2016 Cigna-HealthSpring Prior Authorization Criteria (Updated November 2016)

Drug Name	Prior Authorization Type Description	Product Group	Covered Uses	Exclusion Criteria	Required Medical Information	Age Restrictions	Prescriber Restrictions	Coverage Duration	Other Criteria	Excluded Drug Criteria
ABELCET	Prior Authorization Applies	Antifungals, Polyene	All medically accepted indications not otherwise excluded from Part D.					6 months	B vs D coverage determination	
ABRAXANE	Part D vs. Part B Prior Authorization Only							12 months		
ACAMPROSATE CALCIUM DR	Prior Authorization Applies	Alcohol Dependence Agents	All FDA-approved indications not otherwise excluded from Part D.		Documentation of alcohol dependence			12 months		
ACETYLCYSTEINE	Part D vs. Part B Prior Authorization Only							12 months		
ACITRETIN	Prior Authorization Applies	Acitretin	All medically accepted indications not otherwise excluded from Part D		Documentation of diagnosis			12 months		
ACTIMMUNE	Prior Authorization Applies to New Starts Only	Actimmune	All medically accepted indications not otherwise excluded from Part D.					12 months		
ADAGEN	Prior Authorization Applies	IMMUNE STIMULANTS	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis			12 months		
ADEMPAS	Prior Authorization Applies	ADEMPAS	All medically accepted indications not otherwise excluded from Part D.					12 months		
ADRUCIL	Part D vs. Part B Prior Authorization Only							12 months		
AFINITOR	Prior Authorization Applies to New Starts Only	Afinitor	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis and past medication history			12 months	Afinitor is considered medically necessary for the treatment of patients with advanced renal cell carcinoma after failure of treatment with Sutent (sunitinib) OR Nexavar (sorafenib).	
AFINITOR DISPERZ	Prior Authorization Applies to New Starts Only	Afinitor	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis and past medication history			12 months	Afinitor is considered medically necessary for the treatment of patients with advanced renal cell carcinoma after failure of treatment with Sutent (sunitinib) OR Nexavar (sorafenib).	
ALBUTEROL SULFATE	Part D vs. Part B Prior Authorization Only							12 months		
ALDURAZYME	Prior Authorization Applies	Enzyme Replacement/Modifiers	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis			12 months		
ALECENSA	Prior Authorization Applies to New Starts Only	Molecular Target Inhibitors	All medically accepted indications not otherwise excluded from Part D.					12 months		
ALIMTA	Part D vs. Part B Prior Authorization Only							12 months		
ALORA	Prior Authorization Applies	HRM - Estrogens	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent, AND the physician has documented that the patient has tried and failed two (2) safer formulary alternatives or provided clinical rationale why two safer formulary alternatives are not appropriate for the patient.	Automatic approval if member is less than 65 years of age. Prior Authorization is required for age 65 or older.		Approval duration is through the end of the plan year.	Safer alternatives to the estrogen high risk medications depend on the indication. For Hot Flashes, safer alternatives are: Estradiol Valerate, Depo-Estradiol, SSRIs, venlafaxine, gabapentin, and Femring. For Vaginal Symptoms of menopause, safer alternatives are: Premarin Cream, Estring, Femring, and Estradiol Valerate. For Bone Density, safer alternatives are: alendronate, risedronate, raloxifene, and Prolia.	
ALOSETRON HYDROCHLORIDE	Prior Authorization Applies	Lotronex	All medically accepted indications not otherwise excluded from Part D	Alosetron will not be approved for use in men, as safety and efficacy in men has not been established.				12 months		
ALOXI (Non-formulary for Cigna-HealthSpring Secure (PDP) and Cigna-HealthSpring Secure-Extra (PDP))	Part D vs. Part B Prior Authorization Only							12 months		
AMBISOME	Prior Authorization Applies	Antifungals, Polyene	All medically accepted indications not otherwise excluded from Part D.					6 months	B vs D coverage determination	
AMIFOSTINE	Part D vs. Part B Prior Authorization Only							12 months		
AMINOSYN	Part D vs. Part B Prior Authorization Only							12 months		

AMINOSYN 7%/ELECTROLYTES	Part D vs. Part B Prior Authorization Only							12 months		
AMINOSYN 8.5%/ELECTROLYTES	Part D vs. Part B Prior Authorization Only							12 months		
AMINOSYN II	Part D vs. Part B Prior Authorization Only							12 months		
AMINOSYN II 8.5%/ELECTROLYTES	Part D vs. Part B Prior Authorization Only							12 months		
AMINOSYN M	Part D vs. Part B Prior Authorization Only							12 months		
AMINOSYN-HBC	Part D vs. Part B Prior Authorization Only							12 months		
AMINOSYN-HF (Non-formulary for Cigna-HealthSpring Secure (PDP) and Cigna-HealthSpring Secure-Extra (PDP))	Part D vs. Part B Prior Authorization Only							12 months		
AMINOSYN-PF	Part D vs. Part B Prior Authorization Only							12 months		
AMINOSYN-PF 7%	Part D vs. Part B Prior Authorization Only							12 months		
AMINOSYN-RF	Part D vs. Part B Prior Authorization Only							12 months		
AMITRIPTYLINE HCL	Prior Authorization Applies to New Starts Only	HRM - Tricyclic Antidepressants	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent, AND the physician has documented that the patient has tried and failed two (2) safer formulary alternatives or provided clinical rationale why two safer formulary alternatives are not appropriate for the patient.	Automatic approval if member is less than 65 years of age. Prior Authorization is required for age 65 or older.		Approval duration is through the end of the plan year.	Safer alternatives depend on indication. For Depression, safer alternatives are: Nortriptyline, Protriptyline, Desipramine, Amoxapine, Citalopram, Venlafaxine, Fluoxetine, Paroxetine, Sertraline, Duloxetine, and Bupropion. For headache prophylaxis, safer alternatives are: Propranolol, Topiramate, and Divalproex sodium. For headache treatment, safer alternatives are: Sumatriptan, Naratriptan, and Dihydroergotamine. For Pain/Neuropathy, safer alternatives are: Duloxetine, Lyrica, and Gabapentin.	
AMPHOTERICIN B	Prior Authorization Applies	Antifungals, Polyene	All medically accepted indications not otherwise excluded from Part D.					6 months	B vs D coverage determination	
AMPYRA	Prior Authorization Applies	Ampyra	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis.			12 months	Ampyra is considered medically necessary for patients with multiple sclerosis with medical documentation of impaired walking ability.	
ANADROL-50	Prior Authorization Applies	ANABOLIC STEROIDS, ANDROGENS	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis.			12 months		
ANDROGEL (Non-formulary for Cigna-HealthSpring Secure (PDP) and Cigna-HealthSpring Secure-Extra (PDP))	Prior Authorization Applies	ANABOLIC STEROIDS, ANDROGENS	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis.			12 months		
ANDROGEL PUMP	Prior Authorization Applies	ANABOLIC STEROIDS, ANDROGENS	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis.			12 months		
ANDROXY	Prior Authorization Applies	ANABOLIC STEROIDS, ANDROGENS	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis.			12 months		
APOKYN	Prior Authorization Applies	Apokyn	All medically accepted indications not otherwise excluded from Part D.					12 months		
ARALAST NP	Part D vs. Part B Prior Authorization Only							12 months		
ARANESP ALBUMIN FREE	Prior Authorization Applies	HEMATOPOIETICS	All medically accepted indications not otherwise excluded from Part D.		For the indication of anemia, documentation of Hemoglobin less than 11, transferrin saturation greater than 20%, and ferritin levels greater than 100 obtained over the last 3 months			6 months	BvD Determination	
ARCALYST	Prior Authorization Applies	Arcalyst	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis of Cryopyrin-Associated Periodic Syndromes (CAPS), including Familial Cold Auto-inflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS)	12 years of age and older		12 months	B vs D coverage determination	

ARMODAFINIL	Prior Authorization Applies	Non-amphetamine Central Nervous System Agents	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis and sleep study for the diagnosis of sleep apnea or narcolepsy			12 months		
ARZERRA	Part D vs. Part B Prior Authorization Only							12 months		
ASCOMP/CODEINE	Prior Authorization Applies	HRM - Butalbital Combinations	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent, AND the physician has documented that the patient has tried and failed two (2) safer formulary alternatives or provided clinical rationale why two safer formulary alternatives are not appropriate for the patient.	Automatic approval if member is less than 65 years of age. Prior Authorization is required for age 65 or older.		Approval duration is through the end of the plan year.	Safer alternatives are: naproxen sodium and ibuprofen.	
ASTAGRAF XL	Prior Authorization Applies to New Starts Only	IMMUNE SUPPRESSANTS - TRANSPLANT RELATED	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D determination.	
ATGAM	Prior Authorization Applies to New Starts Only	IMMUNE SUPPRESSANTS - TRANSPLANT RELATED	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D determination.	
AVASTIN	Part D vs. Part B Prior Authorization Only							12 months		
AZACITIDINE	Part D vs. Part B Prior Authorization Only							12 months		
AZASAN	Prior Authorization Applies to New Starts Only	IMMUNE SUPPRESSANTS - TRANSPLANT RELATED	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D determination.	
AZATHIOPRINE	Prior Authorization Applies to New Starts Only	IMMUNE SUPPRESSANTS - TRANSPLANT RELATED	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D determination.	
BANZEL	Prior Authorization Applies to New Starts Only	Banzel	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis			12 months		
BELEODAQ	Prior Authorization Applies to New Starts Only	Beleodaq	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D coverage determination	
BENDEKA	Part D vs. Part B Prior Authorization Only							12 months		
BENLYSTA	Prior Authorization Applies	BENLYSTA	All medically accepted indications not otherwise excluded from Part D.		The patient must have a positive autoantibody test (i.e., anti-nuclear antibody [ANA] greater than or equal to 1:80 and/or anti-double-stranded DNA [anti-dsDNA] greater than or equal to 30 IU/ml) AND active disease state as documented by a SELENA-SLEDAI score of 6 or greater on the current treatment regimen.			12 months	The patient must be receiving one standard therapy for SLE with any of the following: corticosteroids, hydroxychloroquine, immunosuppressives (cyclophosphamide, azathioprine, mycophenolate, methotrexate, cyclosporine) or nonsteroidal anti-inflammatory drugs AND there must be an absence of severe active lupus nephritis or severe active central nervous system lupus before Benlysta is authorized. BvsD Determination.	
BENZTROPINE MESYLATE	Prior Authorization Applies	HRM - Benztropine	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent, AND the physician has documented that the patient has tried and failed two (2) safer formulary alternatives if two are available or provided clinical rationale why two safer formulary alternatives are not appropriate for the patient. If only one (1) safer formulary alternative is available, then only that particular medication would need to be documented as tried and failed or clinical rationale provided as to why that one safer formulary alternative is not appropriate for the patient.	Automatic approval if member is less than 65 years of age. Prior Authorization is required for age 65 or older.		Approval duration is through the end of the plan year.	Safer alternatives depend on indication. For Parkinsonism, safer alternatives are: Carbidopa/Levodopa, Pramipexole, Ropinirole, Bromocriptine, Amantadine, and Selegiline. For extrapyramidal symptoms, a safer alternative is: Amantadine.	
BICNU	Part D vs. Part B Prior Authorization Only							12 months		
BIVIGAM	Part D vs. Part B Prior Authorization Only							12 months		
BLEOMYCIN SULFATE	Part D vs. Part B Prior Authorization Only							12 months		
BOSULIF	Prior Authorization Applies to New Starts Only	Molecular Target Inhibitors	All medically accepted indications not otherwise excluded from Part D.					12 months		

BUDESONIDE	Part D vs. Part B Prior Authorization Only							12 months		
BUPRENORPHINE HCL	Prior Authorization Applies	Opioid Agonist-Antagonist Analgesics	All FDA-approved indications not otherwise excluded from Part D.		Documentation of opioid dependence. Documentation that patient is involved in a comprehensive addiction care program that incorporates non drug therapy			Buprenorphine-1 month, or 6 mo if pregnant/hypersensitive to naloxone. Suboxone (bup/nalox)-6 mo	The use of buprenorphine for maintenance therapy should be limited to patients who have experienced a hypersensitivity reaction to naloxone or require buprenorphine during pregnancy.	
BUPRENORPHINE HCL/NALOXONE HCL	Prior Authorization Applies	Opioid Agonist-Antagonist Analgesics	All FDA-approved indications not otherwise excluded from Part D.		Documentation of opioid dependence. Documentation that patient is involved in a comprehensive addiction care program that incorporates non drug therapy			Buprenorphine-1 month, or 6 mo if pregnant/hypersensitive to naloxone. Suboxone (bup/nalox)-6 mo	The use of buprenorphine for maintenance therapy should be limited to patients who have experienced a hypersensitivity reaction to naloxone or require buprenorphine during pregnancy.	
BUSULFEX	Part D vs. Part B Prior Authorization Only							12 months		
BUTALBITAL/ACETAMINOPHEN/CAFFEINE	Prior Authorization Applies	HRM - Butalbital Combinations	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent, AND the physician has documented that the patient has tried and failed two (2) safer formulary alternatives or provided clinical rationale why two safer formulary alternatives are not appropriate for the patient.	Automatic approval if member is less than 65 years of age. Prior Authorization is required for age 65 or older.		Approval duration is through the end of the plan year.	Safer alternatives are: naproxen sodium and ibuprofen.	
BUTALBITAL/ACETAMINOPHEN/CAFFEINE/CODEINE	Prior Authorization Applies	HRM - Butalbital Combinations	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent, AND the physician has documented that the patient has tried and failed two (2) safer formulary alternatives or provided clinical rationale why two safer formulary alternatives are not appropriate for the patient.	Automatic approval if member is less than 65 years of age. Prior Authorization is required for age 65 or older.		Approval duration is through the end of the plan year.	Safer alternatives are: naproxen sodium and ibuprofen.	
BUTALBITAL/APAP/CAFFEINE	Prior Authorization Applies	HRM - Butalbital Combinations	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent, AND the physician has documented that the patient has tried and failed two (2) safer formulary alternatives or provided clinical rationale why two safer formulary alternatives are not appropriate for the patient.	Automatic approval if member is less than 65 years of age. Prior Authorization is required for age 65 or older.		Approval duration is through the end of the plan year.	Safer alternatives are: naproxen sodium and ibuprofen.	
BUTALBITAL/ASPIRIN/CAFFEINE	Prior Authorization Applies	HRM - Butalbital Combinations	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent, AND the physician has documented that the patient has tried and failed two (2) safer formulary alternatives or provided clinical rationale why two safer formulary alternatives are not appropriate for the patient.	Automatic approval if member is less than 65 years of age. Prior Authorization is required for age 65 or older.		Approval duration is through the end of the plan year.	Safer alternatives are: naproxen sodium and ibuprofen.	
BUTALBITAL/ASPIRIN/CAFFEINE/CODEINE	Prior Authorization Applies	HRM - Butalbital Combinations	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent, AND the physician has documented that the patient has tried and failed two (2) safer formulary alternatives or provided clinical rationale why two safer formulary alternatives are not appropriate for the patient.	Automatic approval if member is less than 65 years of age. Prior Authorization is required for age 65 or older.		Approval duration is through the end of the plan year.	Safer alternatives are: naproxen sodium and ibuprofen.	

