ABRAXANE

Products Affected

- Abraxane

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	B vs D coverage determination

ACITRETIN

Products Affected

- Acitretin

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For initial therapy in the treatment of psoriasis: trial and failure, contraindication, or intolerance to methotrexate or cyclosporine is required. For continuation of therapy, approve if patient has already been started on Acitretin.

ACTEMRA

Products Affected

- Actemra

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis and past medication history.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Use of Actemra is considered medically necessary for the treatment of rheumatoid arthritis (RA) and polyarticular juvenile idiopathic arthritis (PJIA) 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, 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 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

Products Affected

- Actimmune

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

ADEMPAS

Products Affected

- Adempas

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

ALIMTA

Products Affected

- Alimta

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	B vs D coverage determination

ALOSETRON

Products Affected

- Alosetron Hydrochloride

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Alosetron will not be approved for use in men, as safety and efficacy in men has not been established.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Alosetron is considered medically necessary for the treatment of severe IBS-D. At least one of the following must be present for diarrhea to be considered severe: frequent and severe abdominal pain or discomfort, frequent bowel urgency or fecal incontinence, and disability or restriction of daily activities due to IBS.

AMPYRA

Products Affected

- Ampyra

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Ampyra is considered medically necessary for patients with multiple sclerosis with medical documentation of impaired walking ability.

AMYLIN ANALOG

Products Affected

- Symlinpen 120
- Symlinpen 60

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Hemoglobin A1C less than 7% prior to initiating Amylin Analog therapy.
Required Medical Information	Documentation of past and current medication history.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	The member must have documentation of previous insulin failure and documentation of continuation of insulin therapy concomitantly with the requested drug.

ANABOLIC STEROIDS, ANDROGENS

Products Affected

- Anadrol-50
- Androxy
- Oxandrolone TABS
- Testosterone GEL 25MG/2.5GM, 50MG/5GM
- Testosterone Pump GEL 1%

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

ANTIFUNGALS, AZOLE

Products Affected

- Voriconazole INJ
- Voriconazole SUSR
- Voriconazole TABS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 to 6 months, depending on indication
Other Criteria	N/A

ANTIFUNGALS, POLYENE

Products Affected

- Abelcet
- Ambisome
- Amphotericin B INJ

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	B vs D coverage determination

ANTIFUNGALS, SUPERFICIAL AND SYSTEMIC

Products Affected

- Caspofungin Acetate
- Itraconazole CAPS
- Itraconazole SOLN
- Sporanox SOLN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Onychomycosis (fingernails only) - 2mo. Onychomycosis (toenails) - 3mo. All other indications - 12mo
Other Criteria	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 or Sporanox oral solution. For candidiasis infections (unless specified C. glabrata or C. krusei), use of fluconazole is required prior to the use of itraconazole or Sporanox oral solution.

ANTIFUNGALS, TRIAZOLE

Products Affected

- Noxafil SUSP
- Noxafil TBEC

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	For the prophylaxis of invasive Aspergillus and Candida infections: Noxafil is considered medically necessary in patients who are at high risk of developing these infections due to being severely immunocompromised, such as hematopoietic stem cell transplant (HSCT) recipients with graft-versus-host disease (GVHD) or those with hematologic malignancies with prolonged neutropenia from chemotherapy. For the treatment of oropharyngeal candidiasis, the candidiasis must be refractory to itraconazole or fluconazole.

ANTINEOPLASTICS, MONOCLONAL ANTIBODIES

Products Affected

- Aliqopa
- Avastin
- Bavencio
- Besponsa
- Cyramza
- Darzalex
- Erbitux
- Gazyva
- Herceptin INJ 440MG
- Imfinzi
- Kadcyla
- Keytruda INJ 100MG/4ML
- Lartruvo
- Libtayo
- Mylotarg
- Opdivo
- Portrazza
- Poteligeo
- Rituxan
- Rituxan Hycela
- Tecentriq
- Unituxin
- Vectibix INJ 100MG/5ML, 400MG/20ML
- Yervoy

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	B vs D coverage determination

APOKYN

Products Affected

- Apokyn INJ 30MG/3ML

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

ARCALYST

Products Affected

- Arcalyst

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis.
Age Restrictions	12 years of age and older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	B vs D coverage determination

BANZEL

Products Affected

- Banzel

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

BELEODAQ

Products Affected

- Beleodaq

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	B vs D coverage determination

BENLYSTA

Products Affected

- Benlysta INJ 120MG, 400MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	The patient must be receiving one standard therapy for SLE with any of the following: corticosteroids, hydroxychloroquine, or immunosuppressives (cyclophosphamide, azathioprine, mycophenolate, methotrexate, cyclosporine) 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.

