2018 Cigna-HealthSpring Prior Authorization Criteria

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	Prior authorization applies to new starts only (B vs D applies to all)	Abraxane	All medically accepted indications not otherwise excluded from Part D.					12 months	BvsD coverage determination	
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		
ACTEMRA	Prior authorization applies	Actemra	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis and past medication history.			12 months	Use of Actemra is considered medically necessary for the treatment of rheumatoid arthritis (RA) when BOTH of the following criteria are met: 1) 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 2) failure, contraindication or intolerance to Enbrel or Humira. Use of Actemra will also be considered medically necessary for the treatment of polyarticular juvenile idiopathic arthritis (PJIA), systemic juvenile idiopathic arthritis (SJIA), giant cell arteritis (GCA) and chimeric antigen receptor (CAR) T cell-induced cytokine release syndrome (CRS). B vs D coverage determination required for Actemra IV.	
ACTIMMUNE	Prior authorization applies to new starts only	Actimmune	All medically accepted indications not otherwise excluded from Part D.					12 months		
ACYCLOVIR SODIUM	Part D vs. Part B prior authorization only							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	Prior authorization applies to new starts only (B vs D applies to all)	Alimta	All medically accepted indications not otherwise excluded from Part D.					12 months	BvsD coverage determination	
ALIQOPA	Prior authorization applies to new starts only (B vs D applies to all)	Antineoplastics, Monoclonal Antibodies	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D coverage determination	

ALORA (MAPD plans)	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 will continue to monitor for side effects, 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 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: Depo-Estradiol, SSRIs, venlafaxine, gabapentin, and Femring. For Vaginal Symptoms of menopause, safer alternatives are: Premarin Cream, Estring, and Femring. For Bone Density, safer alternatives are: alendronate, risedronate, raloxifene, and Prolia.	
ALORA (PDP SECURE and PDP SECURE EXTRA)	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 will continue to monitor for side effects, 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 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: Depo-Estradiol, SSRIs, venlafaxine, gabapentin, and Femring. For Vaginal Symptoms of menopause, safer alternatives are: Premarin Cream, Estring, and Femring. For Bone Density, safer alternatives are: alendronate, raloxifene, and Prolia.	
ALOSETRON HYDROCHLORIDE	Prior authorization applies	Alosetron	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 PDP Secure, PDP Secure-Extra)	Part D vs. Part B prior authorization only							12 months		
ALUNBRIG	Prior authorization applies to new starts only	Molecular Target Inhibitors	All medically accepted indications not otherwise excluded from Part D.					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-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 will continue to monitor for side effects.	Automatic approval if member is less than 65 years of age. Prior authorization required for age 65 or older.		Approval duration is through the end of the plan year.		
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		
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		
APREPITANT	Part D vs. Part B prior authorization only							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 initial treatment of anemia, documentation of Hemoglobin less than 10, transferrin saturation greater than 20%, and ferritin levels greater than 100 obtained over the last 3 months. For reauthorizations, approvals granted if Hemoglobin does not exceed 10-12g/dL or approvals granted if Hemoglobin does not exceed 10-13g/dL for the indication of reduction of allogeneic red cell transfusions in patients undergoing elective, noncardiac, nonvascular surgery.			6 months	B vs D coverage 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 will continue to monitor for side effects, 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 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 (B vs D applies to all)	IMMUNE SUPPRESSANTS - TRANSPLANT RELATED	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D coverage determination	
ATGAM	Prior authorization applies to new starts only (B vs D applies to all)	IMMUNE SUPPRESSANTS - TRANSPLANT RELATED	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D coverage determination	
AVASTIN	Prior authorization applies to new starts only (B vs D applies to all)	Antineoplastics, Monoclonal Antibodies	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D coverage determination	
AVITA	Prior authorization applies	Dermatological retinoids	All medically accepted indications not otherwise excluded from Part D.					12 months		
AVONEX PEN (PDP Secure)	Prior authorization applies	Immunomodulators	All medically accepted indications not otherwise excluded from Part D.					12 months		
AVONEX (All plans except PDP Secure)	Prior authorization applies	Immunomodulators	All medically accepted indications not otherwise excluded from Part D.					12 months	Patient must have failure, contraindication or intolerance to two of the following: Avonex, Betaseron, Copaxone, Gilenya and Tecfidera before Rebif will be authorized.	

AVONEX (PDP Secure)	Prior authorization applies	Immunomodulators	All medically accepted indications not otherwise excluded from Part D.					12 months		
AVONEX PEN (All plans except PDP Secure)	Prior authorization applies	Immunomodulators	All medically accepted indications not otherwise excluded from Part D.					12 months	Patient must have failure, contraindication or intolerance to two of the following: Avonex, Betaseron, Copaxone, Gilenya and Tecfidera before Rebif will be authorized.	
AZACITIDINE	Part D vs. Part B prior authorization only							12 months		
AZASAN	Prior authorization applies to new starts only (B vs D applies to all)	IMMUNE SUPPRESSANTS - TRANSPLANT RELATED	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D coverage determination	
AZATHIOPRINE	Prior authorization applies to new starts only (B vs D applies to all)	IMMUNE SUPPRESSANTS - TRANSPLANT RELATED	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D coverage 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		
BAVENCIO	Prior authorization applies to new starts only (B vs D applies to all)	Antineoplastics, Monoclonal Antibodies	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D coverage determination	
BELEODAQ	Prior authorization applies to new starts only (B vs D applies to all)	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)			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. B vs D coverage 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 will continue to monitor for side effects, 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 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.	
BESPONSA	Prior authorization applies to new starts only (B vs D applies to all)	Antineoplastics, Monoclonal Antibodies	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D coverage determination	
BETASERON (PDP Secure)	Prior authorization applies	Immunomodulators	All medically accepted indications not otherwise excluded from Part D.					12 months		
BETASERON (All plans except PDP Secure)	Prior authorization applies	Immunomodulators	All medically accepted indications not otherwise excluded from Part D.					12 months	Patient must have failure, contraindication or intolerance to two of the following: Avonex, Betaseron, Copaxone, Gilenya and Tecfidera before Rebif will be authorized.	

