteria Details
Covered Uses	Esbriet is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist.
Coverage Duration	Through the end of the Plan contract year.
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 computed tomography (CT) indicating usual interstitial pneumonia (UIP) or surgical lung biopsy demonstrating UIP.

FARYDAK

Products Affected

- Farydak

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a hematologist or oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	Failure or clinically significant adverse effects to two prior regimens, including Velcade and an immunomodulatory agent (e.g., dexamethasone). For Continuation of Therapy: Maintained on therapy with positive response.

FENTANYL CITRATE ORAL TRANSMUCOSAL

Products Affected

- Fentanyl Citrate Oral Transmucosal

PA Criteria	Criteria Details
Covered Uses	Approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	The drug is not indicated in the management of acute or post-operative pain. This medication must not be used on opioid non-tolerant patients. Not covered for patients with pain not associated with cancer.
Required Medical Information	For the management of breakthrough cancer pain in patients with malignancies who are already receiving and are tolerant to opioid therapy for their underlying cancer pain.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

FIRAZYR

Products Affected

- Firazyr

PA Criteria	Criteria Details
Covered Uses	Firazyr is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of HAE and where diagnosis is documented based on evidence of a normal C1 level and a low C4 level (C4 less than 14 mg/dL normal range 14 to 40 mg/dL, or C4 below the lower limit of normal as defined by the laboratory performing the test) plus: a) A low C1 inhibitor (C1INH) antigenic level (C1INH less than 19 mg/dL normal range 19 to 37 mg/dL or C1INH antigenic level below the lower limit of normal as defined by the laboratory performing the test) OR b) A normal C1INH antigenic level (C1INH greater than or equal to 19 mg/dL) and a low C1INH functional level (functional C1INH less than 50%, or below the lower limit of normal as defined by the laboratory performing the test) and patient must be experiencing at least one symptom of the moderate or severe attack (e.g., airway swelling, severe abdominal pain, facial swelling, nausea and vomiting, painful facial distortion) and medications known to cause angioedema (i.e. ACE-Inhibitors, estrogens, angiotensin II receptor blockers) have been evaluated and discontinued when appropriate.
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescriber must be an immunologist or rheumatologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

GATTEX

Products Affected

- Gattex

PA Criteria	Criteria Details
Covered Uses	Gattex is approved for 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	Through the end of the Plan contract year.
Other Criteria	N/A

GILENYA

Products Affected

- Gilenya

PA Criteria	Criteria Details
Covered Uses	Gilenya is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient's who have experienced any of the following in the last 6 months: MI, Class III or IV Heart failure, stroke, TIA, or unstable angina.
Required Medical Information	Patient must have a relapsing form of MS and an MRI with features of MS.
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescriber must be a neurologist or MS specialist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

GILOTRIF

Products Affected

- Gilotrif

PA Criteria	Criteria Details
Covered Uses	Gilotrif is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Treatment of patients with metastatic non-small cell lung cancer. Documentation confirming the metastatic NSCLC tumors have epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 substitution mutation as detected by an FDA-approved test. Treatment of metastatic squamous cell NSCLC which has progressed following platinum-based chemotherapy (e.g. cisplatin, carboplatin or oxaliplatin).
Age Restrictions	Patient must be 18 years old or older
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

GRANIX

Products Affected

- Granix

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of patient's weight, diagnosis, and absolute neutrophil count. Labs and weight should be within 30 days prior to the request.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	Confirm use is associated with one of the following: 1. Non-myeloid malignancies receiving a myelosuppressive chemotherapy regimen associated with a significant risk of severe neutropenia with fever 2. Induction or consolidation treatment for Acute Myeloid Leukemia (AML) 3. Bone marrow transplantation 4. Peripheral Blood Progenitor Cell (PBPC) Collection 5. Severe Chronic Neutropenia (SCN) with ANC less than 500/ml 6. Advanced HIV with ANC under 1000/ml to allow scheduled dosing of myelosuppressive anti-retroviral medications (e.g. zidovudine and ganciclovir).

HARVONI

Products Affected

- Harvoni

PA Criteria	Criteria Details
Covered Uses	Harvoni is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Confirmation of genotype, previous hepatitis C treatment history, other medications that will be used with Harvoni, and presence or absence of cirrhosis.
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescriber must be a gastroenterologist, hepatologist or an infectious disease specialist.
Coverage Duration	12 weeks to 24 weeks based on genotype and prior treatment, cirrhosis, or liver transplant status.
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance.

HERCEPTIN

Products Affected

- Herceptin INJ 440MG

PA Criteria	Criteria Details
Covered Uses	Herceptin is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation the patient has human epidermal growth factor receptor (HER)-2 positive breast cancer, metastatic gastric or gastroesophageal junction adenocarcinoma prior to initial authorization.
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

HETLIOZ

Products Affected

- Hetlioz

PA Criteria	Criteria Details
Covered Uses	Hetlioz is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

HIGH RISK MEDICATION - DIGOXIN

Products Affected

- Digitek TABS 0.25MG
- Digoxin INJ 0.25MG/ML
- Digoxin SOLN
- Digoxin TABS 250MCG
- Lanoxin INJ
- Lanoxin TABS 250MCG

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Documented trial and failure to doses up to 0.125mg per day OR the prescriber has documented the indication for the continued use of doses greater than 0.125mg per day. The prescriber has attested of an intent to monitor for side effects AND the prescriber must document that patient counseling has occurred outlining the potential risks of the medication.
Age Restrictions	Approve for patients under the age of 65. Prior authorization is required for the medication if the patient is 65 years old or older.
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year
Other Criteria	N/A

HIGH RISK MEDICATION - GLYBURIDE

Products Affected

- Glyburide TABS
- Glyburide Micronized
- Glyburide/metformin Hcl

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	The prescriber has documented the indication for the continued use of the high risk medication including an explanation of the specific benefit with the medication and how that benefit outweighs the potential risk. The prescriber has attested of an intent to monitor for side effects AND the prescriber must document that patient counseling has occurred outlining the potential risks of the medication.
Age Restrictions	Approve for patients under the age of 65. Prior authorization is required for the high risk medication if the patient is 65 years old or older.
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year
Other Criteria	Documented trial and failure to both glimepiride and glipizide, unless contraindicated.