BUPRENORPHINE

Products Affected

- Buprenorphine Hcl SUBL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of opioid dependence.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Induction therapy: 1 month. Pregnancy/Hypersensitvity to naloxone: 12 months
Other Criteria	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-NALOXONE PRODUCTS

Products Affected

- Suboxone FILM
- Zubsolv

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of opioid dependence.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

CAPRELSA

Products Affected

- Caprelsa

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

CARBAGLU

Products Affected

- Carbaglu

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

CAYSTON

Products Affected

- Cayston

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of Cystic Fibrosis and documentation of Pseudomonas aeruginosa infection.
Age Restrictions	7 years and older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

CINRYZE

Products Affected

- Cinryze

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Patient must have a confirmed diagnosis of HAE.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	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 danazol or tranexamic acid. B vs D coverage determination.

COLONY STIMULATING FACTORS

Products Affected

- Zarxio

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

CORLANOR

Products Affected

- Corlanor

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	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).
Required Medical Information	Documentation of diagnosis, previous use of a beta-blocker, LVEF, sinus rhythm, resting HR, and blood pressure.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	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.

CYSTARAN

Products Affected

- Cystaran

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

DERMATOLOGICAL RETINOIDS

Products Affected

- Avita
- Tretinoin CREA
- Tretinoin GEL
- Tretinoin Microsphere
- Tretinoin Microsphere Pump

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

DERMATOLOGICAL WOUND CARE AGENTS

Products Affected

- Regranex

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of wound type.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	5 months
Other Criteria	N/A

DIHYDROERGOTAMINE MESYLATE

Products Affected

- Dihydroergotamine Mesylate NASAL SOLN

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

DRONABINOL

Products Affected

- Dronabinol

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	B vs D coverage determination

DUAVEE

Products Affected

- Duavee

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis and past medication history.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For the prevention of postmenopausal osteoporosis, trial, failure, or intolerance of raloxifene is required prior to the use of Duavee. For the treatment of moderate to severe vasomotor symptoms associated with menopause, use of one of the following is required prior to Duavee being authorized: a SSRI, venlafaxine or gabapentin.

EMPLICITI

Products Affected

- Empliciti

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis and current medication regimen.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	B vs D coverage determination.

ENDOCRINE AND METABOLIC AGENTS

Products Affected

- Somavert

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	The patient must have a diagnosis of acromegaly AND had inadequate response to surgery or radiation therapy or documentation these therapies are not appropriate for the patient.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

ENZYME REPLACEMENT/MODIFIERS

Products Affected

- Aldurazyme
- Elaprase
- Naglazyme

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

EPCLUSA

Products Affected

- Epclusa

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 weeks, based on indication and established treatment guidelines
Other Criteria	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.

EPIDIOLEX

Products Affected

- Epidiolex

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of Lennox-Gastaut syndrome or Dravet syndrome
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

ERIVEDGE

Products Affected

- Erivedge

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of locally advanced or metastatic basal cell carcinoma that has recurred following surgery or who are not candidates for surgery, and who are not candidates for radiation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

ERLEADA

Products Affected

- Erleada

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Erleada is approved for use in combination with a gonadotropin-releasing hormone (GnRH) analog or in patients who have had a bilateral orchiectomy.

ESBRIET

Products Affected

- Esbriet

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Other known causes of interstitial lung disease e.g., domestic and occupational environmental exposures, connective tissue disease, and drug toxicity.
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Esbriet will be used as monotherapy.

EVOMELA

Products Affected

- Evomela

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	B vs D coverage determination

FARYDAK

Products Affected

- Farydak

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

FERRIPROX

Products Affected

- Ferriprox

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

FIRAZYR

Products Affected

- Firazyr

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Patient must have a confirmed diagnosis of HAE.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Firazyr is considered medically necessary for the treatment of acute attacks of hereditary angioedema (HAE) in patients who have tried and failed Ruconest.

FYCOMPA

Products Affected

- Fycompa

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

GATTEX

Products Affected

- Gattex

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	As long as the patient requires parenteral nutrition and/or IV fluids, 3 months up to 12 months
Other Criteria	N/A

HALAVEN

Products Affected

- Halaven

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For metastatic breast cancer, documentation of prior treatment with an anthracycline and a taxane. For unresectable or metastatic liposarcoma, documentation of prior treatment with an anthracycline-containing regimen.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For metastatic breast cancer, patients must have previously received at least two chemotherapeutic regimens for the treatment of metastatic disease. B vs D coverage determination.