BICNU	Part D vs. Part B prior authorization only							12 months		
BLEOMYCIN SULFATE	Part D vs. Part B prior authorization only							12 months		
BORTEZOMIB	Prior authorization applies to new starts only (B vs D applies to all)	Velcade	All medically accepted indications not otherwise excluded from Part D.					12 months	BvsD coverage determination	
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		
BUPHENYL	Prior authorization applies	BUPHENYL	All medically accepted indications not otherwise excluded from Part D.					12 months		
BUPRENORPHINE HCL	Prior authorization applies	Opioid Agonist-Antagonist Analgesics	All medically accepted indications not otherwise excluded from Part D.		Documentation of opioid dependence.			Buprenorphine-1 mo or 6 mo if preg/hypersensitive to naloxone. Zubsolv, Subox, and 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 medically accepted indications not otherwise excluded from Part D.		Documentation of opioid dependence.			Buprenorphine-1 mo or 6 mo if preg/hypersensitive to naloxone. Zubsolv, Subox, and 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.	
BUSULFAN	Part D vs. Part B prior authorization only							12 months		
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 will continue to monitor for side effects, 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 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 will continue to monitor for side effects, 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 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 will continue to monitor for side effects, 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 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 will continue to monitor for side effects, 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 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	Molecular Target Inhibitors	All medically accepted indications not otherwise excluded from Part D.					12 months		
CALQUENCE	Prior authorization applies to new starts only	Molecular Target Inhibitors	All medically accepted indications not otherwise excluded from Part D.					12 months		
CANCIDAS	Prior authorization applies	Antifungals, Superficial and Systemic	All medically accepted indications not otherwise excluded from Part D.					Onychomycosis (fingernails only) - 2mo. Onychomycosis (toenails) - 3mo. All other indications - 12mo	For the treatment of tinea versicolor or pityriasis, 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.	
CAPACET	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 will continue to monitor for side effects, 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 required for age 65 or older.		Approval duration is through the end of the plan year.	Safer alternatives are: naproxen sodium and ibuprofen.	
CAPRELSA	Prior authorization applies to new starts only	Caprelsa	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis			12 months		
CARBAGLU	Prior authorization applies	CARBAGLU	All medically accepted indications not otherwise excluded from Part D.					12 months		
CARBOPLATIN	Part D vs. Part B prior authorization only							12 months		
CARNITOR	Part D vs. Part B prior authorization only							12 months		
CASPOFUNGIN ACETATE	Prior authorization applies	Antifungals, Superficial and Systemic	All medically accepted indications not otherwise excluded from Part D.					Onychomycosis (fingernails only) - 2mo. Onychomycosis (toenails) - 3mo. All other indications - 12mo	For the treatment of tinea versicolor or pityriasis, 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.	
CAYSTON	Prior authorization applies	CAYSTON	All medically accepted indications not otherwise excluded from Part D.			7 years and older		12 months		
CEREZYME	Part D vs. Part B prior authorization only							12 months		
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 coverage 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		
CLINIMIX N14G30E	Part D vs. Part B prior authorization only							12 months		
CLINIMIX N9G15E	Part D vs. Part B prior authorization only							12 months		
CLINISOL SF 15%	Part D vs. Part B prior authorization only							12 months		
CLOFARABINE	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 will continue to monitor for side effects.	Automatic approval if member is less than 65 years of age. Prior authorization required for age 65 or older.		Approval duration is through the end of the plan year.		
COMETRIQ	Prior authorization applies to new starts only	Molecular Target Inhibitors	All medically accepted indications not otherwise excluded from Part D.					12 months		
COPAXONE (PDP Secure)	Prior authorization applies	Immunomodulators	All medically accepted indications not otherwise excluded from Part D.					12 months		
COPAXONE (All plans except PDP Secure)	Prior authorization applies	Immunomodulators	All medically accepted indications not otherwise excluded from Part D.					12 months	Patient must have failure, contraindication or intolerance to two of the following: Avonex, Betaseron, Copaxone, Gilenya and Tecfidera before Rebif will be authorized.	
CORLANOR	Prior authorization applies	CORLANOR	All medically accepted indications not otherwise excluded from Part D.	1.) Blood pressure less than 90/50 mmHg. 2.) Sick sinus syndrome, sinoatrial block, or 3rd degree AV block, unless a functioning demand pacemaker is present. 3.) Resting heart rate less than 60 bpm prior to treatment. 4.) Pacemaker dependence (heart rate maintained exclusively by the pacemaker).	Documentation of diagnosis, previous use of a beta-blocker, LVEF, sinus rhythm, resting HR, and blood pressure			12 months	The patient must have a diagnosis of chronic heart failure with left ventricular ejection fraction less than or equal to 35%, normal sinus rhythm with resting heart rate greater than or equal to 70 beats per minute, and either be on maximally tolerated doses of beta-blockers or have a contraindication to beta-blocker use.	
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		
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 will continue to monitor for side effects.	Automatic approval if member is less than 65 years of age. Prior authorization 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 (B vs D applies to all)	IMMUNE SUPPRESSANTS - TRANSPLANT RELATED	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D coverage determination	
CYCLOSPORINE MODIFIED	Prior authorization applies to new starts only (B vs D applies to all)	IMMUNE SUPPRESSANTS - TRANSPLANT RELATED	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D coverage determination	
CYRAMZA	Prior authorization applies to new starts only (B vs D applies to all)	Antineoplastics, Monoclonal Antibodies	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D coverage determination	
CYSTARAN	Prior authorization applies	CYSTARAN	All medically accepted indications not otherwise excluded from Part D.					12 months		
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		
DACTINOMYCIN	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 (B vs D applies to all)	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%	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 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%/LACTATED RINGERS	Part D vs. Part B prior authorization only							12 months		

DEXTROSE 50%	Part D vs. Part B prior authorization only							12 months		
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 will continue to monitor for side effects, 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 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 will continue to monitor for side effects, 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 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 will continue to monitor for side effects, 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 required for age 65 or older.		Approval duration is through the end of the plan year.		
DIPYRIDAMOLE (only covered on PDP Secure, PDP Secure-Extra)	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 will continue to monitor for side effects, 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 required for age 65 or older.		Approval duration is through the end of the plan year.	Safer alternatives are: Clopidogrel, Warfarin, Jantoven, and aspririn/dipyridamole .	
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 will continue to monitor for side effects.	Automatic approval if member is less than 65 years of age. Prior authorization required for age 65 or older.		Approval duration is through the end of the plan year.		
DOXORUBICIN HCL	Part D vs. Part B prior authorization only							12 months		
DOXORUBICIN HCL LIPOSOME	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	B vs D coverage determination	

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		
ELITEK	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 (B vs D applies to all)	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 coverage 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 (including formulary biosimilars) 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, AND c.) tried and failed at least 1 topical agent (topical steroid, calcipotriene, or tazarotene) 5.) Psoriatic Arthritis in patients with active disease. In addition, use of Humira or Remicade (including formulary biosimilars) 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 coverage determination required for Remicade (including formulary biosimilars).	
ENBREL MINI	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 (including formulary biosimilars) 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, AND c.) tried and failed at least 1 topical agent (topical steroid, calcipotriene, or tazarotene) 5.) Psoriatic Arthritis in patients with active disease. In addition, use of Humira or Remicade (including formulary biosimilars) 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 coverage determination required for Remicade (including formulary biosimilars).	