HIGH RISK MEDICATION - NITROFURANTOIN

Products Affected

- Nitrofurantoin Macrocrystals
- Nitrofurantoin Monohydrate/macrocrystals

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Diagnosis for use. Culture and sensitivity report. The prescriber has documented the indication for the continued use of the high risk medication including an explanation of the specific benefit with nitrofurantoin and how that benefit outweighs the potential risk.
Age Restrictions	Approve for patients under the age of 65. Prior authorization is required for nitrofurantoin if the patient is 65 years old or older.
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year
Other Criteria	Chronic suppressive therapy will only be covered after failure of at least one other therapy (e.g. TMP-SMX, fluoroquinolone, or Trimethoprim) before trying nitrofurantoin unless other effective agents are contraindicated. Patients will be allowed 10 days of therapy before prior authorization is required.

HIGH RISK MEDICATION - NONBENZODIAZEPINE HYPNOTICS

Products Affected

- Zaleplon
- Zolpidem Tartrate TABS
- Zolpidem Tartrate Er

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	The prescriber has documented the indication for the continued use of the high risk medication including an explanation of the specific benefit with the medication and how that benefit outweighs the potential risk. The prescriber has attested of an intent to monitor for side effects AND the prescriber must document that patient counseling has occurred outlining the potential risks of the medication.
Age Restrictions	Approve for patients under the age of 65. Prior authorization is required for the high risk medication if the patient is 65 years old or older.
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year
Other Criteria	Patients will be allowed 90 days of therapy before prior authorization is required.

HIGH RISK MEDICATION-ANTI INFLAMMATORY AGENTS

Products Affected

- Indomethacin CAPS
- Indomethacin Er

PA Criteria	Criteria Details
Covered Uses	All FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	The prescriber has documented the indication for the continued use of the high risk medication including an explanation of the specific benefit with the medication and how that benefit outweighs the potential risk. The prescriber has attested of an intent to monitor for side effects AND the prescriber must document that patient counseling has occurred outlining the potential risks of the medication.
Age Restrictions	Approve for patients under the age of 65. Prior authorization is required for the high risk medication if the patient is 65 years old or older.
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	Trial and failure of two formulary short acting NSAIDS.

HIGH RISK MEDICATIONS

Products Affected

- Alora
- Benztropine Mesylate TABS
- Chlorzoxazone TABS 500MG
- Climara Pro
- Cyclobenzaprine Hcl TABS 10MG, 5MG
- Cyproheptadine Hcl SYRP
- Cyproheptadine Hcl TABS
- Dipyridamole TABS
- Disopyramide Phosphate CAPS
- Ergoloid Mesylates TABS
- Estradiol PTWK
- Estradiol TABS 0.5MG, 1MG, 2MG
- Estropipate TABS
- Guanfacine Hcl
- Hydroxyzine Hcl INJ
- Hydroxyzine Hcl SYRP
- Hydroxyzine Hcl TABS
- Hydroxyzine Pamoate CAPS
- Megestrol Acetate SUSP
- Menest TABS 0.3MG, 0.625MG, 1.25MG
- Meprobamate
- Methocarbamol TABS
- Methyldopa TABS 250MG, 500MG
- Methyldopa/hydrochlorothiazide
- Orphenadrine Citrate Er
- Phenadoz SUPP 12.5MG
- Premarin TABS 0.3MG, 0.45MG, 0.625MG, 0.9MG, 1.25MG
- Premphase
- Prempro
- Promethazine Hcl INJ
- Promethazine Hcl SUPP
- Promethazine Hcl SYRP
- Promethazine Hcl TABS
- Promethegan SUPP 25MG, 50MG
- Talwin
- Trihexyphenidyl Hcl
- Trimethobenzamide Hcl CAPS 300MG

PA Criteria	Criteria Details
Covered Uses	High Risk Medication is approved for all FDA approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	The prescriber has documented the indication for the continued use of the high risk medication including an explanation of the specific benefit with the medication and how that benefit outweighs the potential risk. The prescriber has attested of an intent to monitor for side effects AND the prescriber must document that patient counseling has occurred outlining the potential risks of the medication.
Age Restrictions	Approve for patients under the age of 65. Prior authorization is required for the high risk medication if the patient is 65 years old or older.
Prescriber Restrictions	N/A

Coverage Duration	Through the end of the Plan contract year if all conditions are met
Other Criteria	N/A

HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (PITUITARY)

Products Affected

- Norditropin Flexpro INJ 15MG/1.5ML, 30MG/3ML, 5MG/1.5ML
- Saizen
- Saizen Click.easy

PA Criteria	Criteria Details
Covered Uses	Growth hormone is approved for all FDA-approved uses not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Medical information includes submission of information showing a growth hormone stimulation test with peak growth hormone concentration below 10 microgram per L in children and below 5.1 micrograms per L in adults.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year
Other Criteria	N/A

HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (PITUITARY) - SEROSTIM

Products Affected

- Serostim INJ 4MG, 5MG, 6MG

PA Criteria	Criteria Details
Covered Uses	Serostim is approved for 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	Through the end of the Plan contract year
Other Criteria	N/A

HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (PITUITARY) - ZORBTIVE

Products Affected

- Zorbtive

PA Criteria	Criteria Details
Covered Uses	Zorbtive is approved for 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	Through the end of the Plan contract year
Other Criteria	N/A

HORMONAL AGENTS, SUPPRESSANT (PITUITARY) - SOMAVERT

Products Affected

- Somavert

PA Criteria	Criteria Details
Covered Uses	Somavert is approved for all FDA-approved uses not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year
Other Criteria	N/A

ICLUSIG

Products Affected

- Iclusig

PA Criteria	Criteria Details
Covered Uses	Iclusig is approved for 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	Prescriber must be an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	Documented diagnosis of one of the following: 1. Chronic phase, accelerated phase or blast phase chronic myeloid leukemia (CML) AND Documented confirmation of the presence of the T315i mutation OR No other tyrosine kinase inhibitor (TKI) therapy is indicated (i.e. imatinib, nilotinib). 2. Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ALL) AND Documented confirmation of the presence of the T315i mutation OR No other tyrosine kinase inhibitor (TKI) therapy is indicated (i.e. imatinib, nilotinib).