HARVONI

Products Affected

- Harvoni

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 to 24 weeks based on indication and established treatment guidelines
Other Criteria	N/A

HEMATOPOIETICS

Products Affected

- Aranesp Albumin Free INJ 100MCG/0.5ML, 100MCG/ML, 10MCG/0.4ML, 150MCG/0.3ML, 200MCG/0.4ML, 200MCG/ML, 25MCG/0.42ML, 25MCG/ML, 300MCG/0.6ML, 300MCG/ML, 40MCG/0.4ML, 40MCG/ML, 500MCG/ML, 60MCG/0.3ML, 60MCG/ML
- Procrit
- Retacrit

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	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 12g/dL or approvals granted if Hemoglobin does not exceed 13g/dL for the indication of reduction of allogeneic red cell transfusions in patients undergoing elective, noncardiac, nonvascular surgery.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	B vs D coverage determination

HETLIOZ

Products Affected

- Hetlioz

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation that patient is totally blind and lacks light perception.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

HORMONAL AGENTS, GONADOTROPINS

Products Affected

- Chorionic Gonadotropin INJ

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

HORMONAL AGENTS, SOMATOSTATIN ANALOGS

Products Affected

- Octreotide Acetate
- Somatuline Depot

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

HRM - BENZTROPINE

Products Affected

- Benztropine Mesylate TABS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	Automatic approval if member is less than 65 years of age. Prior authorization required for age 65 or older.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	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.

HRM - BUTALBITAL COMBINATIONS

Products Affected

- Ascomp/codeine
- Butalbital/acetaminophen/caffeine CAPS
- Butalbital/acetaminophen/caffeine TABS 325MG; 50MG; 40MG
- Butalbital/acetaminophen/caffeine/codeine
- Butalbital/aspirin/caffeine CAPS
- Butalbital/aspirin/caffeine/codeine
- Capacet
- Esgic CAPS
- Zebutal CAPS 325MG; 50MG; 40MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	Automatic approval if member is less than 65 years of age. Prior authorization required for age 65 or older.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Safer alternatives are: naproxen sodium and ibuprofen.

HRM - DIGOXIN

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	Automatic approval if member is less than 65 years of age. Prior authorization required for age 65 or older.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

HRM - ESTROGENS

Products Affected

- Alora
- Estradiol ORAL TABS 0.5MG, 1MG, 2MG
- Estradiol PTTW
- Estradiol PTWK
- Fyavolv TABS 2.5MCG; 0.5MG
- Jevantique Lo
- Menostar
- Minivelle
- Norethindrone Acetate/ethinyl Estradiol TABS 2.5MCG; 0.5MG
- Premarin TABS 0.3MG, 0.45MG, 0.625MG, 0.9MG, 1.25MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	Automatic approval if member is less than 65 years of age. Prior authorization required for age 65 or older.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Safer alternatives to the estrogen high risk medications depend on the indication. For Hot Flashes, safer alternatives are: SSRIs, venlafaxine, and gabapentin. For Vaginal Symptoms of menopause, safer alternatives are: Premarin Cream, Estring, Yuvafem and vaginal estradiol tablets. For Bone Density, safer alternatives are: bisphosphonates, raloxifene, and Prolia.

HRM - MEGESTROL

Products Affected

- Megestrol Acetate SUSP 40MG/ML
- Megestrol Acetate TABS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	Automatic approval if member is less than 65 years of age. Prior authorization required for age 65 or older.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For the treatment of cachexia/loss of appetite associated with AIDS (megestrol oral suspension only), 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.

HRM - MENEST

Products Affected

- Menest

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	Automatic approval if member is less than 65 years of age. Prior authorization required for age 65 or older.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For vasomotor symptoms of menopause, safer alternatives are: SSRIs, venlafaxine, and gabapentin. For vaginal symptoms of menopause, safer alternatives are: Premarin Cream, Estring, Yuvafem and vaginal estradiol tablets. For all other indications, no formulary alternative is required.

HRM - PERPHENAZINE/AMITRIPTYLINE

Products Affected

- Perphenazine/amitriptyline

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	Automatic approval if member is less than 65 years of age. Prior authorization required for age 65 or older.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Safer alternatives are: Nortriptyline, Protriptyline, Desipramine, Amoxapine, Citalopram, Venlafaxine, Fluoxetine, Paroxetine, Sertraline, Duloxetine, and Bupropion.