CABOMETYX	Prior Authorization Applies to New Starts Only	CABOMETYX						12 months		
CANCIDAS	Prior Authorization Applies	Antifungals, Superficial and Systemic	All medically accepted indications not otherwise excluded from Part D.					3-12 months depending on the indication	For the treatment of tinea versicolor or ptyriasis, use of oral ketoconazole or a topical antifungal agent is required prior to the use of Itraconazole. For candidiasis infections (unless specified C. glabrata or C. krusei) use of fluconazole is required prior to the use of Itraconazole.	
CAPRELSA	Prior Authorization Applies to New Starts Only	Caprelsa	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis.			12 months		
CARBOPLATIN	Part D vs. Part B Prior Authorization Only							12 months		
CAYSTON	Prior Authorization Applies	CAYSTON	All medically accepted indications not otherwise excluded from Part D.			7 years and older		12 months		
CELLCEPT INTRAVENOUS	Prior Authorization Applies to New Starts Only	IMMUNE SUPPRESSANTS - TRANSPLANT RELATED	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D determination.	
CELLCEPT SUSP (PA applies to Cigna-HealthSpring Rx Secure (PDP) ONLY, otherwise non-formulary)	Prior Authorization Applies to New Starts Only	IMMUNE SUPPRESSANTS - TRANSPLANT RELATED	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D determination.	
CEREZYME	Part D vs. Part B Prior Authorization Only							12 months		
CHLORZOXAZONE (PA applies to Cigna-HealthSpring Rx Secure (PDP) ONLY, otherwise non-formulary)	Prior Authorization Applies	HRM - Skeletal Muscle Relaxants	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent.	Automatic approval if member is less than 65 years of age. Prior Authorization is required for age 65 or older.		Approval duration is through the end of the plan year.		
CHORIONIC GONADOTROPIN	Prior Authorization Applies	Hormonal Agents, Gonadotropins	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis			12 months		
CINRYZE	Prior Authorization Applies	Cinryze	All medically accepted indications not otherwise excluded from Part D.		Patient must have a confirmed diagnosis of HAE.			12 months	The patient must have a history of more than one severe event per month and have failure, contraindication or intolerance to one conventional therapy for HAE prophylaxis such as aminocaproic acid, danazol or tranexamic acid. B vs D Determination.	
CISPLATIN	Part D vs. Part B Prior Authorization Only							12 months		
CLADRIBINE	Part D vs. Part B Prior Authorization Only							12 months		
CLINIMIX 2.75%/DEXTROSE 5%	Part D vs. Part B Prior Authorization Only							12 months		
CLINIMIX 4.25%/DEXTROSE 10%	Part D vs. Part B Prior Authorization Only							12 months		
CLINIMIX 4.25%/DEXTROSE 20%	Part D vs. Part B Prior Authorization Only							12 months		
CLINIMIX 4.25%/DEXTROSE 25%	Part D vs. Part B Prior Authorization Only							12 months		
CLINIMIX 4.25%/DEXTROSE 5%	Part D vs. Part B Prior Authorization Only							12 months		
CLINIMIX 5%/DEXTROSE 15%	Part D vs. Part B Prior Authorization Only							12 months		
CLINIMIX 5%/DEXTROSE 20%	Part D vs. Part B Prior Authorization Only							12 months		
CLINIMIX 5%/DEXTROSE 25%	Part D vs. Part B Prior Authorization Only							12 months		
CLINIMIX E 2.75%/DEXTROSE 10%	Part D vs. Part B Prior Authorization Only							12 months		
CLINIMIX E 4.25%/DEXTROSE 10%	Part D vs. Part B Prior Authorization Only							12 months		
CLINIMIX E 4.25%/DEXTROSE 25%	Part D vs. Part B Prior Authorization Only							12 months		
CLINIMIX E 5%/DEXTROSE 25%	Part D vs. Part B Prior Authorization Only							12 months		
CLINISOL SF 15%	Part D vs. Part B Prior Authorization Only							12 months		
CLOLAR	Part D vs. Part B Prior Authorization Only							12 months		

CLOMIPRAMINE HCL	Prior Authorization Applies to New Starts Only	HRM - Tricyclic Antidepressants	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent, AND the physician has documented that the patient has tried and failed two (2) safer formulary alternatives or provided clinical rationale why two safer formulary alternatives are not appropriate for the patient.	Automatic approval if member is less than 65 years of age. Prior Authorization is required for age 65 or older.		Approval duration is through the end of the plan year.	Safer alternatives depend on indication. For Depression, safer alternatives are: Nortriptyline, Protriptyline, Desipramine, Amoxapine, Citalopram, Venlafaxine, Fluoxetine, Paroxetine, Sertraline, Duloxetine, and Bupropion. For headache prophylaxis, safer alternatives are: Propranolol, Topiramate, and Divalproex sodium. For headache treatment, safer alternatives are: Sumatriptan, Naratriptan, and Dihydroergotamine. For Pain/Neuropathy, safer alternatives are: Duloxetine, Lyrica, and Gabapentin.	
COMETRIQ	Prior Authorization Applies to New Starts Only	Molecular Target Inhibitors	All medically accepted indications not otherwise excluded from Part D.						12 months		
COSMEGEN	Part D vs. Part B Prior Authorization Only								12 months		
COTELLIC	Prior Authorization Applies to New Starts Only	Molecular Target Inhibitors	All medically accepted indications not otherwise excluded from Part D.						12 months		
CROMOLYN SODIUM	Part D vs. Part B Prior Authorization Only								12 months		
CUBICIN	Part D vs. Part B Prior Authorization Only								12 months		
CYCLOBENZAPRINE HCL	Prior Authorization Applies	HRM - Skeletal Muscle Relaxants	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent.	Automatic approval if member is less than 65 years of age. Prior Authorization is required for age 65 or older.			Approval duration is through the end of the plan year.		
CYCLOPHOSPHAMIDE	Part D vs. Part B Prior Authorization Only								12 months		
CYCLOSPORINE	Prior Authorization Applies to New Starts Only	IMMUNE SUPPRESSANTS - TRANSPLANT RELATED	All medically accepted indications not otherwise excluded from Part D.						12 months	B vs D determination.	
CYCLOSPORINE MODIFIED	Prior Authorization Applies to New Starts Only	IMMUNE SUPPRESSANTS - TRANSPLANT RELATED	All medically accepted indications not otherwise excluded from Part D.						12 months	B vs D determination.	
CYRAMZA	Prior Authorization Applies to New Starts Only	Antineoplastics, Monoclonal Antibodies	All medically accepted indications not otherwise excluded from Part D.						12 months	B vs D coverage determination	
CYTARABINE	Part D vs. Part B Prior Authorization Only								12 months		
CYTARABINE AQUEOUS	Part D vs. Part B Prior Authorization Only								12 months		
DACARBAZINE	Part D vs. Part B Prior Authorization Only								12 months		
DALIRESP	Prior Authorization Applies	Phosphodiesterase Type 4 (PDE4 Inhibitors	All medically accepted indications not otherwise excluded from Part D.						12 months		
DAPTOMYCIN	Part D vs. Part B Prior Authorization Only								12 months		
DARZALEX	Prior Authorization Applies to New Starts Only	Antineoplastics, monoclonal antibodies	All medically accepted indications not otherwise excluded from Part D.						12 months	B vs D coverage determination	
DAUNORUBICIN HCL	Part D vs. Part B Prior Authorization Only								12 months		
DEXRAZOXANE	Part D vs. Part B Prior Authorization Only								12 months		
DEXTROSE 10%/NACL 0.45%	Part D vs. Part B Prior Authorization Only								12 months		
DEXTROSE 5% /ELECTROLYTE #48 VIAFLEX	Part D vs. Part B Prior Authorization Only								12 months		
DEXTROSE 10% FLEX CONTAINER	Part D vs. Part B Prior Authorization Only								12 months		

DEXTROSE 10%/NACL 0.2%	Part D vs. Part B Prior Authorization Only							12 months		
DEXTROSE 2.5%/NACL 0.45%	Part D vs. Part B Prior Authorization Only							12 months		
DEXTROSE 2.5%/SODIUM CHLORIDE 0.45%	Part D vs. Part B Prior Authorization Only							12 months		
DEXTROSE 20%	Part D vs. Part B Prior Authorization Only							12 months		
DEXTROSE 25%	Part D vs. Part B Prior Authorization Only							12 months		
DEXTROSE 30%	Part D vs. Part B Prior Authorization Only							12 months		
DEXTROSE 40%	Part D vs. Part B Prior Authorization Only							12 months		
DEXTROSE 5%	Part D vs. Part B Prior Authorization Only							12 months		
DEXTROSE 5%/NACL 0.2%	Part D vs. Part B Prior Authorization Only							12 months		
DEXTROSE 5%/NACL 0.225%	Part D vs. Part B Prior Authorization Only							12 months		
DEXTROSE 5%/NACL 0.3%	Part D vs. Part B Prior Authorization Only							12 months		
DEXTROSE 5%/NACL 0.33%	Part D vs. Part B Prior Authorization Only							12 months		
DEXTROSE 5%/NACL 0.45%	Part D vs. Part B Prior Authorization Only							12 months		
DEXTROSE 5%/NACL 0.9%	Part D vs. Part B Prior Authorization Only							12 months		
DEXTROSE 5%/POTASSIUM CHLORIDE 0.15%	Part D vs. Part B Prior Authorization Only							12 months		
DEXTROSE 5%/SODIUM CHLORIDE 0.2%	Part D vs. Part B Prior Authorization Only							12 months		
DEXTROSE 5%/SODIUM CHLORIDE 0.45%	Part D vs. Part B Prior Authorization Only							12 months		
DEXTROSE 50%	Part D vs. Part B Prior Authorization Only							12 months		
DEXTROSE 70%	Part D vs. Part B Prior Authorization Only							12 months		
DICLOFENAC GEL	Prior Authorization Applies	DICLOFENAC GEL	All medically accepted indications not otherwise excluded from Part D.					12 months	The patient must have a trial and failure of brand Voltaren Gel before diclofenac gel would be approved.	
DIGITEK	Prior Authorization Applies	HRM - Digoxin	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent, AND the physician has documented that the patient has tried and failed digoxin 0.125mg daily or provided clinical rationale as to why the lower dose is not appropriate for the patient.	Automatic approval if member is less than 65 years of age. Prior Authorization is required for age 65 or older.		Approval duration is through the end of the plan year.		
DIGOX	Prior Authorization Applies	HRM - Digoxin	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent, AND the physician has documented that the patient has tried and failed digoxin 0.125mg daily or provided clinical rationale as to why the lower dose is not appropriate for the patient.	Automatic approval if member is less than 65 years of age. Prior Authorization is required for age 65 or older.		Approval duration is through the end of the plan year.		

DIGOXIN	Prior Authorization Applies	HRM - Digoxin	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent, AND the physician has documented that the patient has tried and failed digoxin 0.125mg daily or provided clinical rationale as to why the lower dose is not appropriate for the patient.	Automatic approval if member is less than 65 years of age. Prior Authorization is required for age 65 or older.		Approval duration is through the end of the plan year.		
DIPYRIDAMOLE (PA applies to Cigna-HealthSpring Rx Secure (PDP) and Cigna-HealthSpring Rx Secure-Extra (PDP) ONLY, otherwise non-formulary)	Prior Authorization Applies	HRM - Platelet Modifying Agents	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent, AND the physician has documented that the patient has tried and failed two (2) safer formulary alternatives or provided clinical rationale why two safer formulary alternatives are not appropriate for the patient.	Automatic approval if member is less than 65 years of age. Prior Authorization is required for age 65 or older.		Approval duration is through the end of the plan year.	Safer alternatives are: Clopidogrel, Warfarin, Jantoven, and Aggrenox.	
DOCEFREZ	Part D vs. Part B Prior Authorization Only								12 months		
DOCETAXEL	Part D vs. Part B Prior Authorization Only								12 months		
DOXEPIN HCL	Prior Authorization Applies to New Starts Only	HRM - Tricyclic Antidepressants	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent, AND the physician has documented that the patient has tried and failed two (2) safer formulary alternatives or provided clinical rationale why two safer formulary alternatives are not appropriate for the patient.	Automatic approval if member is less than 65 years of age. Prior Authorization is required for age 65 or older.		Approval duration is through the end of the plan year.	Safer alternatives depend on indication. For Depression, safer alternatives are: Nortriptyline, Protriptyline, Desipramine, Amoxapine, Citalopram, Venlafaxine, Fluoxetine, Paroxetine, Sertraline, Duloxetine, and Bupropion. For headache prophylaxis, safer alternatives are: Propranolol, Topiramate, and Divalproex sodium. For headache treatment, safer alternatives are: Sumatriptan, Naratriptan, and Dihydroergotamine. For Pain/Neuropathy, safer alternatives are: Duloxetine, Lyrica, and Gabapentin.	
DOXORUBICIN HCL	Part D vs. Part B Prior Authorization Only								12 months		
DRONABINOL	Prior Authorization Applies	Dronabinol	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis			6 months	Use of Dronabinol is considered medically necessary for the treatment of patients with anorexia associated with weight loss in patients with AIDS and nausea and vomiting associated with cancer chemotherapy.	
ELAPRASE	Prior Authorization Applies	Enzyme Replacement/Modifiers	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis			12 months		
ELIGARD	Prior Authorization Applies to New Starts Only	Pituitary Hormones	All medically accepted indications not otherwise excluded from Part D.					12 months		
ELIQUIS (PA applies to Cigna-HealthSpring RX Secure (PDP) and Cigna-HealthSpring Rx Secure-Extra (PDP) ONLY)	Prior Authorization Applies	Oral Factor Xa Inhibitors/Oral DTIs	All medically accepted indications not otherwise excluded from Part D.		Documentation of Diagnosis			3 to 12 months depending on indication and clinical information provided		
ELITEK	Part D vs. Part B Prior Authorization Only								12 months		
ELLENCE (PA applies to Cigna-HealthSpring Rx Secure (PDP) ONLY, otherwise non-formulary)	Part D vs. Part B Prior Authorization Only								12 months		