IMATINIB

Products Affected

- Imatinib Mesylate

PA Criteria	Criteria Details
Covered Uses	Imatinib (generic for Gleevec) is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Hypersensitivity to imatinib or to any other component of imatinib.
Required Medical Information	When being used in pediatric patients with Ph+ ALL, must provide documentation of use of Imatinib in combination with chemotherapy.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist or hematologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

IMBRUVICA

Products Affected

- Imbruvica

PA Criteria	Criteria Details
Covered Uses	Imbruvica is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of mantle cell lymphoma, chronic lymphocytic leukemia (CLL), CLL with 17p deletion, or Waldenstrom's macroglobulinemia. For diagnosis of mantle cell lymphoma or chronic lymphocytic leukemia (CLL), documentation patient has received at least one prior therapy.
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

IMFINZI

Products Affected

- Imfinzi

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	N/A
Required Medical Information	Failure of or disease progression on a platinum-containing chemotherapy
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

IMMUNOLOGICAL AGENTS

Products Affected

- Enbrel
- Enbrel Sureclick
- Humira
- Humira Pen
- Humira Pen-crohns Diseasestarter
- Humira Pen-psoriasis Starter
- Kineret
- Orencia
- Orencia Clickject
- Remicade

PA Criteria	Criteria Details
Covered Uses	Enbrel, Humira, Remicade, Orencia and Kineret are approved for 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	Through the end of the Plan contract year
Other Criteria	For diagnosis of RA, psoriatic arthritis or psoriasis, trial and failure of at least two oral disease-modifying anti-rheumatic drugs or immunosuppressants, unless contraindicated. Systemic therapy may include methotrexate, leflunomide, hydroxychloroquine, cyclosporine, sulfasalazine, and azathioprine. For diagnosis of Crohn's Disease or Ulcerative Colitis, an inadequate response to immunosuppressants such as corticosteroids, azathioprine, or 6-mercaptopurine (6-MP).

IMMUNOLOGICAL AGENTS - ILARIS

Products Affected

- Ilaris INJ 180MG

PA Criteria	Criteria Details
Covered Uses	Ilaris is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of current weight
Age Restrictions	Patient must be at least 2 years of age
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year
Other Criteria	N/A

IMMUNOLOGICAL AGENTS - PEG-INTRON, PEGASYS

Products Affected

- Pegasys
- Pegasys Proclick
- Pegintron INJ 50MCG/0.5ML
- Peg-intron Redipen INJ 120MCG/0.5ML

PA Criteria	Criteria Details
Covered Uses	Peg-Intron and Pegasys are approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For Hepatitis C, submission of initial viral load and 12 week lab values showing a viral load of at least a 2 log decrease from baseline for HCV monotherapy or dual therapy with RBV alone.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year
Other Criteria	N/A

IMMUNOLOGICAL AGENTS - SOVALDI

Products Affected

- Sovaldi

PA Criteria	Criteria Details
Covered Uses	Sovaldi is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis for use and labs to support diagnosis including genotype. Documentation of previous or current therapy and outcome.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a gastroenterologist, hepatologist, or an infectious disease specialist.
Coverage Duration	12wks, 16wks, 24wks or 48wks depending on baseline viral load, prior treatment, and cirrhosis status
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance.

INLYTA

Products Affected

- Inlyta

PA Criteria	Criteria Details
Covered Uses	Inlyta is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	For renal cell carcinoma: Requests for new starts are covered following trial and failure of one prior systemic therapy.

IRRITABLE BOWEL SYNDROME AGENTS

Products Affected

- Alosetron Hydrochloride

PA Criteria	Criteria Details
Covered Uses	Lotronex is approved for all FDA-approved uses not otherwise excluded from Part D
Exclusion Criteria	Male patients
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year
Other Criteria	Female patient with severe diarrhea-predominant chronic irritable bowel syndrome of greater than 6 months duration

JAKAFI

Products Affected

- Jakafi

PA Criteria	Criteria Details
Covered Uses	Jakafi is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documented diagnosis of myelofibrosis, current platelet count, and complete blood count.
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescriber must be an oncologist or hematologist.
Coverage Duration	Initial approval: 6 months. Extended approval through the end of the Plan contract year.
Other Criteria	Extended approval requires documentation of reduction in spleen volume or symptom improvement after 6 months of therapy.

JUXTAPID

Products Affected

- Juxtapid

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrent use with Kynamro, Praluent, or Repatha.
Required Medical Information	Homozygous familial hypercholesterolemia (HoFH): Submission of medical records (eg, chart notes, laboratory values) documenting diagnosis of HoFH as confirmed by one of the following: genetic confirmation of 2 mutant alleles in the LDL receptor, ApoB, PCSK9, or LDL receptor adaptor protein 1, OR untreated LDL-C greater than 500 mg/dL, OR treated LDL-C greater than 300 mg/dL, OR the patient has clinical manifestations of HoFH (e.g., cutaneous xanthomas, tendon xanthomas). History of failure or intolerance to Repatha therapy. Patient has tried one high-intensity statin therapy at maximum tolerated dose (i.e., atorvastatin, rosuvastatin) for greater than or equal to 8 continuous weeks and the LDL-C level remains greater than or equal to 100 mg/dL OR the patient has been determined to be statin intolerant.
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescribed by, or in consultation with, a cardiologist, endocrinologist, or lipid specialist
Coverage Duration	Through the end of the Plan contract year
Other Criteria	HoFH: Use in combination with a statin at the maximally tolerated dose (or other LDL-C lowering prescription therapy if patient is unable to take a statin). Patient is not pregnant. Patient does not have moderate or severe hepatic impairment (ie, Child-Pugh category B or C) or active liver disease including unexplained persistent abnormal liver function tests. Patient is not concomitantly on moderate or strong CYP 3A4 inhibitors (eg, clarithromycin).