HRM - PLATELET MODIFYING AGENTS

Products Affected

- Dipyridamole TABS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	Automatic approval if member is less than 65 years of age. Prior authorization required for age 65 or older.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Safer alternatives are: Clopidogrel, Warfarin, Jantoven, and aspirin/dipyridamole .

HRM - PROMETHAZINE

Products Affected

- Promethazine Hcl SYRP
- Promethazine Hcl TABS 12.5MG, 25MG
- Promethazine Hcl Plain
- Promethazine Hydrochloride TABS 50MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	Automatic approval if member is less than 65 years of age. Prior authorization required for age 65 or older.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For postoperative 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.

HRM - SEDATIVE HYPNOTICS

Products Affected

- Zolpidem Tartrate TABS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	Automatic approval if member is less than 65 years of age. Prior authorization required for age 65 or older.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

HRM - SKELETAL MUSCLE RELAXANTS

Products Affected

- Cyclobenzaprine Hcl TABS 10MG, 5MG
- Methocarbamol TABS
- Orphenadrine Citrate Er

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	Automatic approval if member is less than 65 years of age. Prior authorization required for age 65 or older.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

HRM - TRICYCLIC ANTIDEPRESSANTS

Products Affected

- Amitriptyline Hcl TABS
- Clomipramine Hcl CAPS
- Doxepin Hcl CAPS
- Doxepin Hcl CONC
- Imipramine Hcl TABS 25MG, 50MG
- Imipramine Hydrochloride TABS 10MG
- Trimipramine Maleate CAPS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	Automatic approval if member is less than 65 years of age. Prior authorization required for age 65 or older.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Safer alternatives depend on indication. For Depression, safer alternatives are: Nortriptyline, Protriptyline, Desipramine, Amoxapine, Citalopram, Escitalopram, Fluvoxamine, Venlafaxine, Fluoxetine, Paroxetine, Sertraline, Duloxetine, and Bupropion. For headache prophylaxis, safer alternatives are: Propranolol, Topiramate, and Divalproex sodium. For headache treatment, safer alternatives are: Sumatriptan, Naratriptan, Rizatriptan and Dihydroergotamine. For Pain/Neuropathy, safer alternatives are: Duloxetine, Lyrica, and Gabapentin. If using requested medication for a medically-accepted indication not listed above, then no trial of alternatives is required.

HRM - TRIHEXYPHENIDYL

Products Affected

- Trihexyphenidyl Hcl

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	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.
Age Restrictions	Automatic approval if member is less than 65 years of age. Prior authorization required for age 65 or older.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

HYDROXYPROGESTERONE

Products Affected

- Hydroxyprogesterone Caproate INJ 1.25GM/5ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	B vs D coverage determination

IMMUNE STIMULANTS

Products Affected

- Adagen

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

IMMUNE STIMULANTS, NON-VACCINE

Products Affected

- Pegasys
- Pegasys Proclick

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of genotype to determine length of therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 to 48 weeks based on indication and established treatment guidelines
Other Criteria	N/A

IMMUNE SUPPRESSANTS

Products Affected

- Enbrel
- Enbrel Mini
- Enbrel Sureclick
- Humira
- Humira Pediatric Crohns Disease Starter Pack
- Humira Pen
- Humira Pen-cd/uc/hs Starter
- Humira Pen-ps/uv Starter
- Renflexis

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis and past medication history.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months

Other Criteria	Use of Humira, Enbrel, or Renflexis 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 Renflexis 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 Renflexis will also be considered medically necessary for the treatment of fistulizing Crohn's disease. B vs D coverage determination required for Renflexis.

IMMUNE SUPPRESSANTS - TRANSPLANT RELATED

Products Affected

- Astagraf XL
- Atgam
- Azasan
- Azathioprine INJ
- Azathioprine TABS
- Cyclosporine CAPS
- Cyclosporine INJ
- Cyclosporine Modified
- Envarsus Xr
- Gengraf
- Mycophenolate Mofetil
- Mycophenolic Acid Dr
- Prograf INJ
- Rapamune SOLN
- Sandimmune SOLN
- Sirolimus TABS
- Tacrolimus CAPS
- Zortress

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	B vs D coverage determination

IMMUNOMODULATORS

Products Affected

- Avonex
- Avonex Pen
- Betaseron
- Copaxone INJ 20MG/ML, 40MG/ML
- Gilenya
- Rebif
- Rebif Rebidose
- Rebif Rebidose Titration Pack
- Rebif Titration Pack
- Tecfidera
- Tecfidera Starter Pack

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of a relapsing form of multiple sclerosis (MS) (e.g., relapsing-remitting MS, progressive-relapsing MS, or secondary progressive MS with relapses).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Before Rebif will be authorized, patient must have failure, contraindication or intolerance to two of the following: Avonex, Betaseron, Copaxone, Gilenya and Tecfidera. For other immunomodulators, no trial and failure is required.