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 (including formulary biosimilars) 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, AND c.) tried and failed at least 1 topical agent (topical steroid, calcipotriene, or tazarotene) 5.) Psoriatic Arthritis in patients with active disease. In addition, use of Humira or Remicade (including formulary biosimilars) 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 coverage determination required for Remicade (including formulary biosimilars).	
ENGERIX-B	Part D vs. Part B prior authorization only							12 months		
ENVARSUS XR	Prior authorization applies to new starts only (B vs D applies to all)	IMMUNE SUPPRESSANTS - TRANSPLANT RELATED	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D coverage determination	
EPCLUSA	Prior authorization applies	EPCLUSA	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.			12 weeks, based on indication and established treatment guidelines	For genotype 1, 4, 5 and 6, clinical information must be provided confirming the patient is not a candidate for Harvoni before Epclusa will be authorized.	
EPIRUBICIN HCL	Part D vs. Part B prior authorization only							12 months		
ERBITUX	Prior authorization applies to new starts only (B vs D applies to all)	Antineoplastics, Monoclonal Antibodies	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D coverage determination	
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 will continue to monitor for side effects, 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 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		
ERLEADA	All medically accepted indications not otherwise excluded from Part D.	Erleada			Documentation of diagnosis			12 months	Erleada is approved for use in combination with a gonadotropin-releasing hormone (GnRH) analog or in patients who have had a bilateral orchiectomy. The patient must have a history of failure, intolerance or contraindication to a secondary hormone therapy (ex: bicalutamide, nilutamide, flutamide, Zytiga) before Erleada is authorized.	

ERWINAZE	Part D vs. Part B prior authorization only							12 months		
ESBRIET	Prior authorization applies	ESBRIET	All medically accepted 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 biopsy pattern is diagnostic of IPF or the combination of HRCT and biopsy pattern is indicative of IPF.			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 will continue to monitor for side effects, 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 required for age 65 or older.		Approval duration is through the end of the plan year.	Safer alternatives are: naproxen sodium and ibuprofen.	
ESTRADIOL (MAPD plans)	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 will continue to monitor for side effects, 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 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: Depo-Estradiol, SSRIs, venlafaxine, gabapentin, and Femring. For Vaginal Symptoms of menopause, safer alternatives are: Premarin Cream, Estring, and Femring. For Bone Density, safer alternatives are: alendronate, risedronate, raloxifene, and Prolia.	
ESTRADIOL (PDP SECURE and PDP SECURE EXTRA)	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 will continue to monitor for side effects, 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 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: Depo-Estradiol, SSRIs, venlafaxine, gabapentin, and Femring. For Vaginal Symptoms of menopause, safer alternatives are: Premarin Cream, Estring, and Femring. For Bone Density, safer alternatives are: alendronate, raloxifene, and Prolia.	
ETHYOL	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 (B vs D applies to all)	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 medically accepted 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).	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		
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.	1.) Pediatric patients or young adults with open epiphyses. 2.) History of prior external beam or implant radiation involving the skeleton	1.) Bone mineral density (BMD) by DEXA at hip and spine. 2.) Confirmation of normal serum alkaline phosphatase or provider statement that Paget's disease has been excluded. 3.) Treatment history			2 years from initiation of therapy	Member has a history of at least one osteoporotic fracture while on Bisphosphonate Therapy OR Member has tried and or failed an oral bisphosphonate or SERM OR the member has documented intolerance, contraindication, or hypersensitivity to other osteoporosis therapies. For patients with a T-score less than or equal to -3.5, failure of oral bisphosphonates or SERMs are not required.	
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		
FYAVOLV (MAPD plans)	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 will continue to monitor for side effects, 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 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: Depo-Estradiol, SSRIs, venlafaxine, gabapentin, and Femring. For Vaginal Symptoms of menopause, safer alternatives are: Premarin Cream, Estring, and Femring. For Bone Density, safer alternatives are: alendronate, risedronate, raloxifene, and Prolia.	
FYAVOLV (PDP SECURE and PDP SECURE EXTRA)	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 will continue to monitor for side effects, 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 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: Depo-Estradiol, SSRIs, venlafaxine, gabapentin, and Femring. For Vaginal Symptoms of menopause, safer alternatives are: Premarin Cream, Estring, and Femring. For Bone Density, safer alternatives are: alendronate, raloxifene, and Prolia.	
FYCOMPA (Prior Authorization only required for PDP SECURE and PDP SECURE EXTRA)	Prior authorization applies to new starts only	FYCOMPA	All medically accepted indications not otherwise excluded from Part D.					12 months		
GAMMAKED	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 (B vs D applies to all)	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 (B vs D applies to all)	IMMUNE SUPPRESSANTS - TRANSPLANT RELATED	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D coverage determination	
GENOTROPIN	Prior authorization applies	Pituitary Hormones	All medically accepted indications not otherwise excluded from Part D.					12 months		
GENOTROPIN MINIQUICK	Prior authorization applies	Pituitary Hormones	All medically accepted indications not otherwise excluded from Part D.					12 months		
GILENYA	Prior authorization applies	Gilenya	All medically accepted indications not otherwise excluded from Part D.					12 months		
GILOTRIF	Prior authorization applies to new starts only	Molecular Target Inhibitors	All medically accepted indications not otherwise excluded from Part D.					12 months		
GRANISETRON HCL	Part D vs. Part B prior authorization only							12 months		
HALAVEN	Prior authorization applies to new starts only (B vs D applies to all)	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 coverage 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.			12 to 24 weeks based on indication and established treatment guidelines		
HECORIA	Prior authorization applies to new starts only (B vs D applies to all)	IMMUNE SUPPRESSANTS - TRANSPLANT RELATED	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D coverage determination	
HEPATAMINE	Part D vs. Part B prior authorization only							12 months		
HERCEPTIN	Prior authorization applies to new starts only (B vs D applies to all)	Antineoplastics, Monoclonal Antibodies	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D coverage determination	
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 (including formulary biosimilars) 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, AND c.) tried and failed at least 1 topical agent (topical steroid, calcipotriene, or tazarotene) 5.) Psoriatic Arthritis in patients with active disease. In addition, use of Humira or Remicade (including formulary biosimilars) 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 coverage determination required for Remicade (including formulary biosimilars).	
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 (including formulary biosimilars) 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, AND c.) tried and failed at least 1 topical agent (topical steroid, calcipotriene, or tazarotene) 5.) Psoriatic Arthritis in patients with active disease. In addition, use of Humira or Remicade (including formulary biosimilars) 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 coverage determination required for Remicade (including formulary biosimilars).	

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 (including formulary biosimilars) 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, AND c.) tried and failed at least 1 topical agent (topical steroid, calcipotriene, or tazarotene) 5.) Psoriatic Arthritis in patients with active disease. In addition, use of Humira or Remicade (including formulary biosimilars) 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 coverage determination required for Remicade (including formulary biosimilars).	
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 (including formulary biosimilars) 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, AND c.) tried and failed at least 1 topical agent (topical steroid, calcipotriene, or tazarotene) 5.) Psoriatic Arthritis in patients with active disease. In addition, use of Humira or Remicade (including formulary biosimilars) 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 coverage determination required for Remicade (including formulary biosimilars).	