EMEND	Part D vs. Part B Prior Authorization Only							12 months		
EMPLICITI	Prior Authorization Applies to New Starts Only	Empliciti	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis and current medication regimen			12 months	Empliciti is approved with concurrent use of dexamethasone and lenalidomide. B vs D determination	
ENBREL	Prior Authorization Applies	Immune Suppressants	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis and past medication history			12 months	Use of Humira, Enbrel, or Remicade is considered medically necessary for the treatment of: 1. Rheumatoid Arthritis in patients that have tried and failed methotrexate OR at least 2 alternative disease modifying antirheumatic drugs (DMARDs). 2. Juvenile Rheumatoid Arthritis in patients that have tried and failed at least 2 DMARDs. 3. Ankylosing Spondylitis in patients that have tried and failed at least 1 non-steroidal anti-inflammatory drug (NSAID), corticosteroid, OR sulfasalazine. 4. Plaque Psoriasis in patients that have: a) moderate to severe chronic disease, b) minimum body surface area (BSA) involvement of greater than or equal to 5% OR involvement of the palms, soles, head, neck or genitalia, c) tried and failed at least 1 topical agent (topical steroid, calcipotriene, or tazarotene) , AND d) tried and failed at least 1 systemic therapy (cyclosporine, methotrexate, or acitretin) OR phototherapy. 5. Psoriatic Arthritis in patients with active disease. In addition, use of Humira or Remicade is considered medically necessary for the treatment of: 1. Moderate to severe Crohn's Disease in patients that have tried and failed at least 2 of the following: immunomodulators, corticosteroids, or aminosalicylates. 2. Treatment of moderately to severely active ulcerative colitis in patients who have had inadequate response to at least 2 of the following: corticosteroids, sulfasalazine, mesalamine, azathioprine, 6-mercaptopurine. Use of Humira will also be considered medically necessary for the treatment of hidradenitis suppurativa and uveitis. Use of Remicade will also be considered medically necessary for the treatment of fistulizing Crohn's disease. B vs D determination required for Remicade.	
ENBREL SURECLICK	Prior Authorization Applies	Immune Suppressants	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis and past medication history			12 months	Use of Humira, Enbrel, or Remicade is considered medically necessary for the treatment of: 1. Rheumatoid Arthritis in patients that have tried and failed methotrexate OR at least 2 alternative disease modifying antirheumatic drugs (DMARDs). 2. Juvenile Rheumatoid Arthritis in patients that have tried and failed at least 2 DMARDs. 3. Ankylosing Spondylitis in patients that have tried and failed at least 1 non-steroidal anti-inflammatory drug (NSAID), corticosteroid, OR sulfasalazine. 4. Plaque Psoriasis in patients that have: a) moderate to severe chronic disease, b) minimum body surface area (BSA) involvement of greater than or equal to 5% OR involvement of the palms, soles, head, neck or genitalia, c) tried and failed at least 1 topical agent (topical steroid, calcipotriene, or tazarotene) , AND d) tried and failed at least 1 systemic therapy (cyclosporine, methotrexate, or acitretin) OR phototherapy. 5. Psoriatic Arthritis in patients with active disease. In addition, use of Humira or Remicade is considered medically necessary for the treatment of: 1. Moderate to severe Crohn's Disease in patients that have tried and failed at least 2 of the following: immunomodulators, corticosteroids, or aminosalicylates. 2. Treatment of moderately to severely active ulcerative colitis in patients who have had inadequate response to at least 2 of the following: corticosteroids, sulfasalazine, mesalamine, azathioprine, 6-mercaptopurine. Use of Humira will also be considered medically necessary for the treatment of hidradenitis suppurativa and uveitis. Use of Remicade will also be considered medically necessary for the treatment of fistulizing Crohn's disease. B vs D determination required for Remicade.	
ENGERIX-B	Part D vs. Part B Prior Authorization Only							12 months		
ENTRESTO	Prior Authorization Applies	ENTRESTO	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis			12 months	The patient must have a diagnosis of chronic Heart Failure, NYHA Class II – IV, have left ventricular ejection fraction less than or equal to 40%), and have no concomitant therapy with an ACE inhibitor, ARB, or direct renin inhibitor when starting on Entresto	
ENVARSUS XR	Prior Authorization Applies to New Starts Only	IMMUNE SUPPRESSANTS - TRANSPLANT RELATED	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D determination.	
EPIRUBICIN HCL	Part D vs. Part B Prior Authorization Only							12 months		
ERBITUX	Part D vs. Part B Prior Authorization Only							12 months		

ERGOLOID MESYLATES	Prior Authorization Applies	HRM - Antidementia Agents	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent, AND the physician has documented that the patient has tried and failed two (2) safer formulary alternatives or provided clinical rationale why two safer formulary alternatives are not appropriate for the patient.	Automatic approval if member is less than 65 years of age. Prior Authorization is required for age 65 or older.		Approval duration is through the end of the plan year.	Safer alternatives are: donepezil, galantamine and rivastigmine.	
ERIVEDGE	Prior Authorization Applies to New Starts Only	Erivedge	All medically accepted indications not otherwise excluded from Part D.					12 months		
ERWINAZE	Part D vs. Part B Prior Authorization Only							12 months		
ESBRIET	Prior Authorization Applies	ESBRIET	All FDA-approved indications not otherwise excluded from part D.	Other known causes of interstitial lung disease e.g., domestic and occupational environmental exposures, connective tissue disease, and drug toxicity.	Diagnosis confirmed by 1) in patients without surgical lung biopsy: Usual interstitial pneumonia (UIP) pattern on high resolution computed tomography (HRCT) is indicative of IPF. or 2) in patients with surgical lung biopsy: The combination of HRCT and biopsy pattern is indicative of IPF. Documented forced vital capacity (% FVC) greater than or equal to 50% performed within the last 6 months.		Prescribed by pulmonologist.	12 months	Esbriet will be used as monotherapy.	
ESGIC	Prior Authorization Applies	HRM - Butalbital Combinations	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent, AND the physician has documented that the patient has tried and failed two (2) safer formulary alternatives or provided clinical rationale why two safer formulary alternatives are not appropriate for the patient.	Automatic approval if member is less than 65 years of age. Prior Authorization is required for age 65 or older.		Approval duration is through the end of the plan year.	Safer alternatives are: naproxen sodium and ibuprofen.	
ESTRADIOL	Prior Authorization Applies	HRM - Estrogens	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent, AND the physician has documented that the patient has tried and failed two (2) safer formulary alternatives or provided clinical rationale why two safer formulary alternatives are not appropriate for the patient.	Automatic approval if member is less than 65 years of age. Prior Authorization is required for age 65 or older.		Approval duration is through the end of the plan year.	Safer alternatives to the estrogen high risk medications depend on the indication. For Hot Flashes, safer alternatives are: Estradiol Valerate, Depo-Estradiol, SSRIs, venlafaxine, gabapentin, and Femring. For Vaginal Symptoms of menopause, safer alternatives are: Premarin Cream, Estring, Femring, and Estradiol Valerate. For Bone Density, safer alternatives are: alendronate, risedronate, raloxifene, and Prolia.	
ESTRADIOL/NORETHINDRONE ACETATE	Prior Authorization Applies	HRM - Estrogens	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent, AND the physician has documented that the patient has tried and failed two (2) safer formulary alternatives or provided clinical rationale why two safer formulary alternatives are not appropriate for the patient.	Automatic approval if member is less than 65 years of age. Prior Authorization is required for age 65 or older.		Approval duration is through the end of the plan year.	Safer alternatives to the estrogen high risk medications depend on the indication. For Hot Flashes, safer alternatives are: Estradiol Valerate, Depo-Estradiol, SSRIs, venlafaxine, gabapentin, and Femring. For Vaginal Symptoms of menopause, safer alternatives are: Premarin Cream, Estring, Femring, and Estradiol Valerate. For Bone Density, safer alternatives are: alendronate, risedronate, raloxifene, and Prolia.	
ETOPOPHOS	Part D vs. Part B Prior Authorization Only							12 months		
ETOPOSIDE	Part D vs. Part B Prior Authorization Only							12 months		
EVOMELA	Prior Authorization Applies to New Starts Only	EVOMELA	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D coverage determination	
FABRAZYME	Part D vs. Part B Prior Authorization Only							12 months		
FARYDAK	Prior Authorization Applies to New Starts Only	FARYDAK	All medically accepted indications not otherwise excluded from Part D.					12 months		
FASLODEX	Part D vs. Part B Prior Authorization Only							12 months		
FENTANYL CITRATE	Part D vs. Part B Prior Authorization Only							12 months		

FENTANYL CITRATE ORAL TRANSMUCOSAL	Prior Authorization Applies	Transmucosal Fentanyl Citrate	All FDA-approved indications not otherwise excluded from Part D.		Documentation from the medical record of diagnosis.	16 years of age and older for fentanyl citrate (lozenge/troche). 18 years of age and older for Lazanda	Enrollment in the Transmucosal Immediate-Release Fentanyl (TIRF) REMS Access program	12 months	Transmucosal fentanyl products will only be covered with documentation of breakthrough cancer pain. The patient must be currently receiving and be tolerant to opioid therapy for persistent cancer pain.The patient must be enrolled in the TIRF REMS Access program.	
FERRIPROX	Prior Authorization Applies	FERRIPROX	All medically accepted indications not otherwise excluded from Part D.					12 months		
FIRAZYR	Prior Authorization Applies	Firazyr	All medically accepted indications not otherwise excluded from Part D.		Patient must have a confirmed diagnosis of HAE.			12 months	The patient must have a history of a moderate or severe attack (e.g., airway swelling, severe abdominal pain, facial swelling, nausea and vomiting, painful facial distortion).	
FIRMAGON	Part D vs. Part B Prior Authorization Only							12 months		
FLEBOGAMMA DIF	Part D vs. Part B Prior Authorization Only							12 months		
FLUDARABINE PHOSPHATE	Part D vs. Part B Prior Authorization Only							12 months		
FLUOROURACIL	Part D vs. Part B Prior Authorization Only							12 months		
FOLOTYN	Part D vs. Part B Prior Authorization Only							12 months		
FORTEO	Prior Authorization Applies	Metabolic Bone Disease agents	All medically accepted indications not otherwise excluded from Part D.		BMD T-Score, Medical documentation reflecting high risk for a fracture, medication history regarding the prior use of bisphosphonates			12 months	Patients with a BMD T-score indicating high risk despite therapy with a bisphosphonate for six months OR Patients with a history of osteoporotic fracture while receiving treatment with bisphosphonates OR Patients unable to tolerate oral bisphosphonates due to gastrointestinal comorbidities or is unable to adhere to dosing requirements (i.e., unable to remain upright for 30 minutes). For the diagnosis of postmenopausal osteoporosis patients unable to tolerate oral bisphosphonates must have tried and failed Prolia for a total duration of at least 6 months prior to the use of Forteo.	
FOSCARNET SODIUM	Part D vs. Part B Prior Authorization Only							12 months		
FREAMINE HBC 6.9%	Part D vs. Part B Prior Authorization Only							12 months		
FREAMINE III	Part D vs. Part B Prior Authorization Only							12 months		
GAMASTAN S/D	Part D vs. Part B Prior Authorization Only							12 months		
GAMMAGARD LIQUID	Part D vs. Part B Prior Authorization Only							12 months		
GAMMAKED	Part D vs. Part B Prior Authorization Only							12 months		
GAMMAPLEX	Part D vs. Part B Prior Authorization Only							12 months		
GAMUNEX-C	Part D vs. Part B Prior Authorization Only							12 months		
GANCICLOVIR	Part D vs. Part B Prior Authorization Only							12 months		
GATTEX	Prior Authorization Applies	GATTEX	All medically accepted indications not otherwise excluded from Part D.					As long as the patient requires parenteral nutrition and/or IV fluids, 3 months up to 12 months.		
GAZYVA	Prior Authorization Applies to New Starts Only	Antineoplastics, Monoclonal Antibodies	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D coverage determination	
GEMCITABINE	Part D vs. Part B Prior Authorization Only							12 months		
GEMCITABINE HCL	Part D vs. Part B Prior Authorization Only							12 months		
GENGRAF	Prior Authorization Applies to New Starts Only	IMMUNE SUPPRESSANTS - TRANSPLANT RELATED	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D determination.	

GILOTRIF	Prior Authorization Applies to New Starts Only	Molecular Target Inhibitors	All medically accepted indications not otherwise excluded from Part D.					12 months		
GLEEVEC	Prior Authorization Applies to New Starts Only	Molecular Target Inhibitors	All medically accepted indications not otherwise excluded from Part D.					12 months		
GLYBURIDE/METFORMIN HCL (PA applies to Cigna-HealthSpring Rx Secure (PDP) ONLY, otherwise non-formulary)	Prior Authorization Applies	HRM - Glyburide/Metformin	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent, AND the physician has documented that the patient has tried and failed glipizide-metformin or provided clinical rationale as to why that safer formulary alternative is not appropriate for the patient.	Automatic approval if member is less than 65 years of age. Prior Authorization is required for age 65 or older.		Approval duration is through the end of the plan year.		
GRANISETRON HCL	Part D vs. Part B Prior Authorization Only							12 months		
HALAVEN	Prior Authorization Applies to New Starts Only	Halaven	All medically accepted indications not otherwise excluded from Part D.		Documentation of prior treatment with an anthracycline and a taxane.			12 months	Use of Halaven is considered medically necessary for the treatment of patients with metastatic breast cancer who have previously received at least two chemotherapeutic regimens for the treatment of metastatic disease. B vs D determination.	
HARVONI	Prior Authorization Applies	HARVONI	All medically accepted indications not otherwise excluded from Part D.		Documentation from the medical record of diagnosis including genotype, HCV RNA viral levels prior to treatment, history of previous HCV therapies, and presence/absence of cirrhosis.		Hepatologist, gastroenterologist, infectious disease specialist or managed by a liver transplant center	12 to 24 weeks based on indication and established treatment guidelines		
HECORIA	Prior Authorization Applies to New Starts Only	IMMUNE SUPPRESSANTS - TRANSPLANT RELATED	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D determination.	
HEPATAMINE	Part D vs. Part B Prior Authorization Only							12 months		
HERCEPTIN	Part D vs. Part B Prior Authorization Only							12 months		
HETLIOZ	Prior Authorization Applies	HETLIOZ	All medically accepted indications not otherwise excluded from Part D.		Documentation that patient is totally blind and lacks light perception			12 months		
HUMIRA	Prior Authorization Applies	Immune Suppressants	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis and past medication history			12 months	Use of Humira, Enbrel, or Remicade is considered medically necessary for the treatment of: 1. Rheumatoid Arthritis in patients that have tried and failed methotrexate OR at least 2 alternative disease modifying antirheumatic drugs (DMARDs). 2. Juvenile Rheumatoid Arthritis in patients that have tried and failed at least 2 DMARDs. 3. Ankylosing Spondylitis in patients that have tried and failed at least 1 non-steroidal anti-inflammatory drug (NSAID), corticosteroid, OR sulfasalazine. 4. Plaque Psoriasis in patients that have: a) moderate to severe chronic disease, b) minimum body surface area (BSA) involvement of greater than or equal to 5% OR involvement of the palms, soles, head, neck or genitalia, c) tried and failed at least 1 topical agent (topical steroid, calcipotriene, or tazarotene) , AND d) tried and failed at least 1 systemic therapy (cyclosporine, methotrexate, or acitretin) OR phototherapy. 5. Psoriatic Arthritis in patients with active disease. In addition, use of Humira or Remicade is considered medically necessary for the treatment of: 1. Moderate to severe Crohn's Disease in patients that have tried and failed at least 2 of the following: immunomodulators, corticosteroids, or aminosalicylates. 2. Treatment of moderately to severely active ulcerative colitis in patients who have had inadequate response to at least 2 of the following: corticosteroids, sulfasalazine, mesalamine, azathioprine, 6-mercaptopurine. Use of Humira will also be considered medically necessary for the treatment of hidradenitis suppurativa and uveitis. Use of Remicade will also be considered medically necessary for the treatment of fistulizing Crohn's disease. B vs D determination required for Remicade.	

HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK	Prior Authorization Applies	Immune Suppressants	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis and past medication history			12 months	Use of Humira, Enbrel, or Remicade is considered medically necessary for the treatment of: 1. Rheumatoid Arthritis in patients that have tried and failed methotrexate OR at least 2 alternative disease modifying antirheumatic drugs (DMARDs). 2. Juvenile Rheumatoid Arthritis in patients that have tried and failed at least 2 DMARDs. 3. Ankylosing Spondylitis in patients that have tried and failed at least 1 non-steroidal anti-inflammatory drug (NSAID), corticosteroid, OR sulfasalazine. 4. Plaque Psoriasis in patients that have: a) moderate to severe chronic disease, b) minimum body surface area (BSA) involvement of greater than or equal to 5% OR involvement of the palms, soles, head, neck or genitalia, c) tried and failed at least 1 topical agent (topical steroid, calcipotriene, or tazarotene) , AND d) tried and failed at least 1 systemic therapy (cyclosporine, methotrexate, or acitretin) OR phototherapy. 5. Psoriatic Arthritis in patients with active disease. In addition, use of Humira or Remicade is considered medically necessary for the treatment of: 1. Moderate to severe Crohn's Disease in patients that have tried and failed at least 2 of the following: immunomodulators, corticosteroids, or aminosalicylates. 2. Treatment of moderately to severely active ulcerative colitis in patients who have had inadequate response to at least 2 of the following: corticosteroids, sulfasalazine, mesalamine, azathioprine, 6-mercaptopurine. Use of Humira will also be considered medically necessary for the treatment of hidradenitis suppurativa and uveitis. Use of Remicade will also be considered medically necessary for the treatment of fistulizing Crohn's disease. B vs D determination required for Remicade.	
HUMIRA PEN	Prior Authorization Applies	Immune Suppressants	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis and past medication history			12 months	Use of Humira, Enbrel, or Remicade is considered medically necessary for the treatment of: 1. Rheumatoid Arthritis in patients that have tried and failed methotrexate OR at least 2 alternative disease modifying antirheumatic drugs (DMARDs). 2. Juvenile Rheumatoid Arthritis in patients that have tried and failed at least 2 DMARDs. 3. Ankylosing Spondylitis in patients that have tried and failed at least 1 non-steroidal anti-inflammatory drug (NSAID), corticosteroid, OR sulfasalazine. 4. Plaque Psoriasis in patients that have: a) moderate to severe chronic disease, b) minimum body surface area (BSA) involvement of greater than or equal to 5% OR involvement of the palms, soles, head, neck or genitalia, c) tried and failed at least 1 topical agent (topical steroid, calcipotriene, or tazarotene) , AND d) tried and failed at least 1 systemic therapy (cyclosporine, methotrexate, or acitretin) OR phototherapy. 5. Psoriatic Arthritis in patients with active disease. In addition, use of Humira or Remicade is considered medically necessary for the treatment of: 1. Moderate to severe Crohn's Disease in patients that have tried and failed at least 2 of the following: immunomodulators, corticosteroids, or aminosalicylates. 2. Treatment of moderately to severely active ulcerative colitis in patients who have had inadequate response to at least 2 of the following: corticosteroids, sulfasalazine, mesalamine, azathioprine, 6-mercaptopurine. Use of Humira will also be considered medically necessary for the treatment of hidradenitis suppurativa and uveitis. Use of Remicade will also be considered medically necessary for the treatment of fistulizing Crohn's disease. B vs D determination required for Remicade.	
HUMIRA PEN-CROHNS DISEASESTARTER	Prior Authorization Applies	Immune Suppressants	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis and past medication history			12 months	Use of Humira, Enbrel, or Remicade is considered medically necessary for the treatment of: 1. Rheumatoid Arthritis in patients that have tried and failed methotrexate OR at least 2 alternative disease modifying antirheumatic drugs (DMARDs). 2. Juvenile Rheumatoid Arthritis in patients that have tried and failed at least 2 DMARDs. 3. Ankylosing Spondylitis in patients that have tried and failed at least 1 non-steroidal anti-inflammatory drug (NSAID), corticosteroid, OR sulfasalazine. 4. Plaque Psoriasis in patients that have: a) moderate to severe chronic disease, b) minimum body surface area (BSA) involvement of greater than or equal to 5% OR involvement of the palms, soles, head, neck or genitalia, c) tried and failed at least 1 topical agent (topical steroid, calcipotriene, or tazarotene) , AND d) tried and failed at least 1 systemic therapy (cyclosporine, methotrexate, or acitretin) OR phototherapy. 5. Psoriatic Arthritis in patients with active disease. In addition, use of Humira or Remicade is considered medically necessary for the treatment of: 1. Moderate to severe Crohn's Disease in patients that have tried and failed at least 2 of the following: immunomodulators, corticosteroids, or aminosalicylates. 2. Treatment of moderately to severely active ulcerative colitis in patients who have had inadequate response to at least 2 of the following: corticosteroids, sulfasalazine, mesalamine, azathioprine, 6-mercaptopurine. Use of Humira will also be considered medically necessary for the treatment of hidradenitis suppurativa and uveitis. Use of Remicade will also be considered medically necessary for the treatment of fistulizing Crohn's disease. B vs D determination required for Remicade.	

HUMIRA PEN-PSORIASIS STARTER	Prior Authorization Applies	Immune Suppressants	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis and past medication history			12 months	Use of Humira, Enbrel, or Remicade is considered medically necessary for the treatment of: 1. Rheumatoid Arthritis in patients that have tried and failed methotrexate OR at least 2 alternative disease modifying antirheumatic drugs (DMARDs). 2. Juvenile Rheumatoid Arthritis in patients that have tried and failed at least 2 DMARDs. 3. Ankylosing Spondylitis in patients that have tried and failed at least 1 non-steroidal anti-inflammatory drug (NSAID), corticosteroid, OR sulfasalazine. 4. Plaque Psoriasis in patients that have: a) moderate to severe chronic disease, b) minimum body surface area (BSA) involvement of greater than or equal to 5% OR involvement of the palms, soles, head, neck or genitalia, c) tried and failed at least 1 topical agent (topical steroid, calcipotriene, or tazarotene) , AND d) tried and failed at least 1 systemic therapy (cyclosporine, methotrexate, or acitretin) OR phototherapy. 5. Psoriatic Arthritis in patients with active disease. In addition, use of Humira or Remicade is considered medically necessary for the treatment of: 1. Moderate to severe Crohn's Disease in patients that have tried and failed at least 2 of the following: immunomodulators, corticosteroids, or aminosalicylates. 2. Treatment of moderately to severely active ulcerative colitis in patients who have had inadequate response to at least 2 of the following: corticosteroids, sulfasalazine, mesalamine, azathioprine, 6-mercaptopurine. Use of Humira will also be considered medically necessary for the treatment of hidradenitis suppurativa and uveitis. Use of Remicade will also be considered medically necessary for the treatment of fistulizing Crohn's disease. B vs D determination required for Remicade.	
IBRANCE	Prior Authorization Applies to New Starts Only	Molecular Target Inhibitors	All medically accepted indications not otherwise excluded from Part D.					12 months		
ICLUSIG	Prior Authorization Applies to New Starts Only	Molecular Target Inhibitors	All medically accepted indications not otherwise excluded from Part D.					12 months		
IDARUBICIN HCL	Part D vs. Part B Prior Authorization Only							12 months		
IFOSFAMIDE	Part D vs. Part B Prior Authorization Only							12 months		
ILARIS	Prior Authorization Applies	Ilaris	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D determination	
IMATINIB	Prior Authorization Applies to New Starts Only	Molecular Target Inhibitors	All medically accepted indications not otherwise excluded from Part D.					12 months		
IMBRUVICA	Prior Authorization Applies to New Starts Only	Molecular Target Inhibitors	All medically accepted indications not otherwise excluded from Part D.					12 months		
IMIPRAMINE HCL	Prior Authorization Applies to New Starts Only	HRM - Tricyclic Antidepressants	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent, AND the physician has documented that the patient has tried and failed two (2) safer formulary alternatives or provided clinical rationale why two safer formulary alternatives are not appropriate for the patient.	Automatic approval if member is less than 65 years of age. Prior Authorization is required for age 65 or older.		Approval duration is through the end of the plan year.	Safer alternatives depend on indication. For Depression, safer alternatives are: Nortriptyline, Protriptyline, Desipramine, Amoxapine, Citalopram, Venlafaxine, Fluoxetine, Paroxetine, Sertraline, Duloxetine, and Bupropion. For headache prophylaxis, safer alternatives are: Propranolol, Topiramate, and Divalproex sodium. For headache treatment, safer alternatives are: Sumatriptan, Naratriptan, and Dihydroergotamine. For Pain/Neuropathy, safer alternatives are: Duloxetine, Lyrica, and Gabapentin.	

IMIPRAMINE PAMOATE	Prior Authorization Applies to New Starts Only	HRM - Tricyclic Antidepressants	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent, AND the physician has documented that the patient has tried and failed two (2) safer formulary alternatives or provided clinical rationale why two safer formulary alternatives are not appropriate for the patient.	Automatic approval if member is less than 65 years of age. Prior Authorization is required for age 65 or older.		Approval duration is through the end of the plan year.	Safer alternatives depend on indication. For Depression, safer alternatives are: Nortriptyline, Protriptyline, Desipramine, Amoxapine, Citalopram, Venlafaxine, Fluoxetine, Paroxetine, Sertraline, Duloxetine, and Bupropion. For headache prophylaxis, safer alternatives are: Propranolol, Topiramate, and Divalproex sodium. For headache treatment, safer alternatives are: Sumatriptan, Naratriptan, and Dihydroergotamine. For Pain/Neuropathy, safer alternatives are: Duloxetine, Lyrica, and Gabapentin.	
INCRELEX	Prior Authorization Applies	Insulin-Like Growth Factor	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis. Documentation of lab data reflecting height standard deviation score, basal IGF-1 score, and growth hormone level.		Prescribing physician must be an endocrinologist	12 months	Height standard deviation score must be less than or equal to -3.0 AND the basal IGF-1 score must be below the lower limits of normal for the reporting lab AND the patient must have a normal or elevated growth hormone level (excluding patients with growth hormone gene deletion) AND epiphyses must be confirmed as open in patients greater than or equal to 10 years of age.	
INLYTA	Prior Authorization Applies to New Starts Only	Molecular Target Inhibitors	All medically accepted indications not otherwise excluded from Part D.					12 months		
INTRALIPID	Part D vs. Part B Prior Authorization Only							12 months		
IPRATROPIUM BROMIDE	Part D vs. Part B Prior Authorization Only							12 months		
IPRATROPIUM BROMIDE/ALBUTEROL SULFATE	Part D vs. Part B Prior Authorization Only							12 months		
IRESSA	Prior Authorization Applies to New Starts Only	Molecular Target Inhibitors	All medically accepted indications not otherwise excluded from Part D.					12 months		
IRINOTECAN	Part D vs. Part B Prior Authorization Only							12 months		
ISTODAX	Prior Authorization Applies to New Starts Only	Istodax	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis and past medication history		Prescribing physician must be an oncologist.	12 months	Use of Istodax is considered medically necessary for the treatment of cutaneous T-cell lymphoma in patients that have tried and failed at least 1 prior therapy. B vs D coverage determination.	
ITRACONAZOLE	Prior Authorization Applies	Antifungals, Superficial and Systemic	All medically accepted indications not otherwise excluded from Part D.					3-12 months depending on the indication	For the treatment of tinea versicolor or ptyriasis, use of oral ketoconazole or a topical antifungal agent is required prior to the use of Itraconazole. For candidiasis infections (unless specified C. glabrata or C. krusei) use of fluconazole is required prior to the use of Itraconazole.	
IXEMPRA KIT	Part D vs. Part B Prior Authorization Only							12 months		
JAKAFI	Prior Authorization Applies to New Starts Only	Molecular Target Inhibitors	All medically accepted indications not otherwise excluded from Part D.					12 months		
JEVTANA	Part D vs. Part B Prior Authorization Only							12 months		
KABIVEN	Part D vs. Part B Prior Authorization Only							12 months		
KADCYLA	Prior Authorization Applies to New Starts Only	Antineoplastics, Monoclonal Antibodies	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D coverage determination	
KALYDECO	Prior Authorization Applies	KALYDECO	All medically accepted indications not otherwise excluded from Part D.	Patients with cystic fibrosis (CF) who are homozygous for the F508del mutation in the CFTR gene.	CF mutation test documenting a G551D, G1244E, G1349D, G178R, G551S, R117H, S1251N, S1255P, S549N, or S549R mutation in the CFTR gene.	2 years of age and older for packets. 6 years of age and older for tablets		12 months		
KCL 0.075%/D5W/NACL 0.45%	Part D vs. Part B Prior Authorization Only							12 months		
KCL 0.15%/D5W/ NACL 0.3%	Part D vs. Part B Prior Authorization Only							12 months		

KCL 0.15%/D5W/LR	Part D vs. Part B Prior Authorization Only							12 months		
KCL 0.15%/D5W/NACL 0.2%	Part D vs. Part B Prior Authorization Only							12 months		
KCL 0.15%/D5W/NACL 0.225%	Part D vs. Part B Prior Authorization Only							12 months		
KCL 0.15%/D5W/NACL 0.45%	Part D vs. Part B Prior Authorization Only							12 months		
KCL 0.15%/D5W/NACL 0.9%	Part D vs. Part B Prior Authorization Only							12 months		
KCL 0.3%/D5W/LR IV LAC RING	Part D vs. Part B Prior Authorization Only							12 months		
KCL 0.3%/D5W/NACL 0.45%	Part D vs. Part B Prior Authorization Only							12 months		
KCL 0.3%/D5W/NACL 0.9%	Part D vs. Part B Prior Authorization Only							12 months		
KEYTRUDA	Prior Authorization Applies to New Starts Only	Antineoplastics, Monoclonal Antibodies	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D coverage determination	
KINERET	Prior Authorization Applies	KINERET	All medically accepted indications not otherwise excluded from Part D.			For RA: 18 years and older		12 months	Treatment of rheumatoid arthritis (RA) in adults and when the following criteria are met: inadequate response, intolerance, or contraindication to at least one disease-modifying anti-rheumatic drug (DMARD) (i.e., Methotrexate (MTX) Azathioprine, gold, Hydroxychloroquine, Penicillamine, Sulfasalazine) AND the patient has had failure, contraindication, or intolerance to Enbrel or Humira.	
KORLYM	Prior Authorization Applies	KORLYM	All medically accepted indications not otherwise excluded from Part D.					12 months		
KUVAN	Prior Authorization Applies	Kuvan	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis.			12 months		
KYNAMRO	Prior Authorization Applies	KYNAMRO	All FDA-approved indications not otherwise excluded from part D.	1) Patient receiving LDL apheresis. 2) Patient treated with an MTP inhibitor (e.g. Juxtapid). 3) Patient with moderate or severe hepatic impairment (based on Child-Pugh category B or C), active liver disease or unexplained persistent abnormal liver function tests.	Diagnosis of homozygous familial hypercholesterolemia (HoFH) as demonstrated by 1) genetic confirmation of 2 mutant alleles at the LDL receptor, ApoB, PCSK9 or ARH adaptor protein gene locus OR 2) an untreated LDL-cholesterol concentration greater than 500 mg/dL OR 3) total LDL greater than or equal to 300mg/dl while on a maximum tolerated dose of a high-intensity statin (high-intensity statins include atorvastatin 80mg and Crestor 40mg) taken in combination with any of the following: Zetia (ezetimibe), a bile acid sequestrant, or niacin AND one of the following: a) cutaneous or tendinous xanthoma before the age of 10 years OR b) untreated LDL cholesterol levels consistent with heterozygous familial hypercholesterolemia in both parents (greater than 190mg/dl).	18 years and older.		12 months	Kynamro will be taken in combination with a maximum tolerated dose of atorvastatin OR Crestor and with any one of the following: Zetia (ezetimibe), a bile acid sequestrant, or niacin. Patient is following a low-fat diet.	
LANOXIN PEDIATRIC	Prior Authorization Applies	HRM - Digoxin	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent, AND the physician has documented that the patient has tried and failed digoxin 0.125mg daily or provided clinical rationale as to why the lower dose is not appropriate for the patient.	Automatic approval if member is less than 65 years of age. Prior Authorization is required for age 65 or older.		Approval duration is through the end of the plan year.		
LANOXIN TABS (PA applies to Cigna-HealthSpring Rx Secure (PDP) and Cigna-HealthSpring Rx Secure-Extra (PDP) ONLY, otherwise non-formulary)	Prior Authorization Applies	HRM - Digoxin	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent, AND the physician has documented that the patient has tried and failed digoxin 0.125mg daily or provided clinical rationale as to why the lower dose is not appropriate for the patient.	Automatic approval if member is less than 65 years of age. Prior Authorization is required for age 65 or older.		Approval duration is through the end of the plan year.		