KADCYLA

Products Affected

- Kadcyla INJ 100MG

PA Criteria	Criteria Details
Covered Uses	Kadcyla is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Single agent in treatment of patients with HER-2 positive metastatic breast cancer who previously received trastuzumab and a taxane, either separately or in combination. Documentation that the patient has either received prior therapy for metastatic disease or developed recurrence during or within six months of completing adjuvant therapy.
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

KALYDECO

Products Affected

- Kalydeco

PA Criteria	Criteria Details
Covered Uses	Kalydeco is covered for all FDA approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of a G551D, G178R, S549N, S549R, G551S, G1244E, S1251N, R117H, S1255P, or G1349D mutation in the CFTR gene.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year
Other Criteria	N/A

KEYTRUDA

Products Affected

- Keytruda

PA Criteria	Criteria Details
Covered Uses	Keytruda is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of unresectable or metastatic melanoma. Diagnosis of metastatic non-small cell lung cancer in patients with PD-L1-expressing tumors (as determined by an approved test) who have disease progression on or after platinum-containing chemotherapy. Patients who have metastatic NSCLC with EGFR or ALK genomic tumor aberrations should have disease progression (on approved EGFR- or ALK-directed therapy) prior to receiving pembrolizumab. Diagnosis of recurrent or metastatic squamous cell carcinoma of the head and neck in patients with disease progression on or after platinum-containing chemotherapy (e.g. cisplatin, carboplatin and oxaliplatin).
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

KISQALI

Products Affected

- Kisqali

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	Through the end of the Plan contract year.
Other Criteria	Will be used in combination with an aromatase inhibitor (e.g., letrozole, anastrozole or exemestane) as initial endocrine-based therapy.

KISQALI FEMARA

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

KORLYM

Products Affected

- Korlym

PA Criteria	Criteria Details
Covered Uses	Approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	For females, the patient may not be pregnant. For all patients, no concurrent use of simvastatin, lovastatin, cyclosporine, dihydroergotamine, ergotamine, fentanyl, pimozide, quinidine, sirolimus and tacrolimus.
Required Medical Information	N/A
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

KYNAMRO

Products Affected

- Kynamro

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Documentation of moderate or severe hepatic impairment or active liver disease including unexplained persistent abnormal liver function tests.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by, or in consultation with, a cardiologist, endocrinologist, or lipid specialist
Coverage Duration	Through the end of the Plan contract year
Other Criteria	Failure or contraindication to Repatha 420 mg. Documentation that Kynamro will be used in combination with at least one other lipid-lowering therapy to decrease blood lipids to reach treatment targets.

KYPROLIS

Products Affected

- Kyprolis

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For Multiple Myeloma (MM): Diagnosis of multiple myeloma, disease is refractory or relapsed, and patient has received at least one prior therapy for MM.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	For Continuation of Therapy: Maintained on therapy with a positive response.

LARTRUVO

Products Affected

- Lartruvo INJ 500MG/50ML

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For Soft Tissue Sarcoma: 1) Diagnosis of soft tissue sarcoma, 2) not amenable to curative treatment with radiotherapy or surgery, and 3) used in combination with doxorubicin.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	For Continuation of Therapy: Maintained on therapy with a positive response.

LATUDA

Products Affected

- Latuda

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	Through the end of the Plan contract year.
Other Criteria	Schizophrenia: Failure or clinically significant adverse effects to two of the following generic atypical antipsychotics: risperidone, olanzapine, quetiapine, ziprasidone, aripiprazole. For Continuation of Therapy: Maintained on therapy with positive response.

LAZANDA

Products Affected

- Lazanda

PA Criteria	Criteria Details
Covered Uses	Approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	The drug is not indicated in the management of acute or post-operative pain. This medication must not be used in opioid non-tolerant patients. Not covered for patients with pain not associated with cancer or who are opioid naive.
Required Medical Information	For the management of breakthrough cancer pain in patients with malignancies who are already receiving and are tolerant to opioid therapy for their underlying cancer pain.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	Covered following trial and failure of oral generic transmucosal fentanyl citrate (generic Actiq).

LONSURF

Products Affected

- Lonsurf

PA Criteria	Criteria Details
Covered Uses	Lonsurf is approved for 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 Oncologist
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	For Metastatic Colorectal Cancer, patient has been previously treated with a fluoropyrimidine (e.g., capecitabine, 5-FU) AND oxaliplatin AND irinotecan AND an anti-VEGF biologic (e.g., Avastin, Eylea) AND if the tumor or metastases are wild-type KRAS, Erbitux or Vectibix has been tried.

MEKINIST

Products Affected

- Mekinist

PA Criteria	Criteria Details
Covered Uses	Mekinist is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documented BRAF V600E or V600K mutations as detected by an FDA-approved test prior to initiation to treatment.
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	Can be used in combination with Tafinlar. If Mekinist is being used as a single agent, it is not indicated for use in patients who have received prior BRAF inhibitor therapy (i.e. Zelboraf, Tafinlar).

METABOLIC BONE DISEASE AGENTS - IV
OSTEOPOROSIS

Products Affected

- Forteo INJ 600MCG/2.4ML

PA Criteria	Criteria Details
Covered Uses	Forteo is approved for 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	Through the end of the Plan contract year
Other Criteria	Trial and failure of oral alendronate.

METABOLIC BONE DISEASE AGENTS - PROLIA

Products Affected

- Prolia

PA Criteria	Criteria Details
Covered Uses	Prolia is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Prolia is contraindicated in patients with hypocalcemia. Any pre-existing hypocalcemia must be corrected prior to initiating therapy.
Required Medical Information	Diagnosis for use. Documentation of past therapies and response
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year
Other Criteria	N/A

MISCELLANEOUS THERAPEUTIC AGENTS - BOTOX

Products Affected

- Botox

PA Criteria	Criteria Details
Covered Uses	Botox is approved for 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	Through the end of the Plan contract year
Other Criteria	N/A

MOZOBIL

Products Affected

- Mozobil

PA Criteria	Criteria Details
Covered Uses	Mozobil is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of patient's current weight and absolute neutrophil count (ANC). All labs and patient's weight should be dated within 30 days prior to the request.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist or hematologist
Coverage Duration	Through the end of the Plan contract year
Other Criteria	Patient must have a documented failure to reach and/or maintain a target ANC with an adequate trial of Neupogen.