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 (including formulary biosimilars) 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, AND c.) tried and failed at least 1 topical agent (topical steroid, calcipotriene, or tazarotene) 5.) Psoriatic Arthritis in patients with active disease. In addition, use of Humira or Remicade (including formulary biosimilars) 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 coverage determination required for Remicade (including formulary biosimilars).	
HYDROXYPROGESTERONE CAPROATE	Prior authorization applies to new starts only (B vs D applies to all)	HYDROXYPROGESTERONE	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D coverage determination	
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		
IDHIFA	Prior authorization applies to new starts only	Molecular Target Inhibitors	All medically accepted indications not otherwise excluded from Part D.					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 coverage determination	
IMATINIB MESYLATE	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		
IMFINZI	Prior authorization applies to new starts only (B vs D applies to all)	Antineoplastics, Monoclonal Antibodies	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D coverage determination	
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 will continue to monitor for side effects.	Automatic approval if member is less than 65 years of age. Prior authorization required for age 65 or older.		Approval duration is through the end of the plan year.		
IMOVAX RABIES (H.D.C.V.)	Part D vs. Part B prior authorization only							12 months		

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.			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		
IRINOTECAN HCL	Part D vs. Part B prior authorization only							12 months		
ISTODAX	Prior authorization applies to new starts only (B vs D applies to all)	Istodax	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis and past medication history			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.	
ISTODAX (OVERFILL)	Prior authorization applies to new starts only (B vs D applies to all)	Istodax	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis and past medication history			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.					Onychomycosis (fingernails only) - 2mo. Onychomycosis (toenails) - 3mo. All other indications - 12mo	For the treatment of tinea versicolor or pityriasis, 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		
JEVANTIQUE LO (MAPD plans)	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 will continue to monitor for side effects, 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 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: Depo-Estradiol, SSRIs, venlafaxine, gabapentin, and Femring. For Vaginal Symptoms of menopause, safer alternatives are: Premarin Cream, Estring, and Femring. For Bone Density, safer alternatives are: alendronate, risedronate, raloxifene, and Prolia.	

JEVANTIQUE LO (PDP SECURE and PDP SECURE EXTRA)	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 will continue to monitor for side effects, 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 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: Depo-Estradiol, SSRIs, venlafaxine, gabapentin, and Femring. For Vaginal Symptoms of menopause, safer alternatives are: Premarin Cream, Estring, and Femring. For Bone Density, safer alternatives are: alendronate, raloxifene, and Prolia.	
JEVTANA	Prior authorization applies to new starts only (B vs D applies to all)	Jevtana	All medically accepted indications not otherwise excluded from Part D.					12 months	BvsD coverage determination	
KABIVEN	Part D vs. Part B prior authorization only							12 months		
KADCYLA	Prior authorization applies to new starts only (B vs D applies to all)	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 patient has one mutation in the CFTR gene that is responsive to ivacaftor based on clinical and/or in vitro assay data.	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/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/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 (B vs D applies to all)	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.	
KISQALI	Prior authorization applies to new starts only	Molecular Target Inhibitors	All medically accepted indications not otherwise excluded from Part D.					12 months		
KISQALI FEMARA 200 DOSE	Prior authorization applies to new starts only	Molecular Target Inhibitors	All medically accepted indications not otherwise excluded from Part D.					12 months		
KISQALI FEMARA 400 DOSE	Prior authorization applies to new starts only	Molecular Target Inhibitors	All medically accepted indications not otherwise excluded from Part D.					12 months		
KISQALI FEMARA 600 DOSE	Prior authorization applies to new starts only	Molecular Target Inhibitors	All medically accepted indications not otherwise excluded from Part D.					12 months		
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		
KYPROLIS	Part D vs. Part B prior authorization only							12 months		