INSULIN-LIKE GROWTH FACTOR

Products Affected

- Increlex

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis. Documentation of lab data reflecting height standard deviation score, basal IGF-1 score, and growth hormone level.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	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.

ISTODAX

Products Affected

- Istodax (overfill)
- Romidepsin

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis and past medication history.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	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.

JEVTANA

Products Affected

- Jevtana

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	B vs D coverage determination

KALYDECO

Products Affected

- Kalydeco

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Patients with cystic fibrosis (CF) who are homozygous for the F508del mutation in the CFTR gene.
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

KORLYM

Products Affected

- Korlym

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

KUVAN

Products Affected

- Kuvan

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial Approval: 2 months. Reauthorization: 12 months
Other Criteria	For reauthorization: the patient must have responded to a therapeutic trial of Kuvan. Response is defined as a 30% or greater reduction in blood phenylalanine level from baseline.

LIDOCAINE PATCH

Products Affected

- Lidocaine PTCH

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	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 duloxetine and Lyrica. For cancer related neuropathic pain (including treatment-related neuropathy), no additional criteria are required to be met.

LONSURF

Products Affected

- Lonsurf

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

LUMIZYME

Products Affected

- Lumizyme

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	B vs D coverage determination

MAKENA

Products Affected

- Hydroxyprogesterone Caproate INJ 250MG/ML
- Makena

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	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).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	21 weeks
Other Criteria	B vs D coverage determination

MEMANTINE

Products Affected

- Memantine Hcl
- Memantine Hcl Titration Pak
- Memantine Hydrochloride SOLN
- Memantine Hydrochloride Er

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Automatic approval if member is greater than 26 years of age. Prior Authorization is required for age 26 or younger.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

METABOLIC BONE DISEASE AGENTS

Products Affected

- Forteo INJ 600MCG/2.4ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of osteoporosis based on DEXA (T-score less than or equal to -2.5) or based on presence of documented fragility fracture.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	2 years from initiation of therapy
Other Criteria	Member has tried and/or failed a 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 bisphosphonates or SERMs are not required.

MOLECULAR TARGET INHIBITORS

Products Affected

- Afinitor
- Afinitor Disperz
- Alecensa
- Alunbrig
- Bosulif
- Braftovi
- Cabometyx
- Calquence
- Cometriq
- Copiktra
- Cotellic
- Gilotrif
- Ibrance
- Iclusig
- Idhifa
- Imatinib Mesylate
- Imbruvica
- Inlyta
- Iressa
- Jakafi
- Kisqali
- Kisqali Femara 200 Dose
- Kisqali Femara 400 Dose
- Kisqali Femara 600 Dose
- Lenvima 10 Mg Daily Dose
- Lenvima 12mg Daily Dose
- Lenvima 14 Mg Daily Dose
- Lenvima 18 Mg Daily Dose
- Lenvima 20 Mg Daily Dose
- Lenvima 24 Mg Daily Dose
- Lenvima 4 Mg Daily Dose
- Lenvima 8 Mg Daily Dose
- Lorbrena
- Lynparza
- Mekinist
- Mektovi
- Nerlynx
- Nexavar
- Pomalyst
- Rubraca
- Rydapt
- Sprycel
- Stivarga
- Sutent
- Synribo
- Tafinlar
- Tarceva
- Tasigna
- Tibsovo
- Tykerb
- Verzenio
- Vizimpro
- Votrient
- Xalkori
- Zejula
- Zydelig
- Zykadia

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A

Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

MONOCLONAL ANTIBODIES

Products Affected

- Xolair

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

NAMZARIC

Products Affected

- Namzaric

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Automatic approval if member is greater than 26 years of age. Prior Authorization is required for age 26 or younger.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

NATPARA

Products Affected

- Natpara

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

NINLARO

Products Affected

- Ninlaro

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis and current medication regimen.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Ninlaro is approved with concurrent use of dexamethasone and lenalidomide.