LAZANDA	Prior Authorization Applies	Transmucosal Fentanyl Citrate	All FDA-approved indications not otherwise excluded from Part D.		Documentation from the medical record of diagnosis.	16 years of age and older for fentanyl citrate (lozenge/troche). 18 years of age and older for Lazanda	Enrollment in the Transmucosal Immediate-Release Fentanyl (TIRF) REMS Access program	12 months	Transmucosal fentanyl products will only be covered with documentation of breakthrough cancer pain. The patient must be currently receiving and be tolerant to opioid therapy for persistent cancer pain.The patient must be enrolled in the TIRF REMS Access program.	
LENVIMA	Prior Authorization Applies to New Starts Only	Molecular Target Inhibitors	All medically accepted indications not otherwise excluded from Part D.					12 months		
LETAIRIS	Prior Authorization Applies	Letairis	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis			12 months		
LEUKINE	Prior Authorization Applies	Colony stimulating factors	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis and either CBC with differential or ANC. For the harvesting of peripheral blood stem cells, CBC with differential or ANC is NOT required.			6 months		
LEUPROLIDE ACETATE	Prior Authorization Applies to New Starts Only	Pituitary Hormones	All medically accepted indications not otherwise excluded from Part D.					12 months		
LIDOCAINE	Prior Authorization Applies	Lidocaine Patch	All medically accepted indications not otherwise excluded from Part D.					12 months	For the FDA-labeled indication of post-herpetic neuralgia, no additional criteria are required to be met. For diabetic neuropathic pain: the patient must have previous use and inadequate response or intolerance to any ONE medication that is FDA-labeled for diabetic peripheral neuropathy, including (but not limited to) duloxetine and Lyrica.	
LINEZOLID	Prior Authorization Applies	Antibacterials, other	All medically accepted indications not otherwise excluded from Part D.		Documentation from the medical record of diagnosis, site of infection, recent culture and sensitivity data, current or previous treatment for infection.			1 to 3 months	Use of linezolid is considered medically necessary for use in infections resulting from VRE and MRSA. Linezolid is also considered medically accepted for other clinically appropriate infections when drug allergies prevent the use of clinically appropriate 1st-line agents in other infections.	
LIPOSYN II	Part D vs. Part B Prior Authorization Only							12 months		
LIPOSYN III	Part D vs. Part B Prior Authorization Only							12 months		
LONSURF	Prior Authorization Applies to New Starts Only	LONSURF	All medically accepted indications not otherwise excluded from Part D.					12 months		
LOPREEZA	Prior Authorization Applies	HRM - Estrogens	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent, AND the physician has documented that the patient has tried and failed two (2) safer formulary alternatives or provided clinical rationale why two safer formulary alternatives are not appropriate for the patient.	Automatic approval if member is less than 65 years of age. Prior Authorization is required for age 65 or older.		Approval duration is through the end of the plan year.	Safer alternatives to the estrogen high risk medications depend on the indication. For Hot Flashes, safer alternatives are: Estradiol Valerate, Depo-Estradiol, SSRIs, venlafaxine, gabapentin, and Femring. For Vaginal Symptoms of menopause, safer alternatives are: Premarin Cream, Estring, Femring, and Estradiol Valerate. For Bone Density, safer alternatives are: alendronate, risedronate, raloxifene, and Prolia.	
LUMIZYME	Prior Authorization Applies	Lumizyme	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis			12 months	B vs D determination	
LUPRON DEPOT	Prior Authorization Applies to New Starts Only	Pituitary Hormones	All medically accepted indications not otherwise excluded from Part D.					12 months		
LUPRON DEPOT-PED	Prior Authorization Applies	Pituitary Hormones	All medically accepted indications not otherwise excluded from Part D.					12 months		
LYNPARZA	Prior Authorization Applies to New Starts Only	Molecular Target Inhibitors	All medically accepted indications not otherwise excluded from Part D.					12 months		

MAGNESIUM SULFATE	Part D vs. Part B Prior Authorization Only							12 months		
MARGESIC	Prior Authorization Applies	HRM - Butalbital Combinations	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent, AND the physician has documented that the patient has tried and failed two (2) safer formulary alternatives or provided clinical rationale why two safer formulary alternatives are not appropriate for the patient.	Automatic approval if member is less than 65 years of age. Prior Authorization is required for age 65 or older.		Approval duration is through the end of the plan year.	Safer alternatives are: naproxen sodium and ibuprofen.	
MEGESTROL ACETATE SUSP	Prior Authorization Applies to New Starts Only	HRM - Megestrol Suspension	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent, AND the physician has documented that the patient has tried and failed dronabinol or provided clinical rationale as to why that safer formulary alternative is not appropriate for the patient.	Automatic approval if member is less than 65 years of age. Prior Authorization is required for age 65 or older.		Approval duration is through the end of the plan year.		
MEGESTROL ACETATE TABS	Prior Authorization Applies to New Starts Only	HRM - Megestrol Tabs	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent.	Automatic approval if member is less than 65 years of age. Prior Authorization is required for age 65 or older.		Approval duration is through the end of the plan year.		
MEKINIST	Prior Authorization Applies to New Starts Only	Molecular Target Inhibitors	All medically accepted indications not otherwise excluded from Part D.					12 months		
MELPHALAN HYDROCHLORIDE	Part D vs. Part B Prior Authorization Only							12 months		
MENEST	Prior Authorization Applies	HRM - Menest	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent, AND the physician has documented that the patient has tried and failed one (1) safer formulary alternative or provided clinical rationale why two safer formulary alternative is not appropriate for the patient. For palliative therapy of metastatic breast cancer, no trial of a formulary alternative is required.	Automatic approval if member is less than 65 years of age. Prior Authorization is required for age 65 or older.		Approval duration is through the end of the plan year.	For vasomotor symptoms of menopause, safer alternatives are: SSRIs, venlafaxine, gabapentin, and Femring. For vaginal symptoms of menopause, safer alternatives are: Premarin Cream, Estring, and Femring. For all other indications, no formulary alternative is required.	
MENOSTAR	Prior Authorization Applies	HRM - Estrogens	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent, AND the physician has documented that the patient has tried and failed two (2) safer formulary alternatives or provided clinical rationale why two safer formulary alternatives are not appropriate for the patient.	Automatic approval if member is less than 65 years of age. Prior Authorization is required for age 65 or older.		Approval duration is through the end of the plan year.	Safer alternatives to the estrogen high risk medications depend on the indication. For Hot Flashes, safer alternatives are: Estradiol Valerate, Depo-Estradiol, SSRIs, venlafaxine, gabapentin, and Femring. For Vaginal Symptoms of menopause, safer alternatives are: Premarin Cream, Estring, Femring, and Estradiol Valerate. For Bone Density, safer alternatives are: alendronate, risedronate, raloxifene, and Prolia.	
MESNA	Part D vs. Part B Prior Authorization Only							12 months		

METHYLDOPATE (PA applies to Cigna-HealthSpring Rx Secure (PDP) ONLY, otherwise non-formulary)	Prior Authorization Applies	HRM - Methyldopa	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent, AND the physician has documented that the patient has tried and failed two (2) safer formulary alternatives or provided clinical rationale why two safer formulary alternatives are not appropriate for the patient.	Automatic approval if member is less than 65 years of age. Prior Authorization is required for age 65 or older.		Approval duration is through the end of the plan year.	Safer alternatives are: ACE inhibitors (Benazepril, Captopril, Enalapril, Lisinopril, Quinapril, and Ramipril), ARBs (Candesartan, Irbesartan, Losartan, and Telmisartan), Beta-blockers (Atenolol, Metoprolol, Nadolol, Pindolol, and Propranolol), Calcium channel blockers (Verapamil, Diltiazem, Amlodipine, Felodipine, and Nifedipine ER), and Thiazide diuretics (Hydrochlorothiazide, Chorthalidone, and Indapamide)	
MIMVEY	Prior Authorization Applies	HRM - Estrogens	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent, AND the physician has documented that the patient has tried and failed two (2) safer formulary alternatives or provided clinical rationale why two safer formulary alternatives are not appropriate for the patient.	Automatic approval if member is less than 65 years of age. Prior Authorization is required for age 65 or older.		Approval duration is through the end of the plan year.	Safer alternatives to the estrogen high risk medications depend on the indication. For Hot Flashes, safer alternatives are: Estradiol Valerate, Depo-Estradiol, SSRIs, venlafaxine, gabapentin, and Femring. For Vaginal Symptoms of menopause, safer alternatives are: Premarin Cream, Estring, Femring, and Estradiol Valerate. For Bone Density, safer alternatives are: alendronate, risedronate, raloxifene, and Prolia.	
MIMVEY LO	Prior Authorization Applies	HRM - Estrogens	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent, AND the physician has documented that the patient has tried and failed two (2) safer formulary alternatives or provided clinical rationale why two safer formulary alternatives are not appropriate for the patient.	Automatic approval if member is less than 65 years of age. Prior Authorization is required for age 65 or older.		Approval duration is through the end of the plan year.	Safer alternatives to the estrogen high risk medications depend on the indication. For Hot Flashes, safer alternatives are: Estradiol Valerate, Depo-Estradiol, SSRIs, venlafaxine, gabapentin, and Femring. For Vaginal Symptoms of menopause, safer alternatives are: Premarin Cream, Estring, Femring, and Estradiol Valerate. For Bone Density, safer alternatives are: alendronate, risedronate, raloxifene, and Prolia.	
MINIVELLE	Prior Authorization Applies	HRM - Estrogens	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent, AND the physician has documented that the patient has tried and failed two (2) safer formulary alternatives or provided clinical rationale why two safer formulary alternatives are not appropriate for the patient.	Automatic approval if member is less than 65 years of age. Prior Authorization is required for age 65 or older.		Approval duration is through the end of the plan year.	Safer alternatives to the estrogen high risk medications depend on the indication. For Hot Flashes, safer alternatives are: Estradiol Valerate, Depo-Estradiol, SSRIs, venlafaxine, gabapentin, and Femring. For Vaginal Symptoms of menopause, safer alternatives are: Premarin Cream, Estring, Femring, and Estradiol Valerate. For Bone Density, safer alternatives are: alendronate, risedronate, raloxifene, and Prolia.	
MITOMYCIN	Part D vs. Part B Prior Authorization Only							12 months		
MITOXANTRONE HCL	Part D vs. Part B Prior Authorization Only							12 months		
MODAFINIL	Prior Authorization Applies	Non-amphetamine Central Nervous System Agents	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis and sleep study for the diagnosis of sleep apnea or narcolepsy			12 months		
MODERIBA	Prior Authorization Applies	Immune Stimulants, Non-Vaccine	All medically accepted indications not otherwise excluded from Part D.		Documentation of genotype to determine length of therapy			12 to 48 weeks based on indication and established treatment guidelines.		
MODERIBA 1200 DOSE PACK	Prior Authorization Applies	Immune Stimulants, Non-Vaccine	All medically accepted indications not otherwise excluded from Part D.		Documentation of genotype to determine length of therapy			12 to 48 weeks based on indication and established treatment guidelines.		
MODERIBA 800 DOSE PACK	Prior Authorization Applies	Immune Stimulants, Non-Vaccine	All medically accepted indications not otherwise excluded from Part D.		Documentation of genotype to determine length of therapy			12 to 48 weeks based on indication and established treatment guidelines.		

MUSTARGEN	Part D vs. Part B Prior Authorization Only							12 months		
MYCOPHENOLATE MOFETIL	Prior Authorization Applies to New Starts Only	IMMUNE SUPPRESSANTS - TRANSPLANT RELATED	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D determination.	
MYCOPHENOLIC ACID DR	Prior Authorization Applies to New Starts Only	IMMUNE SUPPRESSANTS - TRANSPLANT RELATED	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D determination.	
NAGLAZYME	Prior Authorization Applies	Enzyme Replacement/Modifiers	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis			12 months		
NALTREXONE HCL	Prior Authorization Applies	Naltrexone	All FDA-approved indications not otherwise excluded from Part D.		Documentation of opioid or alcohol dependance			12 months		
NATPARA	Prior Authorization Applies	Natpara	All medically accepted indications not otherwise excluded from Part D.					12 months		
NEBUPENT	Part D vs. Part B Prior Authorization Only							12 months		
NEPHRAMINE	Part D vs. Part B Prior Authorization Only							12 months		
NEULASTA	Prior Authorization Applies	Colony stimulating factors	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis and either CBC with differential or ANC. For the harvesting of peripheral blood stem cells, CBC with differential or ANC is NOT required.			6 months		
NEUMEGA	Prior Authorization Applies	Neumega	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis and lab data reflecting platelet count.		Certified Hematologist and/or Oncologist	6 months	Neumega is considered medically necessary for patients that have experienced severe thrombocytopenia (platelet count less than or equal to 20,000 mcg/L) from previous chemotherapy OR patients cosidered to be at high risk for the development of severe thrombocytopenia. B vs D coverage determination	
NEUPOGEN	Prior Authorization Applies	Colony stimulating factors	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis and either CBC with differential or ANC. For the harvesting of peripheral blood stem cells, CBC with differential or ANC is NOT required.			6 months		
NEXAVAR	Prior Authorization Applies to New Starts Only	Molecular Target Inhibitors	All medically accepted indications not otherwise excluded from Part D.					12 months		
NICOTROL INHALER	Prior Authorization Applies	Smoking Deterrents	All medically accepted indications not otherwise excluded from Part D.		The patient must be enrolled in a behavioral support/ modification program (e.g., community program, manufacturer sponsored program, counseling by the physician, internet, or telephone quitline).	The patient must be 18 years of age or older		12 months		
NINLARO	Prior Authorization Applies to New Starts Only	Ninlaro	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis and current medication regimen			12 months	Ninlaro is approved with concurrent use of dexamethasone and lenalidomide	
NIPENT	Part D vs. Part B Prior Authorization Only							12 months		
NORMOSOL -R	Part D vs. Part B Prior Authorization Only							12 months		
NORMOSOL-M IN D5W	Part D vs. Part B Prior Authorization Only							12 months		
NORMOSOL-R	Part D vs. Part B Prior Authorization Only							12 months		
NORMOSOL-R IN D5W	Part D vs. Part B Prior Authorization Only							12 months		
NORTHERA	Prior Authorization Applies	NORTHERA	All medically accepted indications not otherwise excluded from Part D.		Documentation from the medical record of diagnosis and prior medication history			12 months		
NOVAREL	Prior Authorization Applies	Hormonal Agents, Gonadotropins	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis			12 months		
NOXAFIL	Prior Authorization Applies	ANTIFUNGALS, TRIAZOLE	All medically accepted indications not otherwise excluded from Part D.					6 months		

NULOJIX	Prior Authorization Applies to New Starts Only	Nulojix	All medically accepted indications not otherwise excluded from Part D.		Documentation of Epstein-Barr virus serology and current medication regimen			12 months	B vs D determination. Documentation of use in combination with basiliximab induction, mycophenolate mofetil, and corticosteroids.	
NUPLAZID	Prior Authorization Applies to New Starts Only	NUPLAZID	All medically accepted indications not otherwise excluded from Part D.					12 months		
NUTRILIPID	Part D vs. Part B Prior Authorization Only							12 months		
NUTRILYTE	Part D vs. Part B Prior Authorization Only							12 months		
NUTRILYTE II	Part D vs. Part B Prior Authorization Only							12 months		
NUVIGIL	Prior Authorization Applies	Non-amphetamine Central Nervous System Agents	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis and sleep study for the diagnosis of sleep apnea or narcolepsy			12 months		
OCTAGAM	Part D vs. Part B Prior Authorization Only							12 months		
OCTREOTIDE ACETATE	Prior Authorization Applies	HORMONAL AGENTS, SOMATOSTATIN ANALOGS	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis			6 months		
ODOMZO	Prior Authorization Applies to New Starts Only	ODOMZO	All medically accepted indications not otherwise excluded from Part D.					12 months		
OLYSIO	Prior Authorization Applies	OLYSIO	All medically accepted indications not otherwise excluded from Part D	Previous failure of Olysio, Incivek or Victrelis.	Documentation from the medical record of diagnosis including genotype, current medication regimen, HCV-RNA levels, history of previous HCV therapies and presence/absence of cirrhosis.		Hepatologist, gastroenterologist, infectious disease specialist or managed by a liver transplant center.	12 to 24 weeks based on indication and treatment guidelines.	Olysio must be used with other concurrent therapy based on indication and established treatment guidelines. For genotype 1, clinical information must be provided confirming the patient is not a candidate for Harvoni before combination therapy with Olysio and Sovaldi will be authorized.	
ONCASPAR	Part D vs. Part B Prior Authorization Only							12 months		
ONDANSETRON HCL	Part D vs. Part B Prior Authorization Only							12 months		
ONDANSETRON ODT	Part D vs. Part B Prior Authorization Only							12 months		
OPDIVO	Prior Authorization Applies to New Starts Only	Antineoplastics, Monoclonal Antibodies	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D coverage determination	
OPSUMIT	Prior Authorization Applies	Vasodilators	All FDA-approved indications not otherwise excluded from Part D.		Documentation of pulmonary arterial hypertension			12 months		
ORPHENADRINE CITRATE ER	Prior Authorization Applies	HRM - Skeletal Muscle Relaxants	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent.	Automatic approval if member is less than 65 years of age. Prior Authorization is required for age 65 or older.		Approval duration is through the end of the plan year.		
OXALIPLATIN	Part D vs. Part B Prior Authorization Only							12 months		
OXANDROLONE	Prior Authorization Applies	ANABOLIC STEROIDS, ANDROGENS	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis.			12 months		
PACLITAXEL	Part D vs. Part B Prior Authorization Only							12 months		
PAMIDRONATE DISODIUM	Part D vs. Part B Prior Authorization Only							12 months		
PEGINTRON	Prior Authorization Applies	Immune Stimulants, Non-Vaccine	All medically accepted indications not otherwise excluded from Part D.		Documentation of genotype to determine length of therapy			12 to 48 weeks based on indication and established treatment guidelines.		