LACTATED RINGERS	Part D vs. Part B prior authorization only							12 months		
LACTATED RINGERS VIAFLEX	Part D vs. Part B prior authorization only							12 months		
LANOXIN (only covered on PDP Secure, PDP Secure-Extra)	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 will continue to monitor for side effects, 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 required for age 65 or older.		Approval duration is through the end of the plan year.		
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 will continue to monitor for side effects, 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 required for age 65 or older.		Approval duration is through the end of the plan year.		
LARTRUVO	Prior authorization applies to new starts only (B vs D applies to all)	Antineoplastics, Monoclonal Antibodies	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D coverage determination	
LENVIMA 10 MG DAILY DOSE	Prior authorization applies to new starts only	Molecular Target Inhibitors	All medically accepted indications not otherwise excluded from Part D.					12 months		
LENVIMA 14 MG DAILY DOSE	Prior authorization applies to new starts only	Molecular Target Inhibitors	All medically accepted indications not otherwise excluded from Part D.					12 months		
LENVIMA 18 MG DAILY DOSE	Prior authorization applies to new starts only	Molecular Target Inhibitors	All medically accepted indications not otherwise excluded from Part D.					12 months		
LENVIMA 20 MG DAILY DOSE	Prior authorization applies to new starts only	Molecular Target Inhibitors	All medically accepted indications not otherwise excluded from Part D.					12 months		
LENVIMA 24 MG DAILY DOSE	Prior authorization applies to new starts only	Molecular Target Inhibitors	All medically accepted indications not otherwise excluded from Part D.					12 months		
LENVIMA 8 MG DAILY DOSE	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.			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. For cancer related neuropathic pain (including treatment-related neuropathy), no additional criteria are required to be met.	
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		
LUMIZYME	Prior authorization applies	Lumizyme	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis			12 months	B vs D coverage determination	
LUPRON DEPOT (4-MONTH)	Prior authorization applies to new starts only	Pituitary Hormones	All medically accepted indications not otherwise excluded from Part D.					12 months		
LUPRON DEPOT (6-MONTH)	Prior authorization applies to new starts only	Pituitary Hormones	All medically accepted indications not otherwise excluded from Part D.					12 months		
LUPRON DEPOT 11.25 MG (3-MONTH)	Prior authorization applies	Pituitary Hormones	All medically accepted indications not otherwise excluded from Part D.					12 months		
LUPRON DEPOT 22.5 MG (3-MONTH)	Prior authorization applies to new starts only	Pituitary Hormones	All medically accepted indications not otherwise excluded from Part D.					12 months		
LUPRON DEPOT 3.75 MG (1-MONTH)	Prior authorization applies	Pituitary Hormones	All medically accepted indications not otherwise excluded from Part D.					12 months		
LUPRON DEPOT 7.5 MG (1-MONTH)	Prior authorization applies to new starts only	Pituitary Hormones	All medically accepted indications not otherwise excluded from Part D.					12 months		
LUPRON DEPOT-PED (1-MONTH)	Prior authorization applies	Pituitary Hormones	All medically accepted indications not otherwise excluded from Part D.					12 months		
LUPRON DEPOT-PED (3-MONTH)	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 IN D5W	Part D vs. Part B prior authorization only							12 months		
MAGNESIUM SULFATE INJ	Part D vs. Part B prior authorization only							12 months		
MAGNESIUM SULFATE IV	Part D vs. Part B prior authorization only							12 months		
MAKENA	Prior authorization applies	Makena	All medically accepted indications not otherwise excluded from Part D.		Makena is authorized to reduce the risk of preterm birth when ALL of the following are met: 1.) current singleton pregnancy AND 2.) previous singleton spontaneous preterm birth (preterm birth defined as birth from the period of viability through week 36, 6 days gestation) AND 3.) treatment will be initiated between week 16, 0 days and week 20, 6 days of gestation and not continue beyond week 36, 6 days of gestation or time of delivery (whichever occurs first).			21 weeks	B vs D coverage determination	
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 will continue to monitor for side effects, 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 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 ORAL 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 will continue to monitor for side effects, AND for chachexia/loss of appetite associated with AIDS, 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. For all other indications, trial of dronabinol is not required.	Automatic approval if member is less than 65 years of age. Prior authorization 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 will continue to monitor for side effects.	Automatic approval if member is less than 65 years of age. Prior authorization 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		
MEMANTINE HCL	Prior authorization applies	memantine IR/Namenda XR	All medically accepted indications not otherwise excluded from Part D.			Automatic approval if member is greater than 26 years of age. Prior Authorization is required for age 26 or younger.		12 months		
MEMANTINE HYDROCHLORIDE ER	Prior authorization applies	memantine IR/Namenda XR	All medically accepted indications not otherwise excluded from Part D.			Automatic approval if member is greater than 26 years of age. Prior Authorization is required for age 26 or younger.		12 months		
MEMANTINE HCL TITRATION PAK	Prior authorization applies	memantine IR/Namenda XR	All medically accepted indications not otherwise excluded from Part D.			Automatic approval if member is greater than 26 years of age. Prior Authorization is required for age 26 or younger.		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 will continue to monitor for side effects, 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 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 (MAPD plans)	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 will continue to monitor for side effects, 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 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: Depo-Estradiol, SSRIs, venlafaxine, gabapentin, and Femring. For Vaginal Symptoms of menopause, safer alternatives are: Premarin Cream, Estring, and Femring. For Bone Density, safer alternatives are: alendronate, risedronate, raloxifene, and Prolia.	
MENOSTAR (PDP SECURE and PDP SECURE EXTRA)	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 will continue to monitor for side effects, 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 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: Depo-Estradiol, SSRIs, venlafaxine, gabapentin, and Femring. For Vaginal Symptoms of menopause, safer alternatives are: Premarin Cream, Estring, and Femring. For Bone Density, safer alternatives are: alendronate, raloxifene, and Prolia.	
MESNA	Part D vs. Part B prior authorization only							12 months		
METHOCARBAMOL	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 will continue to monitor for side effects.	Automatic approval if member is less than 65 years of age. Prior authorization required for age 65 or older.		Approval duration is through the end of the plan year.		
MINIVELLE (MAPD plans)	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 will continue to monitor for side effects, 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 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: Depo-Estradiol, SSRIs, venlafaxine, gabapentin, and Femring. For Vaginal Symptoms of menopause, safer alternatives are: Premarin Cream, Estring, and Femring. For Bone Density, safer alternatives are: alendronate, risedronate, raloxifene, and Prolia.	
MINIVELLE (PDP SECURE and PDP SECURE EXTRA)	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 will continue to monitor for side effects, 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 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: Depo-Estradiol, SSRIs, venlafaxine, gabapentin, and Femring. For Vaginal Symptoms of menopause, safer alternatives are: Premarin Cream, Estring, and Femring. For Bone Density, safer alternatives are: alendronate, 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		
MUSTARGEN	Part D vs. Part B prior authorization only							12 months		
MYCOPHENOLATE MOFETIL	Prior authorization applies to new starts only (B vs D applies to all)	IMMUNE SUPPRESSANTS - TRANSPLANT RELATED	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D coverage determination	

MYCOPHENOLIC ACID DR	Prior authorization applies to new starts only (B vs D applies to all)	IMMUNE SUPPRESSANTS - TRANSPLANT RELATED	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D coverage determination	
MYLOTARG	Prior authorization applies to new starts only (B vs D applies to all)	Antineoplastics, Monoclonal Antibodies	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D coverage determination	
NAGLAZYME	Prior authorization applies	Enzyme Replacement/ Modifiers	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis			12 months		
NAMENDA XR	Prior authorization applies	memantine IR/Namenda XR	All medically accepted indications not otherwise excluded from Part D.			Automatic approval if member is greater than 26 years of age. Prior Authorization is required for age 26 or younger.		12 months		
NAMENDA XR TITRATION PACK	Prior authorization applies	memantine IR/Namenda XR	All medically accepted indications not otherwise excluded from Part D.			Automatic approval if member is greater than 26 years of age. Prior Authorization is required for age 26 or younger.		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		
NERLYNX	Prior authorization applies to new starts only	Molecular Target Inhibitors	All medically accepted indications not otherwise excluded from Part D.					12 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			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 considered to be at high risk for the development of severe thrombocytopenia. B vs D coverage determination.	
NEXAVAR	Prior authorization applies to new starts only	Molecular Target Inhibitors	All medically accepted indications not otherwise excluded from Part D.					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		
NORETHINDRONE ACETATE/ETHINYL ESTRADIOL (MAPD plans)	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 will continue to monitor for side effects, 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 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: Depo-Estradiol, SSRIs, venlafaxine, gabapentin, and Femring. For Vaginal Symptoms of menopause, safer alternatives are: Premarin Cream, Estring, and Femring. For Bone Density, safer alternatives are: alendronate, risedronate, raloxifene, and Prolia.	

NORETHINDRONE ACETATE/ETHINYL ESTRADIOL (PDP SECURE and PDP SECURE EXTRA)	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 will continue to monitor for side effects, 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 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: Depo-Estradiol, SSRIs, venlafaxine, gabapentin, and Femring. For Vaginal Symptoms of menopause, safer alternatives are: Premarin Cream, Estring, and Femring. For Bone Density, safer alternatives are: alendronate, raloxifene, and Prolia.	
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	The patient must have failure, contraindication or intolerance to fludrocortisone acetate or midodrine.	
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 (B vs D applies to all)	Nulojix	All medically accepted indications not otherwise excluded from Part D.		Documentation of Epstein-Barr virus serology and current medication regimen			12 months	Documentation of use in combination with basiliximab induction, mycophenolate mofetil, and corticosteroids. B vs D coverage determination.	
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		
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		
OFEV	Prior authorization applies	Ofev	All medically accepted 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 biopsy pattern is diagnostic of IPF or the combination of HRCT and biopsy pattern is indicative of IPF.			12 months	Ofev will be used as monotherapy.	
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 (B vs D applies to all)	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 medically accepted indications not otherwise excluded from Part D.		Documentation of pulmonary arterial hypertension			12 months		