NON-AMPHETAMINE CENTRAL NERVOUS SYSTEM AGENTS

Products Affected

- Armodafinil

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis and sleep study for the diagnosis of sleep apnea or narcolepsy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

NORTHERA

Products Affected

- Northera

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Northera will be used for patients with neurogenic orthostatic hypotension associated with one of the following diagnoses: 1.) Primary autonomic failure due to Parkinson's disease, multiple system atrophy, or pure autonomic failure, OR 2.) Dopamine beta hydroxylase deficiency, OR 3.) Non-diabetic autonomic neuropathy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial Approval: 3 months. Reauthorization: 12 months
Other Criteria	The patient must have failure, contraindication or intolerance to fludrocortisone acetate or midodrine. Reauthorization Criteria: The member has experienced a positive clinical response with Northera use.

NUEDEXTA

Products Affected

- Nuedexta

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

NULOJIX

Products Affected

- Nulojix

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of Epstein-Barr virus serology and current medication regimen.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Documentation of use in combination with basiliximab induction, mycophenolate mofetil, and corticosteroids. B vs D coverage determination.

NUPLAZID

Products Affected

- Nuplazid

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For the treatment of Parkinson's disease psychosis: The patient has experienced hallucinations or delusions associated with Parkinson's disease psychosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

ODOMZO

Products Affected

- Odomzo

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For the treatment of Locally Advanced Basal Cell Carcinoma: the cancer has recurred following surgery or radiation therapy OR the patient is not a candidate for surgery or radiation therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

OFEV

Products Affected

- Ofev

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Other known causes of interstitial lung disease e.g., domestic and occupational environmental exposures, connective tissue disease, and drug toxicity.
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Ofev will be used as monotherapy.

ORKAMBI

Products Affected

- Orkambi

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	CF mutation test documenting the patient is homozygous for the F508del mutation in the CFTR gene.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

PERJETA

Products Affected

- Perjeta

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of previous and current treatment.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	B vs D coverage determination

PHOSPHODIESTERASE TYPE 4 (PDE4) INHIBITORS

Products Affected

- Daliresp

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For initial therapy: trial and failure, contraindication, or intolerance to two formulary inhaled COPD agents is required. For continuation of therapy, approve if patient has already been started on Daliresp.

PHOSPHODIESTERASE TYPE 5 (PDE5) INHIBITORS

Products Affected

- Sildenafil TABS 20MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Medical documentation of pulmonary arterial hypertension.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

PITUITARY HORMONES

Products Affected

- Eligard
- Genotropin
- Genotropin Miniquick
- Leuprolide Acetate INJ
- Lupron Depot (1-month)
- Lupron Depot (3-month)
- Lupron Depot (4-month)
- Lupron Depot (6-month)
- Lupron Depot-ped (1-month)
- Lupron Depot-ped (3-month)
- Synarel
- Trelstar
- Trelstar Mixject
- Triptodur

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

POTIGA

Products Affected

- Potiga

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

PRALUENT

Products Affected

- Praluent

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of one of the following: Clinical atherosclerotic cardiovascular disease (ASCVD) OR Heterozygous familial hypercholesterolemia (HeFH)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial:6 mo. Reauthorization for 12 mo requires documented evidence of clinical beneficial response
Other Criteria	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.

PROMACTA

Products Affected

- Promacta

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

PURIXAN

Products Affected

- Purixan

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Documentation of trial, contraindication, or failure to mercaptopurine tablets.

RELISTOR

Products Affected

- Relistor INJ

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis and past medication history.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	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.

REPATHA

Products Affected

- Repatha
- Repatha Pushtronex System
- Repatha Sureclick

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of one of the following: Clinical atherosclerotic cardiovascular disease (ASCVD) OR Primary Hyperlipidemia (including Heterozygous familial hypercholesterolemia (HeFH)) 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.)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial:6 mo. Reauthorization for 12 mo requires documented evidence of clinical beneficial response
Other Criteria	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

Products Affected

- Revlimid

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

RUCONEST

Products Affected

- Ruconest

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Patient must have a confirmed diagnosis of HAE.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

SABRIL

Products Affected

- Sabril TABS
- Vigabatrin
- Vigadrone

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation from the medical record of diagnosis and past medication history.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	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

Products Affected

- Samsca

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Maximum of 30 days for each course of treatment (initial or retreatment)
Other Criteria	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).