NATPARA

Products Affected

- Natpara

PA Criteria	Criteria Details
Covered Uses	Natpara is approved for 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	Through the end of the Plan contract year.
Other Criteria	For Chronic hypoparathyroidism. Before initiating therapy with Natpara, documentation serum calcium concentration is greater than 7.5 mg/dL and 25-hydroxyvitamin D stores are sufficient AND patient cannot be well-controlled on calcium supplements and active forms of vitamin D alone per the prescribing physician.

NERLYNX

Products Affected

- Nerlynx

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	CONTINUATION OF THERAPY: Patient has a positive response.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	Documentation of previous treatment with Herceptin (trastuzumab) as adjuvant therapy.

NEUPOGEN

Products Affected

- Neupogen

PA Criteria	Criteria Details
Covered Uses	Neupogen is approved for all medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of patient's weight, diagnosis, and absolute neutrophil count. Labs and weight should be within 30 days prior to the request.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	Confirm use is associated with one of the following: 1. Non-myeloid malignancies receiving a myelosuppressive chemotherapy regimen associated with a significant risk of severe neutropenia with fever 2. Induction or consolidation treatment for Acute Myeloid Leukemia (AML) 3. Bone marrow transplantation 4. Peripheral Blood Progenitor Cell (PBPC) Collection 5. Severe Chronic Neutropenia (SCN) with ANC less than 500/ml 6. Advanced HIV with ANC under 1000/ml to allow scheduled dosing of myelosuppressive anti-retroviral medications (e.g. zidovudine and ganciclovir).

NEXAVAR

Products Affected

- Nexavar

PA Criteria	Criteria Details
Covered Uses	Nexavar is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Contraindicated in patient with a known severe hypersensitivity to sorafenib or any component of the product.
Required Medical Information	Approved for hepatocellular carcinoma when it is unresectable. Approved for renal cell carcinoma that is advanced. Approved for locally recurrent or metastatic progressive differentiated thyroid carcinoma that is refractory to iodine treatment.
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

NINLARO

Products Affected

- Ninlaro

PA Criteria	Criteria Details
Covered Uses	NINLARO is approved for 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 Oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	For Multiple Myeloma, used in combination with Revlimid and dexamethasone AND pt has received at least ONE previous therapy for multiple myeloma (e.g., Velcade, Kyprolis, Thalomid, Revlimid, Pomalyst, Alkeran, dexamethasone, prednisone).

NORTHERA

Products Affected

- Northera

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

ODOMZO

Products Affected

- Odomzo

PA Criteria	Criteria Details
Covered Uses	ODOMZO is approved for 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	Through the end of the Plan contract year.
Other Criteria	For locally advanced Basal Cell Carcinoma for patients when the BCC has recurred following surgery/radiation therapy or if the patient is not a candidate for surgery or radiation therapy, according to the prescribing physician.

OFEV

Products Affected

- Ofev

PA Criteria	Criteria Details
Covered Uses	Ofev is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Must be 18 years old or older.
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist.
Coverage Duration	Through the end of the Plan contract year.
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 computed tomography (CT) indicating usual interstitial pneumonia (UIP) or surgical lung biopsy demonstrating UIP.

OPSUMIT

Products Affected

- Opsumit

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Pregnancy
Required Medical Information	PAH WHO group, right heart catheterization
Age Restrictions	N/A
Prescriber Restrictions	PAH - Prescribed by or in consultation with a cardiologist or a pulmonologist.
Coverage Duration	Through the end of the Plan contract year
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. Right heart catheterization is NOT required in patients who are currently receiving Opsumit or another agent indicated for PAH (WHO group 1). Failure or contraindication to acute vasodilator testing or calcium channel blockers.

ORENITRAM

Products Affected

- Orenitram

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist or a pulmonologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

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	Documentation patient is homozygous for the F508del mutation in the CFTR gene
Age Restrictions	Patient must be 12 years of age or older
Prescriber Restrictions	Prescriber must be a pulmonologist or a physician who specializes in CF
Coverage Duration	Through the end of the Plan contract year
Other Criteria	N/A

QUININE

Products Affected

- Quinine Sulfate CAPS 324MG

PA Criteria	Criteria Details
Covered Uses	Quinine is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Not approved for treatment or prevention of leg cramps, prevention of malaria or in patients with complicated P. falciparum.
Required Medical Information	Indicated only for the treatment of uncomplicated Plasmodium falciparum malaria. Quinine sulfate has been shown to be effective in geographical regions where resistance has been documented to chloroquine.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	7 days
Other Criteria	N/A

REBIF

Products Affected

- Rebif
- Rebif Rebidose
- Rebif Rebidose Titration Pack
- Rebif Titration Pack

PA Criteria	Criteria Details
Covered Uses	Rebif is approved for all FDA-approved indications not otherwise excluded under Part D.
Exclusion Criteria	Patients with a hypersensitivity to human albumin or natural or recombinant interferon. Concurrent use with other disease-modifying agents in the treatment of MS.
Required Medical Information	Patient must have a relapsing form of MS or have experienced a first clinical episode of MS and must have an MRI with features consistent with MS.
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescriber must be a neurologist or MS specialist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

REPATHA

Products Affected

- Repatha
- Repatha Pushtronex System
- Repatha Sureclick

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrent use of Juxtapid, Kynamro, or Praluent.
Required Medical Information	LDL-C, prior therapies tried and response to treatment, medication adverse event history, and medical history. Reauthorization requests require confirmation of continued statin therapy at the maximally tolerated dose AND documentation of LDL reduction while on Repatha therapy. For patients who are statin-intolerant, confirmation of statin-intolerance and documentation of LDL reduction while on Repatha therapy.
Age Restrictions	For ASCVD/HeFH, 18 years or older. For HoFH, 13 years or older.
Prescriber Restrictions	Prescribed by, or in consultation with, a cardiologist, endocrinologist, or lipid specialist
Coverage Duration	Initial: 3 months. For continuation, through the end of the Plan contract year.
Other Criteria	Clinically significant adverse effect(s), contraindication(s), intolerance or failure to two statins (e.g. atorvastatin, Crestor, simvastatin, Vytorin, pitavastatin, pravastatin, fluvastatin, or lovastatin) at maximally tolerated doses.