ORKAMBI	Prior authorization applies	Orkambi	All medically accepted indications not otherwise excluded from Part D.		CF mutation test documenting the patient is homozygous for the F508del mutation in the CFTR gene.	Patients must be 6 years of age and older.		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 will continue to monitor for side effects.	Automatic approval if member is less than 65 years of age. Prior authorization 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		
PEGASYS	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.		
PEGASYS PROCLICK	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 (B vs D applies to all)	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 will continue to monitor for side effects, 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 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.	
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 (B vs D applies to all)	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 /SODIUM CHLORIDE	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 0.22% 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/DEXTROSE	Part D vs. Part B prior authorization only							12 months		
POTASSIUM CHLORIDE/DEXTROSE/LACTATED RINGERS	Part D vs. Part B prior authorization only							12 months		
POTASSIUM CHLORIDE/SODIUM CHLORIDE	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		
PRALUENT	Prior authorization applies	PRALUENT	All medically accepted indications not otherwise excluded from Part D.		Diagnosis of one of the following: Clinical atherosclerotic cardiovascular disease (ASCVD) OR Heterozygous familial hypercholesterolemia (HeFH) (confirmed by genetic testing or WHO/Dutch Lipid Group criteria or Simon-Broome criteria).			Initial:6 mo. Reauthorization for 12 mo requires documented evidence of clinical beneficial response	For ASCVD or HeFH: Patient is on high-intensity statin therapy or maximally tolerated statin therapy, is not at LDL-C level goal (LDL-C greater than 70 mg/dL) and will be continued on high intensity or maximally tolerated statin therapy while on the PCSK9-inhibitor. Patients intolerant to statins as demonstrated by experiencing statin-associated rhabdomyolysis to one statin OR has tried 2 statins (any combination of high or moderate intensity statins) and has experienced skeletal –muscle related symptoms on both agents, no concurrent statin use required.	
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 (MAPD plans)	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 will continue to monitor for side effects, 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 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: Depo-Estradiol, SSRIs, venlafaxine, gabapentin, and Femring. For Vaginal Symptoms of menopause, safer alternatives are: Premarin Cream, Estring, and Femring. For Bone Density, safer alternatives are: alendronate, risedronate, raloxifene, and Prolia.	
PREMARIN (PDP SECURE and PDP SECURE EXTRA)	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 will continue to monitor for side effects, 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 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: Depo-Estradiol, SSRIs, venlafaxine, gabapentin, and Femring. For Vaginal Symptoms of menopause, safer alternatives are: Premarin Cream, Estring, and Femring. For Bone Density, safer alternatives are: alendronate, raloxifene, and Prolia.	
PREMASOL	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 initial treatment of anemia, documentation of Hemoglobin less than 10, transferrin saturation greater than 20%, and ferritin levels greater than 100 obtained over the last 3 months. For reauthorizations, approvals granted if Hemoglobin does not exceed 10-12g/dL or approvals granted if Hemoglobin does not exceed 10-13g/dL for the indication of reduction of allogeneic red cell transfusions in patients undergoing elective, noncardiac, nonvascular surgery.			6 months	B vs D coverage determination	

PROGRAF	Prior authorization applies to new starts only (B vs D applies to all)	IMMUNE SUPPRESSANTS - TRANSPLANT RELATED	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D coverage 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 b.) chronic immune (idiopathic) thrombocytopenic purpura (ITP) with documentation of previous therapy with corticosteroids OR intravenous immune globulin (IVIG) therapy over a period of at least 30 days OR insufficient response to a splenectomy, or c.) severe aplastic anemia with documentation of inadequate response to previous immunosuppressive therapy (e.g. Atgam, Thymoglobulin, cyclosporine).			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 (idiopathic) thrombocytopenic purpura (ITP) that have failed corticosteroid OR intravenous immune globulin (IVIG) therapy OR have had an insufficient response to a splenectomy.	
PROMETHAZINE HCL	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 will continue to monitor for side effects, 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 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. 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	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 will continue to monitor for side effects, 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 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. 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.	
RABAVERT	Part D vs. Part B prior authorization only							12 months		
RAPAMUNE	Prior authorization applies to new starts only (B vs D applies to all)	IMMUNE SUPPRESSANTS - TRANSPLANT RELATED	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D coverage determination	
REBIF (Non-formulary for PDP Secure)	Prior authorization applies	Immunomodulators	All medically accepted indications not otherwise excluded from Part D.					12 months	Patient must have failure, contraindication or intolerance to two of the following: Avonex, Betaseron, Copaxone, Gilenya and Tecfidera before Rebif will be authorized.	
REBIF REBIDOSE (Non-formulary for PDP Secure)	Prior authorization applies	Immunomodulators	All medically accepted indications not otherwise excluded from Part D.					12 months	Patient must have failure, contraindication or intolerance to two of the following: Avonex, Betaseron, Copaxone, Gilenya and Tecfidera before Rebif will be authorized.	
REBIF REBIDOSE TITRATION PACK (Non-formulary for PDP Secure)	Prior authorization applies	Immunomodulators	All medically accepted indications not otherwise excluded from Part D.					12 months	Patient must have failure, contraindication or intolerance to two of the following: Avonex, Betaseron, Copaxone, Gilenya and Tecfidera before Rebif will be authorized.	
REBIF TITRATION PACK (Non-formulary for PDP Secure)	Prior authorization applies	Immunomodulators	All medically accepted indications not otherwise excluded from Part D.					12 months	Patient must have failure, contraindication or intolerance to two of the following: Avonex, Betaseron, Copaxone, Gilenya and Tecfidera before Rebif will be authorized.	
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			12 months		
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 AND Amitiza.	
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 (including formulary biosimilars) 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, AND c.) tried and failed at least 1 topical agent (topical steroid, calcipotriene, or tazarotene) 5.) Psoriatic Arthritis in patients with active disease. In addition, use of Humira or Remicade (including formulary biosimilars) 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 coverage determination required for Remicade (including formulary biosimilars).	
REMODULIN	Part D vs. Part B prior authorization only							12 months		
RENFLEXIS	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 (including formulary biosimilars) 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, AND c.) tried and failed at least 1 topical agent (topical steroid, calcipotriene, or tazarotene) 5.) Psoriatic Arthritis in patients with active disease. In addition, use of Humira or Remicade (including formulary biosimilars) 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 coverage determination required for Remicade (including formulary biosimilars).	