SIGNIFOR

Products Affected

- Signifor

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

SIRTURO

Products Affected

- Sirturo

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation from the medical record required indicating the patient has multi-drug resistant tuberculosis resistant to isoniazid and rifampin.
Age Restrictions	The patient must be 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	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 PHENYLBUTYRATE

Products Affected

- Sodium Phenylbutyrate POWD 3GM/TSP
- Sodium Phenylbutyrate TABS

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

SYLATRON

Products Affected

- Sylatron

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

SYNAGIS

Products Affected

- Synagis INJ 100MG/ML, 50MG/0.5ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	N/A

TAGRISSO

Products Affected

- Tagrisso

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of metastatic epidermal growth factor receptor (EGFR) T790M mutation-positive non-small cell lung cancer (NSCLC) or exon 19 deletions or exon 21 L858R mutations.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

TETRABENAZINE

Products Affected

- Tetrabenazine

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis of chorea associated with Huntington's Disease. CYP 2D6 genotype must be provided for doses greater than 50mg/day.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

THALIDOMIDE (THALOMID)

Products Affected

- Thalomid

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

THIOTEPA

Products Affected

- Thiotepa INJ 15MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	B vs D coverage determination

TOPICAL LIDOCAINE

Products Affected

- Glydo
- Lidocaine OINT
- Lidocaine Hcl EXTERNAL SOLN 4%
- Lidocaine Hcl GEL
- Lidocaine Hcl Jelly
- Lidocaine/prilocaine CREA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	If being used as part of a compounded product, all active ingredients in the compounded product must be FDA approved for topical use.

TRANSMUCOSAL FENTANYL CITRATE

Products Affected

- Fentanyl Citrate Oral Transmucosal

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation from the medical record of diagnosis.
Age Restrictions	16 years of age and older for fentanyl citrate (lozenge/troche)
Prescriber Restrictions	Enrollment in the Transmucosal Immediate-Release Fentanyl (TIRF) REMS Access program.
Coverage Duration	12 months
Other Criteria	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.

TYSABRI

Products Affected

- Tysabri

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

VALCHLOR GEL

Products Affected

- Valchlor

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis and past medical history.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	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.

VASODILATORS

Products Affected

- Opsumit
- Tracleer

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of pulmonary arterial hypertension.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

VELCADE

Products Affected

- Bortezomib
- Velcade

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	B vs D coverage determination

VENCLEXTA

Products Affected

- Venclexta
- Venclexta Starting Pack

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

VENTAVIS

Products Affected

- Ventavis

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	B vs D coverage determination

VIBERZI

Products Affected

- Viberzi

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of irritable bowel syndrome with diarrhea.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	The patient must have a history of failure, contraindication or intolerance to one antidiarrheal drug.

VOSEVI

Products Affected

- Vosevi

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Treatment naive patients
Required Medical Information	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.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 weeks, based on indication and established treatment guidelines
Other Criteria	N/A

XATMEP

Products Affected

- Xatmep

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

XGEVA

Products Affected

- Xgeva

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 Months
Other Criteria	For initial therapy in the treatment of hypercalcemia of malignancy: trial and failure, contraindication, or intolerance to one intravenous bisphosphonate (e.g. pamidronate, zoledronic acid) is required. For continuation of therapy in the treatment of hypercalcemia of malignancy, approve if patient has already been started on Xgeva. For other medically accepted indication, no trial of alternatives is required.

XIFAXAN

Products Affected

- Xifaxan TABS 550MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	For diagnosis for Traveler's Diarrhea: 1 month. All other indications: 12 months
Other Criteria	N/A

XTANDI

Products Affected

- Xtandi

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation from medical records of diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Xtandi is considered medically necessary in patients who have a diagnosis of castration-resistant prostate cancer.

XYREM

Products Affected

- Xyrem

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	The patient must not be taking any sedative hypnotic agents or other CNS depressants.
Required Medical Information	Documentation of diagnosis, sleep study, and enrollment in Xyrem REMS Program.
Age Restrictions	The patient must be 7 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	For the initial treatment of excessive daytime sleepiness (EDS) in patients with narcolepsy: trial and failure, contraindication, or intolerance to one CNS stimulant (e.g., methylphenidate, dexmethylphenidate, dextroamphetamine) or armodafinil is required. For continuation of therapy in the treatment of excessive daytime sleepiness (EDS) in patients with narcolepsy, approve if patient has already been started on Xyrem. For other medically accepted indication, no trial of alternatives is required.

YONDELIS

Products Affected

- Yondelis

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	B vs D coverage determination

YONSA

Products Affected

- Yonsa

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation from medical records of diagnosis
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Yonsa is approved for use in combination with methylprednisolone for treatment of metastatic castration-resistant prostate cancer. The patient must have a history of failure, intolerance, or contraindication to Zytiga and Xtandi before Yonsa will be authorized.

ZALTRAP

Products Affected

- Zaltrap

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	B vs D coverage determination

ZELBORAF

Products Affected

- Zelboraf

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For unresectable or metastatic melanoma, requires documentation of BRAF V600E mutation. For Erdheim-Chester Disease, requires documentation of BRAF V600 mutation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

ZYTIGA

Products Affected

- Zytiga

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Zytiga is approved for use in combination with prednisone.