PEG-INTRON	Prior Authorization Applies	Immune Stimulants, Non-Vaccine	All medically accepted indications not otherwise excluded from Part D.		Documentation of genotype to determine length of therapy			12 to 48 weeks based on indication and established treatment guidelines.		
PEG-INTRON REDIPEN	Prior Authorization Applies	Immune Stimulants, Non-Vaccine	All medically accepted indications not otherwise excluded from Part D.		Documentation of genotype to determine length of therapy			12 to 48 weeks based on indication and established treatment guidelines.		
PEG-INTRON REDIPEN PAK 4	Prior Authorization Applies	Immune Stimulants, Non-Vaccine	All medically accepted indications not otherwise excluded from Part D.		Documentation of genotype to determine length of therapy			12 to 48 weeks based on indication and established treatment guidelines.		
PERFOROMIST	Part D vs. Part B Prior Authorization Only							12 months		
PERIKABIVEN	Part D vs. Part B Prior Authorization Only							12 months		
PERJETA	Prior Authorization Applies to New Starts Only	PERJETA	All medically accepted indications not otherwise excluded from Part D.		Documentation of previous and current treatment			12 months	B vs D coverage determination.	
PERPHENAZINE/AMITRIPTYLINE	Prior Authorization Applies to New Starts Only	HRM - Perphenazine/Amitriptyline	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent, AND the physician has documented that the patient has tried and failed two (2) safer formulary alternatives or provided clinical rationale why two safer formulary alternatives are not appropriate for the patient.	Automatic approval if member is less than 65 years of age. Prior Authorization is required for age 65 or older.		Approval duration is through the end of the plan year.	Safer alternatives are: Nortriptyline, Protriptyline, Desipramine, Amoxapine, Citalopram, Venlafaxine, Fluoxetine, Paroxetine, Sertraline, Duloxetine, and Bupropion.	
PHENADOZ (PA applies to Cigna-HealthSpring Rx Secure (PDP) ONLY, otherwise non-formulary)	Prior Authorization Applies	HRM - Promethazine	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent, AND the physician has documented that the patient has tried and failed one (1) safer formulary alternative if available or provided clinical rationale why the safer formulary alternative is not appropriate for the patient.	Automatic approval if member is less than 65 years of age. Prior Authorization is required for age 65 or older.		Approval duration is through the end of the plan year.	For nausea and vomiting, the safer alternative is ondansetron (QL = 90/30). For perennial and seasonal allergic rhinitis, safer alternatives are: levocetirizine and desloratadine. For any other indications, trial of a formulary alternative is not required.	
PHENERGAN (PA applies to Cigna-HealthSpring Rx Secure (PDP) ONLY, otherwise non-formulary)	Prior Authorization Applies	HRM - Promethazine	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent, AND the physician has documented that the patient has tried and failed one (1) safer formulary alternative if available or provided clinical rationale why the safer formulary alternative is not appropriate for the patient.	Automatic approval if member is less than 65 years of age. Prior Authorization is required for age 65 or older.		Approval duration is through the end of the plan year.	For nausea and vomiting, the safer alternative is ondansetron (QL = 90/30). For perennial and seasonal allergic rhinitis, safer alternatives are: levocetirizine and desloratadine. For any other indications, trial of a formulary alternative is not required.	
PLENAMINE	Part D vs. Part B Prior Authorization Only							12 months		
POMALYST	Prior Authorization Applies to New Starts Only	Molecular Target Inhibitors	All medically accepted indications not otherwise excluded from Part D.					12 months		
PORTRAZZA	Prior Authorization Applies to New Starts Only	Antineoplastics, Monoclonal Antibodies	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D coverage determination	
POTASSIUM CHLORIDE	Part D vs. Part B Prior Authorization Only							12 months		
POTASSIUM CHLORIDE 0.15% /NACL 0.45% VIAFLEX	Part D vs. Part B Prior Authorization Only							12 months		

POTASSIUM CHLORIDE 0.15% D5W/NACL 0.33%	Part D vs. Part B Prior Authorization Only							12 months		
POTASSIUM CHLORIDE 0.15% D5W/NACL 0.45%	Part D vs. Part B Prior Authorization Only							12 months		
POTASSIUM CHLORIDE 0.15% D5W/NACL 0.45% VIAFLEX	Part D vs. Part B Prior Authorization Only							12 months		
POTASSIUM CHLORIDE 0.15% W/NACL 0.9% VIAFLEX	Part D vs. Part B Prior Authorization Only							12 months		
POTASSIUM CHLORIDE 0.15%/D5W	Part D vs. Part B Prior Authorization Only							12 months		
POTASSIUM CHLORIDE 0.15%/NACL 0.9%	Part D vs. Part B Prior Authorization Only							12 months		
POTASSIUM CHLORIDE 0.22% D5W/NACL 0.45%	Part D vs. Part B Prior Authorization Only							12 months		
POTASSIUM CHLORIDE 0.224%/D5W/NACL 0.45%	Part D vs. Part B Prior Authorization Only							12 months		
POTASSIUM CHLORIDE 0.3%/ NACL 0.9%	Part D vs. Part B Prior Authorization Only							12 months		
POTASSIUM CHLORIDE 0.3%/D5W	Part D vs. Part B Prior Authorization Only							12 months		
POTASSIUM CHLORIDE 0.3%/NACL 0.9%/VIAFLEX	Part D vs. Part B Prior Authorization Only							12 months		
POTIGA	Prior Authorization Applies to New Starts Only	POTIGA	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis			12 months		
PRADAXA (PA applies to Cigna-HealthSpring Rx Secure (PDP) and Cigna-HealthSpring Rx Secure-Extra (PDP) ONLY)	Prior Authorization Applies	Oral Factor Xa Inhibitors/Oral DTIs	All medically accepted indications not otherwise excluded from Part D.		Documentation of Diagnosis			3 to 12 months depending on indication and clinical information provided		
PREGNYL W/DILUENT BENZYL ALCOHOL/NACL	Prior Authorization Applies	Hormonal Agents, Gonadotropins	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis			12 months		
PREMARIN	Prior Authorization Applies	HRM - Estrogens	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent, AND the physician has documented that the patient has tried and failed two (2) safer formulary alternatives or provided clinical rationale why two safer formulary alternatives are not appropriate for the patient.	Automatic approval if member is less than 65 years of age. Prior Authorization is required for age 65 or older.		Approval duration is through the end of the plan year.	Safer alternatives to the estrogen high risk medications depend on the indication. For Hot Flashes, safer alternatives are: Estradiol Valerate, Depo-Estradiol, SSRIs, venlafaxine, gabapentin, and Femring. For Vaginal Symptoms of menopause, safer alternatives are: Premarin Cream, Estring, Femring, and Estradiol Valerate. For Bone Density, safer alternatives are: alendronate, risedronate, raloxifene, and Prolia.	
PREMASOL	Part D vs. Part B Prior Authorization Only							12 months		
PRIVIGEN	Part D vs. Part B Prior Authorization Only							12 months		
PROCALAMINE	Part D vs. Part B Prior Authorization Only							12 months		
PROCRIT	Prior Authorization Applies	HEMATOPOIETICS	All medically accepted indications not otherwise excluded from Part D.		For the indication of anemia, documentation of Hemoglobin less than 11, transferrin saturation greater than 20%, and ferritin levels greater than 100 obtained over the last 3 months			6 months	BvD Determination	
PROGRAF	Prior Authorization Applies to New Starts Only	IMMUNE SUPPRESSANTS - TRANSPLANT RELATED	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D determination.	
PROLASTIN-C	Part D vs. Part B Prior Authorization Only							12 months		
PROLEUKIN	Part D vs. Part B Prior Authorization Only							12 months		

PROMACTA	Prior Authorization Applies	Promacta	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis of: a) thrombocytopenia in patients with chronic hepatitis C, or b) chronic immune (idopathic) thrombocytopenic purpura (ITP) with documentation of previous therapy with corticosteroids OR intravenous immune globuline (IVIG) therapy over a period of at least 30 days OR insufficient response to a splenectomy.			12 months	Use of Promacta for the treatment of thrombocytopenia is considered medically necessary in: a) patients with chronic hepatitis C, or b) patients with chronic immune (idopathic) thrombocytopenic purpura (ITP) that have failed corticosteroid OR intravenous immune globuline (IVIG) therapy OR have had an insufficient response to a splenectomy.	
PROMETHAZINE HCL INJ SOLN (PA applies to Cigna-HealthSpring Rx Secure (PDP) ONLY, otherwise non-formulary)	Prior Authorization Applies	HRM - Promethazine	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent, AND the physician has documented that the patient has tried and failed one (1) safer formulary alternative if available or provided clinical rationale why the safer formulary alternative is not appropriate for the patient.	Automatic approval if member is less than 65 years of age. Prior Authorization is required for age 65 or older.		Approval duration is through the end of the plan year.	For nausea and vomiting, the safer alternative is ondansetron (QL = 90/30). For perennial and seasonal allergic rhinitis, safer alternatives are: levocetirizine and desloratadine. For any other indications, trial of a formulary alternative is not required.	
PROMETHAZINE HCL PLAIN SYRUP	Prior Authorization Applies	HRM - Promethazine	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent, AND the physician has documented that the patient has tried and failed one (1) safer formulary alternative if available or provided clinical rationale why the safer formulary alternative is not appropriate for the patient.	Automatic approval if member is less than 65 years of age. Prior Authorization is required for age 65 or older.		Approval duration is through the end of the plan year.	For nausea and vomiting, the safer alternative is ondansetron (QL = 90/30). For perennial and seasonal allergic rhinitis, safer alternatives are: levocetirizine and desloratadine. For any other indications, trial of a formulary alternative is not required.	
PROMETHAZINE HCL SUPP (PA applies to Cigna-HealthSpring Rx Secure (PDP) ONLY, otherwise non-formulary)	Prior Authorization Applies	HRM - Promethazine	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent, AND the physician has documented that the patient has tried and failed one (1) safer formulary alternative if available or provided clinical rationale why the safer formulary alternative is not appropriate for the patient.	Automatic approval if member is less than 65 years of age. Prior Authorization is required for age 65 or older.		Approval duration is through the end of the plan year.	For nausea and vomiting, the safer alternative is ondansetron (QL = 90/30). For perennial and seasonal allergic rhinitis, safer alternatives are: levocetirizine and desloratadine. For any other indications, trial of a formulary alternative is not required.	
PROMETHAZINE HCL SYRUP	Prior Authorization Applies	HRM - Promethazine	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent, AND the physician has documented that the patient has tried and failed one (1) safer formulary alternative if available or provided clinical rationale why the safer formulary alternative is not appropriate for the patient.	Automatic approval if member is less than 65 years of age. Prior Authorization is required for age 65 or older.		Approval duration is through the end of the plan year.	For nausea and vomiting, the safer alternative is ondansetron (QL = 90/30). For perennial and seasonal allergic rhinitis, safer alternatives are: levocetirizine and desloratadine. For any other indications, trial of a formulary alternative is not required.	
PROMETHAZINE HCL TABS	Prior Authorization Applies	HRM - Promethazine	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent, AND the physician has documented that the patient has tried and failed one (1) safer formulary alternative if available or provided clinical rationale why the safer formulary alternative is not appropriate for the patient.	Automatic approval if member is less than 65 years of age. Prior Authorization is required for age 65 or older.		Approval duration is through the end of the plan year.	For nausea and vomiting, the safer alternative is ondansetron (QL = 90/30). For perennial and seasonal allergic rhinitis, safer alternatives are: levocetirizine and desloratadine. For any other indications, trial of a formulary alternative is not required.	

PROMETHEGAN (PA applies to Cigna-HealthSpring Rx Secure (PDP) ONLY, otherwise non-formulary)	Prior Authorization Applies	HRM - Promethazine	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent, AND the physician has documented that the patient has tried and failed one (1) safer formulary alternative if available or provided clinical rationale why the safer formulary alternative is not appropriate for the patient.	Automatic approval if member is less than 65 years of age. Prior Authorization is required for age 65 or older.		Approval duration is through the end of the plan year.	For nausea and vomiting, the safer alternative is ondansetron (QL = 90/30). For perennial and seasonal allergic rhinitis, safer alternatives are: levocetirizine and desloratadine. For any other indications, trial of a formulary alternative is not required.	
PROSOL	Part D vs. Part B Prior Authorization Only								12 months		
PULMOZYME	Part D vs. Part B Prior Authorization Only								12 months		
PURIXAN	Prior Authorization Applies to New Starts Only	Purixan	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis				12 months	Documentation of trial, contraindication, or failure to mercaptopurine tablets	
RAPAMUNE SOLN	Prior Authorization Applies to New Starts Only	IMMUNE SUPPRESSANTS - TRANSPLANT RELATED	All medically accepted indications not otherwise excluded from Part D.						12 months	B vs D determination.	
RAPAMUNE TABS (PA applies to Cigna-HealthSpring Rx Secure (PDP) ONLY, otherwise non-formulary)	Prior Authorization Applies to New Starts Only	IMMUNE SUPPRESSANTS - TRANSPLANT RELATED	All medically accepted indications not otherwise excluded from Part D.						12 months	B vs D determination.	
REBETOL	Prior Authorization Applies	Immune Stimulants, Non-Vaccine	All medically accepted indications not otherwise excluded from Part D.		Documentation of genotype to determine length of therapy				12 to 48 weeks based on indication and established treatment guidelines.		
RECOMBIVAX HB	Part D vs. Part B Prior Authorization Only								12 months		
REGRANEX	Prior Authorization Applies	Dermatological Wound Care Agents	All medically accepted indications not otherwise excluded from Part D.		Documentation of wound type and wound care therapy provided.				12 months	Regranex must be used as adjunctive therapy to clinically appropriate ulcer wound care including debridement, infection control, and/or pressure relief.	
RELISTOR	Prior Authorization Applies	Relistor	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis and past medication history.				6 months	Use of Relistor is considered medically necessary for the treatment of opioid-induced constipation in patients with advanced illnesses who are receiving palliative care AND have tried and failed laxative therapy with lactulose or polyethylene glycol. Relistor is also considered medically necessary for the treatment of opioid-induced constipation in adult patients with chronic non-cancer pain who have tried and failed laxative therapy with lactulose or polyethylene glycol.	