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 (ASCVD) OR Primary Hyperlipidemia (including 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 greater than 300mg/dl with either: presence of xanthomas before the age of 10 years or evidence of heterozygous familial hypercholesterolemia in both parents.)			Initial:6 mo. Reauthorization for 12 mo requires documented evidence of clinical beneficial response	For ASCVD or Primary Hyperlipidemia (including HeFH): Patient is on high-intensity statin therapy or maximally tolerated statin therapy, is not at LDL-C level goal (LDL-C greater than 70 mg/dL) and will be continued on high intensity or maximally tolerated statin therapy while on the PCSK9-inhibitor. Patients intolerant to statins as demonstrated by experiencing statin-associated rhabdomyolysis to one statin OR has tried 2 statins (any combination of high or moderate intensity statins) and has experienced skeletal –muscle related symptoms on both agents, no concurrent statin use required. For HoFH: Patient is on high-intensity or maximally tolerated lipid lowering therapy (such as statins and/or ezetimibe), is not at LDL-C level goal (LDL-C greater than 70 mg/dL), and will be continued on high intensity or maximally tolerated lipid lowering therapy while on Repatha. For patients with HoFH who are intolerant to statins, no concurrent statin use required.	
REPATHA PUSHTRONEX SYSTEM	Prior authorization applies	REPATHA	All medically accepted indications not otherwise excluded from Part D.		Diagnosis of one of the following: Clinical atherosclerotic cardiovascular disease (ASCVD) OR Primary Hyperlipidemia (including 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 greater than 300mg/dl with either: presence of xanthomas before the age of 10 years or evidence of heterozygous familial hypercholesterolemia in both parents.)			Initial:6 mo. Reauthorization for 12 mo requires documented evidence of clinical beneficial response	For ASCVD or Primary Hyperlipidemia (including HeFH): Patient is on high-intensity statin therapy or maximally tolerated statin therapy, is not at LDL-C level goal (LDL-C greater than 70 mg/dL) and will be continued on high intensity or maximally tolerated statin therapy while on the PCSK9-inhibitor. Patients intolerant to statins as demonstrated by experiencing statin-associated rhabdomyolysis to one statin OR has tried 2 statins (any combination of high or moderate intensity statins) and has experienced skeletal –muscle related symptoms on both agents, no concurrent statin use required. For HoFH: Patient is on high-intensity or maximally tolerated lipid lowering therapy (such as statins and/or ezetimibe), is not at LDL-C level goal (LDL-C greater than 70 mg/dL), and will be continued on high intensity or maximally tolerated lipid lowering therapy while on Repatha. For patients with HoFH who are intolerant to statins, no concurrent statin use required.	
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 (ASCVD) OR Primary Hyperlipidemia (including 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 greater than 300mg/dl with either: presence of xanthomas before the age of 10 years or evidence of heterozygous familial hypercholesterolemia in both parents.)			Initial:6 mo. Reauthorization for 12 mo requires documented evidence of clinical beneficial response	For ASCVD or Primary Hyperlipidemia (including HeFH): Patient is on high-intensity statin therapy or maximally tolerated statin therapy, is not at LDL-C level goal (LDL-C greater than 70 mg/dL) and will be continued on high intensity or maximally tolerated statin therapy while on the PCSK9-inhibitor. Patients intolerant to statins as demonstrated by experiencing statin-associated rhabdomyolysis to one statin OR has tried 2 statins (any combination of high or moderate intensity statins) and has experienced skeletal –muscle related symptoms on both agents, no concurrent statin use required. For HoFH: Patient is on high-intensity or maximally tolerated lipid lowering therapy (such as statins and/or ezetimibe), is not at LDL-C level goal (LDL-C greater than 70 mg/dL), and will be continued on high intensity or maximally tolerated lipid lowering therapy while on Repatha. For patients with HoFH who are intolerant to statins, no concurrent statin use required.	
REVLIMID	Prior authorization applies to new starts only	Revlimid	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis			12 months		
RIBAVIRIN INH	Part D vs. Part B prior authorization only							12 months		
RINGERS INJECTION	Part D vs. Part B prior authorization only							12 months		
RITUXAN	Prior authorization applies to new starts only (B vs D applies to all)	Antineoplastics, Monoclonal Antibodies	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D coverage determination	
RITUXAN HYCELA	Prior authorization applies to new starts only (B vs D applies to all)	Antineoplastics, Monoclonal Antibodies	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D coverage determination	
ROMIDEPSIN	Prior authorization applies to new starts only (B vs D applies to all)	Istodax	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis and past medication history			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.	
RUBRACA	Prior authorization applies to new starts only	Molecular Target Inhibitors	All medically accepted indications not otherwise excluded from Part D.					12 months		
RYDAPT	Prior authorization applies to new starts only	Molecular Target Inhibitors	All medically accepted indications not otherwise excluded from Part D.					12 months		

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 and vigabatrin are 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, divalproex, lamotrigine, and levetiracetam. For the indication of Infantile Spasms, failure of another drug(s) is not required.	
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 (B vs D applies to all)	IMMUNE SUPPRESSANTS - TRANSPLANT RELATED	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D coverage determination	
SANDOSTATIN LAR DEPOT (Non-formulary for PDP Secure, PDP Secure-Extra)	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 medically accepted 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 (B vs D applies to all)	IMMUNE SUPPRESSANTS - TRANSPLANT RELATED	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D coverage 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		
SODIUM PHENYLBUTYRATE	Prior authorization applies	BUPHENYL	All medically accepted indications not otherwise excluded from Part D.					12 months		
SODIUM PHENYLBUTYRATE	Prior authorization applies	BUPHENYL	All medically accepted indications not otherwise excluded from Part D.					12 months		
SOMATULINE DEPOT 120mg/0.5mL	Prior authorization applies	HORMONAL AGENTS, SOMATOSTATIN ANALOGS	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis			6 months		
SOMATULINE DEPOT 60mg/0.2mL and 90mg/0.3mL	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		
SOMAVERT	Prior authorization applies	Endocrine and Metabolic Agents	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis			12 months		
SPORANOX	Prior authorization applies	Antifungals, Superficial and Systemic	All medically accepted indications not otherwise excluded from Part D.					Onychomycosis (fingernails only) - 2mo. Onychomycosis (toenails) - 3mo. All other indications - 12mo	For the treatment of tinea versicolor or pityriasis, 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 medically accepted indications not otherwise excluded from Part D.		Documentation of opioid dependence.			Buprenorphine-1 mo or 6 mo if preg/hypersensitive to naloxone. Zubsolv, Subox, and 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.	
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		
SYMLINPEN 120 (Non-Formulary for PDP Secure)	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			12 months	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 PDP Secure)	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			12 months	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 (B vs D applies to all)	IMMUNE SUPPRESSANTS - TRANSPLANT RELATED	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D coverage 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	Tagrisso	All medically accepted indications not otherwise excluded from Part D.		Documentation of metastatic epidermal growth factor receptor (EGFR) T790M mutation-positive non-small cell lung cancer (NSCLC).			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		
TECENTRIQ	Prior authorization applies to new starts only (B vs D applies to all)	Antineoplastics, Monoclonal Antibodies	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D coverage determination	
TECFIDERA (All plans except PDP Secure)	Prior authorization applies	Immunomodulators	All medically accepted indications not otherwise excluded from Part D.					12 months	Patient must have failure, contraindication or intolerance to two of the following: Avonex, Betaseron, Copaxone, Gilenya and Tecfidera before Rebif will be authorized.	
TECFIDERA (PDP Secure)	Prior authorization applies	Immunomodulators	All medically accepted indications not otherwise excluded from Part D.					12 months		
TECFIDERA STARTER PACK (All plans except PDP Secure)	Prior authorization applies	Immunomodulators	All medically accepted indications not otherwise excluded from Part D.					12 months	Patient must have failure, contraindication or intolerance to two of the following: Avonex, Betaseron, Copaxone, Gilenya and Tecfidera before Rebif will be authorized.	
TECFIDERA STARTER PACK (PDP Secure)	Prior authorization applies	Immunomodulators	All medically accepted indications not otherwise excluded from Part D.					12 months		
TEPADINA	Prior authorization applies to new starts only (B vs D applies to all)	THIOTEPA	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D coverage determination	