RESPIRATORY TRACT AGENTS

Products Affected

- Xolair

PA Criteria	Criteria Details
Covered Uses	Xolair is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For diagnosis of asthma, submission of IgE serum levels between 30 and 700 IU per milliliter.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year
Other Criteria	Trial and failure of combined therapy with inhaled corticosteroids with long acting beta agonists in the 90 days prior to the request.

REVLIMID

Products Affected

- Revlimid

PA Criteria	Criteria Details
Covered Uses	Revlimid is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Not covered for patients who are pregnant.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

REXULTI

Products Affected

- Rexulti

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	Through the end of the Plan contract year.
Other Criteria	Schizophrenia: Failure or clinically significant adverse effects to two of the following generic atypical antipsychotics: risperidone, olanzapine, quetiapine, ziprasidone, aripiprazole. For Continuation of Therapy: Maintained on therapy with positive response.

RITUXAN

Products Affected

- Rituxan INJ 500MG/50ML

PA Criteria	Criteria Details
Covered Uses	Rituxan is approved for 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	If all conditions are met, the request will be authorized for 6 months.
Other Criteria	For the diagnosis of rheumatoid arthritis, Rituxan is being used in combination with methotrexate AND patient has had an inadequate response or intolerance to Enbrel or Humira.

RUBRACA

Products Affected

- Rubraca TABS 200MG, 300MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Ovarian cancer: Diagnosis of advanced ovarian cancer and presence of deleterious or suspected deleterious germline BRCA mutation as detected by an FDA-approved test (e.g. FoundationFocus).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	Failure or clinically significant adverse effects to two or more prior chemotherapy regimens.

RYDAPT

Products Affected

- Rydapt

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Acute Myeloid Leukemia: Positive for the FLT3 mutation as detected by an FDA-approved test (e.g., LeukoStrat® CDx FLT3 Mutation Assay).
Age Restrictions	N/A
Prescriber Restrictions	Acute Myeloid Leukemia: Prescribed by or in consultation with an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	Acute Myeloid Leukemia: Prescribed in combination with daunorubicin for induction therapy AND in combination with cytarabine for induction and consolidation therapy.

SILDENAFIL - IV

Products Affected

- Sildenafil INJ

PA Criteria	Criteria Details
Covered Uses	Approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concomitant use with organic nitrates (e.g. isosorbide, nitroglycerin). Sildenafil is not covered for the diagnosis of ED/impotence.
Required Medical Information	Diagnosis of pulmonary arterial hypertension (PAH)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial approval: 4 months. Extended approval: Annually with documentation of response
Other Criteria	N/A

SILDENAFIL - PAH

Products Affected

- Sildenafil TABS

PA Criteria	Criteria Details
Covered Uses	Approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concomitant use with organic nitrates (e.g. isosorbide, nitroglycerin). Sildenafil is not covered for the diagnosis of ED/impotence.
Required Medical Information	Diagnosis of pulmonary arterial hypertension (PAH)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial approval: 4 months. Extended approval: Annually with documentation of response
Other Criteria	Sildenafil - PAH is only approved for 20mg three times a day.

SPRYCEL

Products Affected

- Sprycel

PA Criteria	Criteria Details
Covered Uses	Sprycell is approved for 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	Prescriber must be an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	A documented diagnosis of one of the following: 1. Newly diagnosed Philadelphia chromosome-positive chronic phase chronic myeloid leukemia (Ph+ CP-CML). 2. Chronic, accelerated, or myeloid or lymphoid blast phase Philadelphia chromosome-positive chronic myeloid leukemia (CML) AND resistance or intolerance to prior therapy with imatinib (Gleevec). 3. Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ ALL) AND resistance or intolerance to prior therapy with imatinib (Gleevec).

STIVARGA

Products Affected

- Stivarga

PA Criteria	Criteria Details
Covered Uses	Stivarga is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	Treatment of locally advanced, unresectable or metastatic gastrointestinal stromal tumors (GIST) in patients who have previously received imatinib or sunitinib OR for the treatment of patients with metastatic colorectal cancer who have been previously treated with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy, an anti-VEGF (vascular endothelial growth factor) therapy (e.g. Avastin). If KRAS wild type colorectal cancer, an anti-EGFR (endothelial growth factor receptor) therapy (e.g. Erbitux, Vectibix) must have been part of the treatment protocol.

SUBOXONE

Products Affected

- Buprenorphine Hcl SUBL
- Suboxone FILM

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For Maintenance Requests: Confirmation of response to treatment.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

SUTENT

Products Affected

- Sutent

PA Criteria	Criteria Details
Covered Uses	Sutent is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	Gastrointestinal stromal tumor AND after disease progression on or intolerance to imatinib.

TAGRISSO

Products Affected

- Tagrisso

PA Criteria	Criteria Details
Covered Uses	TAGRISSO is approved for 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	Through the end of the Plan contract year.
Other Criteria	For NSCLC, patient must have metastatic epidermal growth factor receptor (EGFR) T790M mutation-positive NSCLC AND has progressed on or after an EGFR tyrosine kinase inhibitor (e.g., Tarceva, Iressa, or Gilotrif).

TARCEVA

Products Affected

- Tarceva
- Tasigna

PA Criteria	Criteria Details
Covered Uses	Approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For Tarceva, documentation for patient with pancreatic cancer that the medication is being used in combination with gemcitabine. For Tasigna, prior therapies tried for CML.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	Tarceva is covered 1) for the treatment of locally advanced or metastatic NSCLC after failure of at least one prior chemotherapy regimen. 2) Covered for first line treatment for locally advanced or metastatic NSCLC, with or without platinium-based therapy, in patients with a known active EGFR mutation or overexpression. 3) Covered for maintenance treatment in patients with locally advanced or metastatic non-small cell lung cancer (NSCLC) whose disease has not progressed after four cycles of platinum-based first-line chemotherapy. 4) Covered in combination with gemcitabine (Gemzar) for the first-line treatment of patients with locally advanced, unresectable or metastatic pancreatic cancer. Tasigna is covered for chronic phase and accelerated phase Ph+ CML, resistant or intolerant to prior therapy.