REMICADE	Prior Authorization Applies	Immune Suppressants	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis and past medication history			12 months	Use of Humira, Enbrel, or Remicade is considered medically necessary for the treatment of: 1. Rheumatoid Arthritis in patients that have tried and failed methotrexate OR at least 2 alternative disease modifying antirheumatic drugs (DMARDs). 2. Juvenile Rheumatoid Arthritis in patients that have tried and failed at least 2 DMARDs. 3. Ankylosing Spondylitis in patients that have tried and failed at least 1 non-steroidal anti-inflammatory drug (NSAID), corticosteroid, OR sulfasalazine. 4. Plaque Psoriasis in patients that have: a) moderate to severe chronic disease, b) minimum body surface area (BSA) involvement of greater than or equal to 5% OR involvement of the palms, soles, head, neck or genitalia, c) tried and failed at least 1 topical agent (topical steroid, calcipotriene, or tazarotene) , AND d) tried and failed at least 1 systemic therapy (cyclosporine, methotrexate, or acitretin) OR phototherapy. 5. Psoriatic Arthritis in patients with active disease. In addition, use of Humira or Remicade is considered medically necessary for the treatment of: 1. Moderate to severe Crohn's Disease in patients that have tried and failed at least 2 of the following: immunomodulators, corticosteroids, or aminosalicylates. 2. Treatment of moderately to severely active ulcerative colitis in patients who have had inadequate response to at least 2 of the following: corticosteroids, sulfasalazine, mesalamine, azathioprine, 6-mercaptopurine. Use of Humira will also be considered medically necessary for the treatment of hidradenitis suppurativa and uveitis. Use of Remicade will also be considered medically necessary for the treatment of fistulizing Crohn's disease. B vs D determination required for Remicade.	
REMODULIN	Part D vs. Part B Prior Authorization Only							12 months		
REPATHA	Prior Authorization Applies	REPATHA	All medically accepted indications not otherwise excluded from Part D.		Diagnosis of one of the following: Clinical atherosclerotic cardiovascular disease OR Heterozygous familial hypercholesterolemia (HeFH) (confirmed by genetic testing or WHO/Dutch Lipid Group criteria or Simon-Broome criteria) OR Homozygous Familial Hypercholesterolemia (HoFH) (confirmed by either: Genetic testing or History of untreated low-density lipoprotein cholesterol (LDL-C) greater than 500mg/dl or treated LDL > 300mg/dl with either: presence of xanthomas before the age of 10 years or evidence of heterozygous familial hypercholesterolemia in both parents)		Prescriber must be cardiologist, endocrinologist, or lipid specialist	6 mo. Reauthorization for 12 mo requires documented evidence of clinical beneficial response	For atherosclerotic cardiovascular disease (ASCVD) or heterozygous familial hypercholesterolemaia (HeFH):Patient is on high-intensity statin therapy or maximally tolerated statin therapy, is not at LDL-C level goal, and will be continued on high intensity or maximally tolerated statin therapy while on Repatha. For Homozygous Familial Hypercholesterolemia (HoFH): Patient will is on high-intensity or maximally tolerated lipid lowering therapy (such as statins and/or Zetia), is not at LDL-C level goal, and will be continued on high intensity or maximally tolerated lipid lowering therapy while on Repatha.	
REPATHA PUSHTRONEX	Prior Authorization Applies	REPATHA	All medically accepted indications not otherwise excluded from Part D.		Diagnosis of one of the following: Clinical atherosclerotic cardiovascular disease OR Heterozygous familial hypercholesterolemia (HeFH) (confirmed by genetic testing or WHO/Dutch Lipid Group criteria or Simon-Broome criteria) OR Homozygous Familial Hypercholesterolemia (HoFH) (confirmed by either: Genetic testing or History of untreated low-density lipoprotein cholesterol (LDL-C) greater than 500mg/dl or treated LDL > 300mg/dl with either: presence of xanthomas before the age of 10 years or evidence of heterozygous familial hypercholesterolemia in both parents)		Prescriber must be cardiologist, endocrinologist, or lipid specialist	6 mo. Reauthorization for 12 mo requires documented evidence of clinical beneficial response	For atherosclerotic cardiovascular disease (ASCVD) or heterozygous familial hypercholesterolemaia (HeFH):Patient is on high-intensity statin therapy or maximally tolerated statin therapy, is not at LDL-C level goal, and will be continued on high intensity or maximally tolerated statin therapy while on Repatha. For Homozygous Familial Hypercholesterolemia (HoFH): Patient will is on high-intensity or maximally tolerated lipid lowering therapy (such as statins and/or Zetia), is not at LDL-C level goal, and will be continued on high intensity or maximally tolerated lipid lowering therapy while on Repatha.	
REPATHA SURECLICK	Prior Authorization Applies	REPATHA	All medically accepted indications not otherwise excluded from Part D.		Diagnosis of one of the following: Clinical atherosclerotic cardiovascular disease OR Heterozygous familial hypercholesterolemia (HeFH) (confirmed by genetic testing or WHO/Dutch Lipid Group criteria or Simon-Broome criteria) OR Homozygous Familial Hypercholesterolemia (HoFH) (confirmed by either: Genetic testing or History of untreated low-density lipoprotein cholesterol (LDL-C) greater than 500mg/dl or treated LDL > 300mg/dl with either: presence of xanthomas before the age of 10 years or evidence of heterozygous familial hypercholesterolemia in both parents)		Prescriber must be cardiologist, endocrinologist, or lipid specialist	6 mo. Reauthorization for 12 mo requires documented evidence of clinical beneficial response	For atherosclerotic cardiovascular disease (ASCVD) or heterozygous familial hypercholesterolemaia (HeFH):Patient is on high-intensity statin therapy or maximally tolerated statin therapy, is not at LDL-C level goal, and will be continued on high intensity or maximally tolerated statin therapy while on Repatha. For Homozygous Familial Hypercholesterolemia (HoFH): Patient will is on high-intensity or maximally tolerated lipid lowering therapy (such as statins and/or Zetia), is not at LDL-C level goal, and will be continued on high intensity or maximally tolerated lipid lowering therapy while on Repatha.	

REVLIMID	Prior Authorization Applies to New Starts Only	Revlimid	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis			12 months		
RIBASPHERE	Prior Authorization Applies	Immune Stimulants, Non-Vaccine	All medically accepted indications not otherwise excluded from Part D.		Documentation of genotype to determine length of therapy			12 to 48 weeks based on indication and established treatment guidelines.		
RIBASPHERE RIBAPAK	Prior Authorization Applies	Immune Stimulants, Non-Vaccine	All medically accepted indications not otherwise excluded from Part D.		Documentation of genotype to determine length of therapy			12 to 48 weeks based on indication and established treatment guidelines.		
RIBATAB	Prior Authorization Applies	Immune Stimulants, Non-Vaccine	All medically accepted indications not otherwise excluded from Part D.		Documentation of genotype to determine length of therapy			12 to 48 weeks based on indication and established treatment guidelines.		
RIBAVIRIN	Prior Authorization Applies	Immune Stimulants, Non-Vaccine	All medically accepted indications not otherwise excluded from Part D.		Documentation of genotype to determine length of therapy			12 to 48 weeks based on indication and established treatment guidelines.		
RITUXAN	Prior Authorization Applies to New Starts Only	Antineoplastics, Monoclonal Antibodies	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D coverage determination	
ROSUVASTATIN	Prior Authorization Applies	ROSUVASTATIN	All medically accepted indications not otherwise excluded from Part D.		Documentation from the provider that patient has had a trial and failure of brand Crestor			12 months	The patient must have a trial and failure of brand Crestor before rosuvastatin calcium would be approved.	
SABRIL	Prior Authorization Applies to New Starts Only	Sabril	All medically accepted indications not otherwise excluded from Part D.		Documentation from the medical record of diagnosis and past medication history.			12 months	Sabril is considered medically necessary in patients that have failed to receive a clinically appropriate response from optimal doses and administration of at least two of the following: phenytoin, Depakote (divalproex), Lamotrigine, and Keppra (levetiracetam). For the indication of Infantile Spasms failure of another drug(s) is not required.	
SAIZEN	Prior Authorization Applies	Pituitary Hormones	All medically accepted indications not otherwise excluded from Part D.					12 months		
SAIZEN CLICK.EASY	Prior Authorization Applies	Pituitary Hormones	All medically accepted indications not otherwise excluded from Part D.					12 months		
SAMSCA	Prior Authorization Applies	Samsca	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis			Maximum of 30 days for each course of treatment (initial or retreatment)	Samsca is considered medically necessary for the treatment of patients with significant hypervolemic and euvolemic hyponatremia (serum sodium less than 125 mEq/L) or symptomatic hyponatremia that has not been corrected with restriction of fluids including heart failure and Syndrome of Inappropriate Antidiuretic Hormone (SIADH).	
SANDIMMUNE	Prior Authorization Applies to New Starts Only	IMMUNE SUPPRESSANTS - TRANSPLANT RELATED	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D determination.	
SANDOSTATIN LAR DEPOT	Prior Authorization Applies	HORMONAL AGENTS, SOMATOSTATIN ANALOGS	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis			6 months		
SIGNIFOR	Prior Authorization Applies	SIGNIFOR	All medically accepted indications not otherwise excluded from Part D.					12 months		

SILDENAFIL	Prior Authorization Applies	Phosphodiesterase Type 5 (PDE5 Inhibitors)	All FDA-approved indications not otherwise excluded from Part D.		Medical documentation of pulmonary arterial hypertension			12 months		
SILDENAFIL CITRATE	Prior Authorization Applies	Phosphodiesterase Type 5 (PDE5 Inhibitors)	All FDA-approved indications not otherwise excluded from Part D.		Medical documentation of pulmonary arterial hypertension			12 months		
SIMULECT	Part D vs. Part B Prior Authorization Only							12 months		
SIROLIMUS	Prior Authorization Applies to New Starts Only	IMMUNE SUPPRESSANTS - TRANSPLANT RELATED	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D determination.	
SIRTURO	Prior Authorization Applies	SIRTURO	All medically accepted indications not otherwise excluded from Part D.		Documentation from the medical record required indicating the patient has multi-drug resistant tuberculosis resistant to isoniazid and rifampin	The patient must be 18 years of age or older.		6 months	Use of Sirturo for the treatment of multi-drug resistant tuberculosis is considered medically necessary in patients with multi-drug resistant tuberculosis in combination with at least 3 other agents.	
SODIUM LACTATE	Part D vs. Part B Prior Authorization Only							12 months		
SOMATULINE DEPOT 120MG/0.5ML	Prior Authorization Applies to New Starts Only	HORMONAL AGENTS, SOMATOSTATIN ANALOGS	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis			6 months		
SOMATULINE DEPOT 60MG/0.2ML & 90MG/0.3ML	Prior Authorization Applies	HORMONAL AGENTS, SOMATOSTATIN ANALOGS	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis			6 months		
SOMAVERT	Prior Authorization Applies	Endocrine and Metabolic Agents	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis			12 months		
SOVALDI	Prior Authorization Applies	SOVALDI	All medically accepted indications not otherwise excluded from Part D.		Documentation from the medical record of diagnosis including genotype, current medication regimen, HCV-RNA levels, history of previous HCV therapies and presence/absence of cirrhosis.		Hepatologist, gastroenterologist, infectious disease specialist or managed by a liver transplant center.	12 to 48 weeks, based on indication and established treatment guidelines	Must be used with other concurrent therapy based on indication and established treatment guidelines. For genotype 1, clinical information must be provided confirming the patient is not a candidate for Harvoni before combination therapy with Olysio and Sovaldi will be authorized.	
SPORANOX	Prior Authorization Applies	Antifungals, Superficial and Systemic	All medically accepted indications not otherwise excluded from Part D.					3-12 months depending on the indication	For the treatment of tinea versicolor or ptyriasis, use of oral ketoconazole or a topical antifungal agent is required prior to the use of Itraconazole. For candidiasis infections (unless specified C. glabrata or C. krusei) use of fluconazole is required prior to the use of Itraconazole.	
SPRYCEL	Prior Authorization Applies to New Starts Only	Molecular Target Inhibitors	All medically accepted indications not otherwise excluded from Part D.					12 months		
STIVARGA	Prior Authorization Applies to New Starts Only	Molecular Target Inhibitors	All medically accepted indications not otherwise excluded from Part D.					12 months		
SUBOXONE	Prior Authorization Applies	Opioid Agonist-Antagonist Analgesics	All FDA-approved indications not otherwise excluded from Part D.		Documentation of opioid dependence. Documentation that patient is involved in a comprehensive addiction care program that incorporates non drug therapy			Buprenorphine-1 month, or 6 mo if pregnant/hypersensitive to naloxone. Suboxone (bup/nalox)-6 mo	The use of buprenorphine for maintenance therapy should be limited to patients who have experienced a hypersensitivity reaction to naloxone or require buprenorphine during pregnancy.	
SURMONTIL	Prior Authorization Applies to New Starts Only	HRM - Tricyclic Antidepressants	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent, AND the physician has documented that the patient has tried and failed two (2) safer formulary alternatives or provided clinical rationale why two safer formulary alternatives are not appropriate for the patient.	Automatic approval if member is less than 65 years of age. Prior Authorization is required for age 65 or older.		Approval duration is through the end of the plan year.	Safer alternatives depend on indication. For Depression, safer alternatives are: Nortriptyline, Protriptyline, Desipramine, Amoxapine, Citalopram, Venlafaxine, Fluoxetine, Paroxetine, Sertraline, Duloxetine, and Bupropion. For headache prophylaxis, safer alternatives are: Propranolol, Topiramate, and Divalproex sodium. For headache treatment, safer alternatives are: Sumatriptan, Naratriptan, and Dihydroergotamine. For Pain/Neuropathy, safer alternatives are: Duloxetine, Lyrica, and Gabapentin.	