TESTOSTERONE	Prior authorization applies	ANABOLIC STEROIDS, ANDROGENS	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis			12 months		
TESTOSTERONE PUMP	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	Tetrabenazine	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		
THIOTEPA	Prior authorization applies to new starts only (B vs D applies to all)	THIOTEPA	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D coverage 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	Prior authorization applies	Vasodilators	All medically accepted indications not otherwise excluded from Part D.		Documentation of pulmonary arterial hypertension			12 months		
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 will continue to monitor for side effects.	Automatic approval if member is less than 65 years of age. Prior authorization 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 will continue to monitor for side effects.	Automatic approval if member is less than 65 years of age. Prior authorization required for age 65 or older.		Approval duration is through the end of the plan year.		
TRIPTODUR	Prior authorization applies	Pituitary Hormones	All medically accepted indications not otherwise excluded from Part D.					12 months		
TRISENOX	Part D vs. Part B prior authorization only							12 months		
TROGARZO	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 (Cigna HealthSpring plans except PDP SECURE)	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 2.) failure, contraindication or intolerance to one formulary alternative (eg. Avonex, Betaseron, Copaxone, Gilenya, Tecfidera 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 or intolerance to Humira.	
TYSABRI (PDP SECURE FORMULARY)	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 2.) failure, contraindication or intolerance to one formulary alternative (eg. Avonex, Betaseron, Copaxone Gilenya, or Tecfidera). 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 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 (B vs D applies to all)	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	Prior authorization applies to new starts only (B vs D applies to all)	Antineoplastics, Monoclonal Antibodies	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D coverage determination	
VELCADE	Prior authorization applies to new starts only (B vs D applies to all)	Velcade	All medically accepted indications not otherwise excluded from Part D.					12 months	BvsD coverage determination	
VENCLEXTA	Prior authorization applies to new starts only	VENCLEXTA	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis			12 months		
VENCLEXTA STARTING PACK	Prior authorization applies to new starts only	VENCLEXTA	All medically accepted indications not otherwise excluded from Part D.		Documentation of diagnosis			12 months		
VENTAVIS	Prior authorization applies	Ventavis	All medically accepted indications not otherwise excluded from Part D.					12 months	B v D coverage determination	
VERZENIO	Prior authorization applies to new starts only	Molecular Target Inhibitors	All medically accepted indications not otherwise excluded from Part D.					12 months		
VIBERZI	Prior authorization applies	VIBERZI	All medically accepted indications not otherwise excluded from Part D.		Diagnosis of irritable bowel syndrome with diarrhea.	18 years of age or older		12 months	The patient must have a history of failure, contraindication or intolerance to one antidiarrheal drug.	
VIGABATRIN	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 and vigabatrin are 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, divalproex, lamotrigine, and levetiracetam. For the indication of Infantile Spasms, failure of another drug(s) is not required.	
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		
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. For prophylactic use, fungal culture and medical records are not required.			3 to 6 months, depending on indication		
VOSEVI	Prior authorization applies	Vosevi	All medically accepted indications not otherwise excluded from Part D.	Treatment naive patients	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.			12 weeks, based on indication and established treatment guidelines		
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 coverage determination	
VYXEOS	Part D vs. Part B prior authorization only							12 months		
XALKORI	Prior authorization applies to new starts only	Molecular Target Inhibitors	All medically accepted indications not otherwise excluded from Part D.					12 months		
XATMEP	Prior authorization applies to new starts only	XATMEP	All medically accepted indications not otherwise excluded from Part D.					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.		For the diagnosis of Traveler's Diarrhea, customer has previous treatment, intolerance or contraindication to ciprofloxacin, levofloxacin, ofloxacin or azithromycin. For all other diagnoses, no additional criteria are required to be met.			For diagnosis for Traveler's Diarrhea: 1 month. All other indications: 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 medically accepted 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	Prior authorization applies to new starts only (B vs D applies to all)	Antineoplastics , Monoclonal Antibodies	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D coverage determination	
YONDELIS	Prior authorization applies to new starts only (B vs D applies to all)	YONDELIS	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D coverage determination	
ZALTRAP	Prior authorization applies to new starts only (B vs D applies to all)	Zaltrap	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.			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 will continue to monitor for side effects, 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 required for age 65 or older.		Approval duration is through the end of the plan year.	Safer alternatives are: naproxen sodium and ibuprofen.	
ZEJULA	Prior authorization applies to new starts only	Molecular Target Inhibitors	All medically accepted indications not otherwise excluded from Part D.					12 months		
ZELBORAF	Prior authorization applies to new starts only	Zelboraf	All medically accepted indications not otherwise excluded from Part D.		Documentation of BRAF V600E mutation			12 months		
ZEMAIRA	Part D vs. Part B prior authorization only							12 months		
ZOLEDRONIC ACID	Part D vs. Part B prior authorization only							12 months		
ZOLPIDEM TARTRATE	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.	Automatic approval if member is less than 65 years of age. Prior authorization required for age 65 or older.		12 months		
ZORTRESS	Prior authorization applies to new starts only (B vs D applies to all)	IMMUNE SUPPRESSANTS - TRANSPLANT RELATED	All medically accepted indications not otherwise excluded from Part D.					12 months	B vs D coverage determination	
ZUBSOLV	Prior authorization applies	Opioid Agonist-Antagonist Analgesics	All medically accepted indications not otherwise excluded from Part D.		Documentation of opioid dependence.			Buprenorphine-1 mo or 6 mo if preg/hypersensitive to naloxone. Zubsolv, Subox, and 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.	
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.	
Select Mosquito Repellents for Zika virus prevention (TX MMP only)						Coverage provided for females ages 10 - 55 years old and pregnant females of any age. Males ages 14 and older.			Coverage of mosquito repellents will be limited to two cans or bottles per calendar month: only one can or bottle may be dispensed per fill, with one optional refill available per calendar month. For more details including exact NDCs covered, visit the website location: www.txvendordrug.com/formulary/formulary/mosquito-repellent	