TECENTRIQ

Products Affected

- Tecentriq

PA Criteria	Criteria Details
Covered Uses	Tecentriq is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis for use, medication history
Age Restrictions	Patient must be 18 years old or older
Prescriber Restrictions	Prescriber must be an oncologist
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	Trial and failure of platinum-containing chemotherapy (eg. cisplatin, carboplatin)

TECFIDERA

Products Affected

- Tecfidera
- Tecfidera Starter Pack

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	For MS, patient must have a relapsing form of MS and must have an MRI with features consistent with MS. Previous MS therapies tried.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a neurologist or MS specialist.
Coverage Duration	Through the end of the Plan contract year
Other Criteria	N/A

TETRABENAZINE

Products Affected

- Tetrabenazine

PA Criteria	Criteria Details
Covered Uses	Tetrabenazine (generic for Xenazine) is approved for 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	Through the end of the Plan contract year
Other Criteria	Diagnosis of chorea associated with Huntington disease

TYSABRI

Products Affected

- Tysabri

PA Criteria	Criteria Details
Covered Uses	Tysabri is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patients with a history of or existing PML or hypersensitivity to natalizumab. In the diagnosis of MS, concurrent use with other disease modifying agents in the treatment of MS. In the diagnosis of Crohn's, concurrent use with immunosuppressive agents (AZA, 6-MP, Azulfidine).
Required Medical Information	For the diagnosis of MS patient must have a relapsing form of MS or experienced a first clinical episode and must have an MRI with features consistent with MS.
Age Restrictions	Patients must be 18 years old or older.
Prescriber Restrictions	Prescriber must be a neurologist, MS specialist, or gastroenterologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	In the diagnosis of MS, patient must have failed or be intolerant to interferon Beta-1a, Copaxone, or Gilenya. In the diagnosis of Crohn's, patient must have failed or be intolerant to Cimzia Humira, or Remicade.

UPTRAVI

Products Affected

- Uptravi

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	PAH WHO group, right heart catheterization, medication history.
Age Restrictions	N/A
Prescriber Restrictions	PAH - Prescribed by, or in consultation with, a cardiologist or a pulmonologist.
Coverage Duration	Through the end of the Plan contract year
Other Criteria	Pulmonary arterial hypertension (PAH) WHO Group 1 patients not currently on Uptravi 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. Right heart catheterization is NOT required in patients who are currently receiving Uptravi or another agent indicated for PAH (WHO group 1). Failure or contraindication to acute vasodilator testing or calcium channel blockers.

VALCHLOR

Products Affected

- Valchlor

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	Failure or clinically significant adverse effects to one of the following skin-directed therapies: topical corticosteroids (e.g., clobetasol, triamcinolone), Targretin gel, Tazorac, imiquimod, or topical mechlorethamine. For Continuation of Therapy: Maintained on therapy with positive response.

VENCLEXTA

Products Affected

- Venclexta
- Venclexta Starting Pack

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

VOTRIENT

Products Affected

- Votrient

PA Criteria	Criteria Details
Covered Uses	Votrient is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

VRAYLAR

Products Affected

- Vraylar

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	Through the end of the Plan contract year.
Other Criteria	Failure or clinically significant adverse effects to two of the following atypical antipsychotics: aripiprazole, ziprasidone, quetiapine, olanzapine, risperidone

XALKORI

Products Affected

- Xalkori

PA Criteria	Criteria Details
Covered Uses	Xalkori is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation patient is anaplastic lymphoma kinase (ALK)-positive as detected by an FDA-approved test. Positive result confirming ALK using Vysis ALK Break Apart FISH Probe Kit or equivalent.
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

YERVOY

Products Affected

- Yervoy INJ 50MG/10ML

PA Criteria	Criteria Details
Covered Uses	Yervoy is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

ZALTRAP

Products Affected

- Zaltrap INJ 100MG/4ML

PA Criteria	Criteria Details
Covered Uses	Zaltrap is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	A documented diagnosis of metastatic colorectal cancer AND documentation of the following: resistance to or progression of the disease following an oxaliplatin-containing regimen and will be used in combination with 5-fluorouracil, leucovorin, and irinotecan.

ZEJULA

Products Affected

- Zejula

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	Failure or clinically significant adverse effects to platinum-containing chemotherapy (e.g., cisplatin or carboplatin).

ZELBORAF

Products Affected

- Zelboraf

PA Criteria	Criteria Details
Covered Uses	Zelboraf is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Treatment of unresectable or metastatic malignant melanoma in patients with V600E mutation of the BRAF gene as detected by an FDA-approved test. Positive result confirming mutation using Cobas 4800 BRAF V600 Mutation Test or equivalent.
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

ZUBSOLV

Products Affected

- Zubsolv SUBL 1.4MG; 0.36MG, 11.4MG; 2.9MG, 2.9MG; 0.71MG, 5.7MG; 1.4MG, 8.6MG; 2.1MG

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For Maintenance Requests: Confirmation of response to treatment..
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

ZYDELIG

Products Affected

- Zydelig

PA Criteria	Criteria Details
Covered Uses	Zydelig is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	History of serious allergic reaction including anaphylaxis and toxic epidermal necrolysis.
Required Medical Information	Labs within 30 days of request to include: ALT/AST, Complete Blood Cell count.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must oncologist or hematologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	For Relapsed Chronic Lymphocytic Leukemia, Zydelig will be used in combination with rituximab (Rituxan). For Relapsed Follicular B-cell non-Hodgkin Lymphoma and Relapsed Small Lymphocytic Lymphoma, patient has received at least two prior systemic therapies such as Rituxan, Treanda, or other chemotherapy.