SUTENT	Prior Authorization Applies to New Starts Only	Molecular Target Inhibitors	All medically accepted indications not otherwise excluded from Part D.					12 months		
SYLATRON	Prior Authorization Applies to New Starts Only	Sylatron	All medically accepted indications not otherwise excluded from Part D		Documentation of Diagnosis			12 months	Sylatron is considered medically necessary in patients with a diagnosis of malignant melanoma	
SYMLINPEN 120 (Non-formulary for Cigna-HealthSpring Secure (PDP) and Cigna-HealthSpring Secure-Extra (PDP))	Prior Authorization Applies	Amylin Analog	All medically accepted indications not otherwise excluded from Part D.	Hemoglobin A1C less than 7% prior to initiating Amylin Analog therapy	Documentation of past and current medication history			12months	The member must have documentation of previous insulin failure and documentation of continuation of insulin therapy concomitantly with the requested drug	
SYMLINPEN 60 (Non-formulary for Cigna-HealthSpring Secure (PDP) and Cigna-HealthSpring Secure-Extra (PDP))	Prior Authorization Applies	Amylin Analog	All medically accepted indications not otherwise excluded from Part D.	Hemoglobin A1C less than 7% prior to initiating Amylin Analog therapy	Documentation of past and current medication history			12months	The member must have documentation of previous insulin failure and documentation of continuation of insulin therapy concomitantly with the requested drug	
SYNAGIS	Prior Authorization Applies	Synagis	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis			6 months		
SYNAREL	Prior Authorization Applies	Pituitary Hormones	All medically accepted indications not otherwise excluded from Part D.					12 months		
SYNRIBO	Prior Authorization Applies to New Starts Only	Molecular Target Inhibitors	All medically accepted indications not otherwise excluded from Part D.					12 months		
TACROLIMUS	Prior Authorization Applies to New Starts Only	IMMUNE SUPPRESSANTS - TRANSPLANT RELATED	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D determination.	
TAFINLAR	Prior Authorization Applies to New Starts Only	Molecular Target Inhibitors	All medically accepted indications not otherwise excluded from Part D.					12 months		
TAGRISSO	Prior Authorization Applies to New Starts Only	Molecular Target Inhibitors	All medically accepted indications not otherwise excluded from Part D.					12 months		
TARCEVA	Prior Authorization Applies to New Starts Only	Molecular Target Inhibitors	All medically accepted indications not otherwise excluded from Part D.					12 months		
TASIGNA	Prior Authorization Applies to New Starts Only	Molecular Target Inhibitors	All medically accepted indications not otherwise excluded from Part D.					12 months		
TAXOTERE (PA applies to Cigna-HealthSpring Rx Secure (PDP) ONLY, otherwise non-formulary)	Part D vs. Part B Prior Authorization Only							12 months		
TECENTRIQ	Prior Authorization Applies to New Starts Only	Antineoplastics, Monoclonal Antibodies	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D coverage determination	
TESTIM	Prior Authorization Applies	ANABOLIC STEROIDS, ANDROGENS	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis.			12 months		
TESTOSTERONE CYPIONATE	Prior Authorization Applies	ANABOLIC STEROIDS, ANDROGENS	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis.			12 months		
TESTOSTERONE ENANTHATE	Prior Authorization Applies	ANABOLIC STEROIDS, ANDROGENS	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis.			12 months		
TESTOSTERONE PUMP (NON-FORMULARY FOR PDP SECURE AND PDP SECURE-EXTRA)	Prior Authorization Applies	anabolic steroids, androgens	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis.			12 months		
TETRABENAZINE	Prior Authorization Applies	Xenazine	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis of chorea associated with Huntington's Disease. CYP 2D6 genotype must be provided for doses greater than 50mg/day.			12 months		
THALOMID	Prior Authorization Applies to New Starts Only	Thalidomide (Thalomid)	All medically accepted indications not otherwise excluded from Part D.					12 months		

THIORIDAZINE HCL	Prior Authorization Applies to New Starts Only	HRM - 1st Generation Antipsychotics	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent, AND the physician has documented that the patient has tried and failed two (2) safer formulary alternatives or provided clinical rationale why two safer formulary alternatives are not appropriate for the patient.	Automatic approval if member is less than 65 years of age. Prior Authorization is required for age 65 or older.		Approval duration is through the end of the plan year.	Safer alternatives are: Risperidone, Quetiapine, Aripiprazole, Olanzapine, Saphris, and Ziprasidone.	
THIOTEPA	Prior Authorization Applies to New Starts Only	Thiotepa	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D Determination	
THYMOGLOBULIN	Part D vs. Part B Prior Authorization Only							12 months		
TOBRAMYCIN	Part D vs. Part B Prior Authorization Only							12 months		
TOPOSAR	Part D vs. Part B Prior Authorization Only							12 months		
TORISEL	Part D vs. Part B Prior Authorization Only							12 months		
TPN ELECTROLYTES	Part D vs. Part B Prior Authorization Only							12 months		
TRACLEER (NF for PDP Secure)	Prior Authorization Applies	Vasodilators	All FDA-approved indications not otherwise excluded from Part D.		Documentation of pulmonary arterial hypertension			12 months		
TRANEXAMIC ACID	Prior Authorization Applies	COAGULANTS, PROTEASE INHIBITORS	All medically accepted indications not otherwise excluded from Part D.					10 days		
TRAVASOL	Part D vs. Part B Prior Authorization Only							12 months		
TREANDA	Part D vs. Part B Prior Authorization Only							12 months		
TRELSTAR	Prior Authorization Applies to New Starts Only	Pituitary Hormones	All medically accepted indications not otherwise excluded from Part D.					12 months		
TRELSTAR MIXJECT	Prior Authorization Applies to New Starts Only	Pituitary Hormones	All medically accepted indications not otherwise excluded from Part D.					12 months		
TRETINOIN	Prior Authorization Applies	Dermatological retinoids	All medically accepted indications not otherwise excluded from Part D.					12 months		
TRETINOIN MICROSPHERE	Prior Authorization Applies	Dermatological retinoids	All medically accepted indications not otherwise excluded from Part D.					12 months		
TRETINOIN MICROSPHERE PUMP	Prior Authorization Applies	Dermatological retinoids	All medically accepted indications not otherwise excluded from Part D.					12 months		
TRIHEXYPHENIDYL HCL	Prior Authorization Applies	HRM - Trihexyphenidyl	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent.	Automatic approval if member is less than 65 years of age. Prior Authorization is required for age 65 or older.		Approval duration is through the end of the plan year.		
TRIMIPRAMINE MALEATE	Prior Authorization Applies to New Starts Only	HRM - Tricyclic Antidepressants	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent, AND the physician has documented that the patient has tried and failed two (2) safer formulary alternatives or provided clinical rationale why two safer formulary alternatives are not appropriate for the patient.	Automatic approval if member is less than 65 years of age.Prior Auth required for age 65 or older.		Approval duration is through the end of the plan year.	Safer alternatives depend on indication. For Depression, safer alternatives are: Nortriptyline, Protriptyline, Desipramine, Amoxapine, Citalopram, Venlafaxine, Fluoxetine, Paroxetine, Sertraline, Duloxetine, and Bupropion. For headache prophylaxis, safer alternatives are: Propranolol, Topiramate, and Divalproex sodium. For headache treatment, safer alternatives are: Sumatriptan, Naratriptan, and Dihydroergotamine. For Pain/Neuropathy, safer alternatives are: Duloxetine, Lyrica, and Gabapentin.	
TRISENOX	Part D vs. Part B Prior Authorization Only							12 months		
TROPHAMINE	Part D vs. Part B Prior Authorization Only							12 months		

TYKERB	Prior Authorization Applies to New Starts Only	Molecular Target Inhibitors	All medically accepted indications not otherwise excluded from Part D.					12 months		
TYSABRI	Prior Authorization Applies	TYSABRI	All medically accepted indications not otherwise excluded from part D.					12 months	Treatment of relapsing forms of multiple sclerosis (MS) when EITHER of the following criteria is met: 1) history of beneficial clinical response to Tysabri® (natalizumab) for MS or failure, contraindication or intolerance to one formulary alternative (eg. Avonex®, Copaxone® or Rebif®). Treatment of moderately to severely active Crohn's disease (CD) when EITHER of the following criteria is met: 1) history of beneficial clinical response to Tysabri® (natalizumab) for CD or 2) failure, contraindication, intolerance, or inadequate response to one conventional therapy (eg. aminosalicylate, corticosteroids, or immunomodulators) AND failure or intolerance to Humira®.	
TYZEKA	Prior Authorization Applies	Tyzeka	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis.	Adults and adolescents 16 years of age and older		12 months	Coverage is provided for Chronic Hepatitis B.	
UNITUXIN	Prior Authorization Applies to New Starts Only	Antineoplastics, Monoclonal Antibodies	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D coverage determination	
UVADEX	Part D vs. Part B Prior Authorization Only							12 months		
VALCHLOR	Prior Authorization Applies to New Starts Only	Valchlor Gel	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis and past medical history.			12 months	Valchlor Topical Gel is considered medically necessary for the treatment of patients with Stage 1A and 1B mycosis fungoides-type cutaneous T-cell lymphoma who have received prior skin-directed therapy.	
VECTIBIX	Part D vs. Part B Prior Authorization Only							12 months		
VELCADE	Part D vs. Part B Prior Authorization Only							12 months		
VENCLEXTA	Prior Authorization Applies to New Starts Only	VENCLEXTA	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis			12 months		
VINBLASTINE SULFATE	Part D vs. Part B Prior Authorization Only							12 months		
VINCASAR PFS	Part D vs. Part B Prior Authorization Only							12 months		
VINCRISTINE SULFATE	Part D vs. Part B Prior Authorization Only							12 months		
VINORELBINE TARTRATE	Part D vs. Part B Prior Authorization Only							12 months		
VIRAZOLE	Part D vs. Part B Prior Authorization Only							12 months		
VIVELLE-DOT (PA applies to Cigna-HealthSpring Rx Secure (PDP) ONLY, otherwise non-formulary)	Prior Authorization Applies	HRM - Estrogens	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent, AND the physician has documented that the patient has tried and failed two (2) safer formulary alternatives or provided clinical rationale why two safer formulary alternatives are not appropriate for the patient.	Automatic approval if member is less than 65 years of age. Prior Authorization is required for age 65 or older.		Approval duration is through the end of the plan year.	Safer alternatives to the estrogen high risk medications depend on the indication. For Hot Flashes, safer alternatives are: Estradiol Valerate, Depo-Estradiol, SSRIs, venlafaxine, gabapentin, and Femring. For Vaginal Symptoms of menopause, safer alternatives are: Premarin Cream, Estring, Femring, and Estradiol Valerate. For Bone Density, safer alternatives are: alendronate, risedronate, raloxifene, and Prolia.	
VORICONAZOLE	Prior Authorization Applies	Antifungals, Azole	All medically accepted indications not otherwise excluded from Part D.		Documented fungal culture and or notes from medical record suggestive of a serious fungal infection			3 to 6 months, depending on indication		
VOTRIENT	Prior Authorization Applies to New Starts Only	Antiangiogenic Agents	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis.			12 months	Votrient is considered medically necessary for the treatment of patients with a diagnosis of 1.) advanced renal cell carcinoma OR 2.) advanced soft tissue sarcoma who have received prior chemotherapy.	

VPRIV	Prior Authorization Applies	Vpriv	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis			12 months	B vs D determination.	
XALKORI	Prior Authorization Applies to New Starts Only	Molecular Target Inhibitors	All medically accepted indications not otherwise excluded from Part D.					12 months		
XARELTO (PA applies to Cigna-HealthSpring Rx Secure (PDP) and Cigna-HealthSpring Rx Secure-Extra (PDP) ONLY)	Prior Authorization Applies	Oral Factor Xa Inhibitors/Oral DTIs	All medically accepted indications not otherwise excluded from Part D.		Documentation of Diagnosis			3 to 12 months depending on indication and clinical information provided		
XARELTO STARTER PACK (PA applies to Cigna-HealthSpring Secure (PDP) and Cigna-HealthSpring Secure-Extra (PDP) ONLY)	Prior Authorization Applies	Oral Factor Xa Inhibitors/Oral DTIs	All medically accepted indications not otherwise excluded from Part D.		Documentation of Diagnosis			3 to 12 months depending on indication and clinical information provided		
XENAZINE	Prior Authorization Applies	Xenazine	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis of chorea associated with Huntington's Disease. CYP 2D6 genotype must be provided for doses greater than 50mg/day.			12 months		
XGEVA	Prior Authorization Applies	Xgeva	All medically accepted indications not otherwise excluded from Part D					12 Months		
XIFAXAN	Prior Authorization Applies	Xifaxan	All medically accepted indications not otherwise excluded from Part D.					12 months		
XOLAIR	Prior Authorization Applies	Monoclonal Antibodies	All medically accepted indications not otherwise excluded from Part D.		For the diagnosis of asthma: Laboratory data reflecting IgE levels greater than 30 but less than 1500 IU/mL , medical history documenting previous trial and response to inhaled corticosteroids and a leukotriene receptor antagonist. For the diagnosis of chronic idiopathic urticaria (CIU): Documentation that the patient has remained symptomatic despite at least 2 weeks of one H1 antihistamine therapy.			12 months		
XTANDI	Prior Authorization Applies to New Starts Only	XTANDI	All medically accepted indications not otherwise excluded from Part D		Documentation from medical records of diagnosis			12 months	Xtandi is considered medically necessary in patients who have a diagnosis of metastatic castration-resistant prostate cancer.	
XYREM	Prior Authorization Applies	Xyrem	All FDA-approved indications not otherwise excluded from Part D.		Documentation of diagnosis, sleep study, and enrollment in Xyrem REMS Program.	Must be 18 years of age or older.		12 months	Use of Xyrem is considered medically necessary in patients with narcolepsy experiencing excessive daytime sleepiness and cataplexy. The patient must not be taking any sedative hypnotic agents or other CNS depressants.	
YERVOY	Part D vs. Part B Prior Authorization Only							12 months		
YONDELIS	Prior Authorization Applies	YONDELIS	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D determination	
ZALTRAP	Prior Authorization Applies to New Starts Only	Antineoplastics, Monoclonal Antibodies	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D coverage determination	
ZANOSAR	Part D vs. Part B Prior Authorization Only							12 months		
ZARXIO	Prior Authorization Applies	Colony stimulating factors	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis and either CBC with differential or ANC. For the harvesting of peripheral blood stem cells, CBC with differential or ANC is NOT required.			6 months		

ZEBUTAL	Prior Authorization Applies	HRM - Butalbital Combinations	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent, AND the physician has documented that the patient has tried and failed two (2) safer formulary alternatives or provided clinical rationale why two safer formulary alternatives are not appropriate for the patient.	Automatic approval if member is less than 65 years of age. Prior Authorization is required for age 65 or older.		Approval duration is through the end of the plan year.	Safer alternatives are: naproxen sodium and ibuprofen.	
ZELBORAF	Prior Authorization Applies to New Starts Only	Zelboraf	All medically accepted indications not otherwise excluded from Part D.		Documentation of accepted genetic test results			12 months		
ZEMAIRA	Part D vs. Part B Prior Authorization Only							12 months		
ZINECARD (PA applies to Cigna-HealthSpring Rx Secure (PDP) ONLY, otherwise non-formulary)	Part D vs. Part B Prior Authorization Only							12 months		
ZOLEDRONIC ACID	Part D vs. Part B Prior Authorization Only							12 months		
ZOLPIDEM TARTRATE (PA applies to all EXCEPT Cigna-HealthSpring Rx Secure (PDP))	Prior Authorization Applies	HRM - Sedative Hypnotics	All medically accepted indications not otherwise excluded from Part D.		The physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk, AND the physician has documented the ongoing monitoring plan for the agent, AND the physician has documented that the patient has tried and failed two (2) safer formulary alternatives or provided clinical rationale why two safer formulary alternatives are not appropriate for the patient.	Automatic approval if member is less than 65 years of age. Prior Authorization is required for age 65 or older.		Approval duration is through the end of the plan year.	Safer alternatives are: Rozerem and Silenor.	
ZOMETA (PA applies to Cigna-HealthSpring Rx Secure (PDP) ONLY, otherwise non-formulary)	Part D vs. Part B Prior Authorization Only							12 months		
ZORTRESS	Prior Authorization Applies to New Starts Only	IMMUNE SUPPRESSANTS - TRANSPLANT RELATED	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D determination.	
ZYDELIG	Prior Authorization Applies to New Starts Only	Molecular Target Inhibitors	All medically accepted indications not otherwise excluded from Part D.					12 months		
ZYKADIA	Prior Authorization Applies to New Starts Only	Molecular Target Inhibitors	All medically accepted indications not otherwise excluded from Part D.					12 months		
ZYTIGA	Prior Authorization Applies to New Starts Only	Zytiga	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis			12 months	Zytiga is approved for use in combination with prednisone.	
ZYVOX	Prior Authorization Applies	Antibacterials, other	All medically accepted indications not otherwise excluded from Part D.		Documentation from the medical record of diagnosis, site of infection, recent culture and sensitivity data, current or previous treatment for infection.			1 to 3 months	Use of linezolid is considered medically necessary for use in infections resulting from VRE and MRSA. Linezolid is also considered medically accepted for other clinically appropriate infections when drug allergies prevent the use of clinically appropriate 1st-line agents in other infections.	