ZYKADIA

Products Affected

- Zykadia

PA Criteria	Criteria Details
Covered Uses	Zykadia is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Patient must be 18 years old or older.
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	Patient has a diagnosis of anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer (NSCLC) AND has progressed on or is intolerant to crizotinib (Xalkori).

ZYTIGA

Products Affected

- Zytiga

PA Criteria	Criteria Details
Covered Uses	Zytiga is approved for all FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation that prednisone will be used in combination.
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be an oncologist.
Coverage Duration	Through the end of the Plan contract year.
Other Criteria	N/A

PART B VERSUS PART D

Products Affected

- Abelcet
- Acetylcysteine SOLN
- Acyclovir Sodium INJ 50MG/ML
- Adrucil INJ 500MG/10ML
- Albuterol Sulfate NEBU
- Alkeran INJ
- Ambisome
- Aminosyn 7%/electrolytes
- Aminosyn 8.5%/electrolytes
- Aminosyn II INJ 107.6MEQ/L; 1490MG/100ML; 1527MG/100ML; 1050MG/100ML; 1107MG/100ML; 750MG/100ML; 450MG/100ML; 990MG/100ML; 1500MG/100ML; 1575MG/100ML; 258MG/100ML; 447MG/100ML; 1083MG/100ML; 795MG/100ML; 50MEQ/L; 600MG/100ML; 300MG/100ML; 405MG/100ML; 750MG/100ML, 61.1MEQ/L; 844MG/100ML; 865MG/100ML; 595MG/100ML; 627MG/100ML; 425MG/100ML; 255MG/100ML; 561MG/100ML; 850MG/100ML; 893MG/100ML; 146MG/100ML; 253MG/100ML; 614MG/100ML; 450MG/100ML; 33.3MEQ/L; 340MG/100ML; 170MG/100ML; 230MG/100ML; 425MG/100ML, 71.8MEQ/L; 993MG/100ML; 1018MG/100ML; 700MG/100ML; 738MG/100ML; 500MG/100ML; 300MG/100ML; 660MG/100ML; 1000MG/100ML; 1050MG/100ML; 172MG/100ML; 298MG/100ML; 722MG/100ML; 530MG/100ML; 45.3MEQ/L; 400MG/100ML; 200MG/100ML; 270MG/100ML; 500MG/100ML
- Aminosyn II 8.5%/electrolytes
- Aminosyn-hbc
- Aminosyn-pf INJ 46MEQ/L; 698MG/100ML; 1227MG/100ML; 527MG/100ML; 820MG/100ML; 385MG/100ML; 312MG/100ML; 760MG/100ML; 1200MG/100ML; 677MG/100ML; 180MG/100ML; 427MG/100ML; 812MG/100ML; 495MG/100ML; 3.4MEQ/L; 70MG/100ML; 512MG/100ML; 180MG/100ML; 44MG/100ML; 673MG/100ML
- Aminosyn-pf 7%
- Aminosyn-rf
- Amphotericin B INJ
- Aprepitant
- Azasan
- Azathioprine TABS
- Bleomycin Sulfate INJ 30UNIT
- Budesonide SUSP
- Carimune Nanofiltered INJ 6GM
- Cellcept Intravenous
- Cladribine
- Clinimix 2.75%/dextrose 5%
- Clinimix 4.25%/dextrose 10%
- Clinimix 4.25%/dextrose 20%
- Clinimix 4.25%/dextrose 25%
- Clinimix 4.25%/dextrose 5%
- Clinimix 5%/dextrose 15%
- Clinimix 5%/dextrose 20%
- Clinimix 5%/dextrose 25%
- Clinimix E 2.75%/dextrose 10%
- Clinimix E 2.75%/dextrose 5%
- Clinimix E 4.25%/dextrose 10%
- Clinimix E 4.25%/dextrose 25%
- Clinimix E 4.25%/dextrose 5%
- Clinimix E 5%/dextrose 15%
- Clinimix E 5%/dextrose 20%
- Clinimix E 5%/dextrose 25%
- Colistimethate Sodium INJ
- Cromolyn Sodium NEBU
- Cyclophosphamide CAPS
- Cyclosporine CAPS

- Cyclosporine INJ
- Cyclosporine Modified
- Cytarabine Aqueous
- Dronabinol
- Emend CAPS
- Emend Tripack
- Engerix-b
- Envarsus Xr
- Fluorouracil INJ 2.5GM/50ML
- Freamine Hbc 6.9%
- Gamastan S/d
- Gammagard Liquid INJ 2.5GM/25ML
- Gamunex-c INJ 1GM/10ML
- Ganciclovir INJ 500MG
- Gengraf
- Hepatamine
- Intralipid INJ 20GM/100ML, 30GM/100ML
- Ipratropium Bromide INHALATION SOLN 0.02%
- Ipratropium Bromide/albuterol Sulfate
- Levalbuterol NEBU
- Levalbuterol Hcl NEBU 0.31MG/3ML, 0.63MG/3ML
- Mycophenolate Mofetil
- Mycophenolic Acid Dr
- Nebupent
- Nephramine
- Nulojix
- Nutrilipid
- Ondansetron Hcl ORAL SOLN
- Ondansetron Hcl TABS
- Ondansetron Odt
- Plenamine
- Premasol
- Procalamine
- Prograf INJ
- Prosol
- Pulmozyme
- Rapamune SOLN
- Recombivax Hb
- Simulect INJ 20MG
- Sirolimus TABS
- Tacrolimus CAPS
- Thymoglobulin
- Tobramycin NEBU
- Travasol INJ 52MEQ/L; 1760MG/100ML; 880MG/100ML; 34MEQ/L; 1760MG/100ML; 372MG/100ML; 406MG/100ML; 526MG/100ML; 492MG/100ML; 492MG/100ML; 526MG/100ML; 356MG/100ML; 356MG/100ML; 390MG/100ML; 34MG/100ML; 152MG/100ML
- Trophamine
- Vinblastine Sulfate INJ 1MG/ML
- Vincristine Sulfate INJ
- Xopenex NEBU 1.25MG/3ML
- 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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