PART B VERSUS PART D

Products Affected

- Acetylcysteine SOLN
- Acyclovir Sodium INJ 50MG/ML
- Adriamycin INJ 2MG/ML
- Adrucil INJ 2.5GM/50ML, 500MG/10ML, 5GM/100ML
- Albuterol Sulfate NEBU
- Amifostine
- Amino Acid INJ 50MG/ML; 50MG/ML
- Aminosyn INJ 148MEQ/L; 1280MG/100ML; 980MG/100ML; 1280MG/100ML; 300MG/100ML; 720MG/100ML; 940MG/100ML; 720MG/100ML; 400MG/100ML; 440MG/100ML; 5.4MEQ/L; 860MG/100ML; 420MG/100ML; 520MG/100ML; 160MG/100ML; 44MG/100ML; 800MG/100ML, 90MEQ/L; 1100MG/100ML; 850MG/100ML; 35MEQ/L; 1100MG/100ML; 260MG/100ML; 620MG/100ML; 810MG/100ML; 624MG/100ML; 340MG/100ML; 380MG/100ML; 5.4MEQ/L; 750MG/100ML; 370MG/100ML; 460MG/100ML; 150MG/100ML; 44MG/100ML; 680MG/100ML
- Aminosyn 7%/electrolytes
- Aminosyn 8.5%/electrolytes
- Aminosyn II INJ 107.6MEQ/L; 1490MG/100ML; 1527MG/100ML; 1050MG/100ML; 1107MG/100ML; 750MG/100ML; 450MG/100ML; 990MG/100ML; 1500MG/100ML; 1575MG/100ML; 258MG/100ML; 447MG/100ML; 1083MG/100ML; 795MG/100ML; 50MEQ/L; 600MG/100ML; 300MG/100ML; 405MG/100ML; 750MG/100ML, 50.3MEQ/L; 695MG/100ML; 713MG/100ML; 490MG/100ML; 517MG/100ML; 350MG/100ML; 210MG/100ML; 462MG/100ML; 700MG/100ML; 735MG/100ML; 120MG/100ML; 209MG/100ML; 505MG/100ML; 371MG/100ML; 31.3MEQ/L; 280MG/100ML; 140MG/100ML; 189MG/100ML; 350MG/100ML, 61.1MEQ/L; 844MG/100ML; 865MG/100ML; 595MG/100ML; 627MG/100ML; 425MG/100ML; 255MG/100ML; 561MG/100ML; 850MG/100ML; 893MG/100ML; 146MG/100ML; 253MG/100ML; 614MG/100ML; 450MG/100ML; 33.3MEQ/L; 340MG/100ML; 170MG/100ML; 230MG/100ML; 425MG/100ML, 71.8MEQ/L; 993MG/100ML; 1018MG/100ML; 700MG/100ML; 738MG/100ML; 500MG/100ML; 300MG/100ML; 660MG/100ML; 1000MG/100ML; 1050MG/100ML; 172MG/100ML; 298MG/100ML; 722MG/100ML; 530MG/100ML; 38MEQ/L; 400MG/100ML; 200MG/100ML; 270MG/100ML; 500MG/100ML
- Aminosyn II 8.5%/electrolytes

- Aminosyn M INJ 65MEQ/L; 448MG/100ML; 343MG/100ML; 40MEQ/L; 448MG/100ML; 105MG/100ML; 252MG/100ML; 329MG/100ML; 252MG/100ML; 3MEQ/L; 140MG/100ML; 154MG/100ML; 3.5MMOLE/L; 13MEQ/L; 300MG/100ML; 147MG/100ML; 40MEQ/L; 182MG/100ML; 56MG/100ML; 31MG/100ML; 280MG/100ML
- Aminosyn-hbc
- Aminosyn-pf INJ 46MEQ/L; 698MG/100ML; 1227MG/100ML; 527MG/100ML; 820MG/100ML; 385MG/100ML; 312MG/100ML; 760MG/100ML; 1200MG/100ML; 677MG/100ML; 180MG/100ML; 427MG/100ML; 812MG/100ML; 495MG/100ML; 3.4MEQ/L; 70MG/100ML; 512MG/100ML; 180MG/100ML; 44MG/100ML; 673MG/100ML
- Aminosyn-pf 7%
- Aminosyn-rf
- Aprepitant
- Aralast Np INJ 1000MG, 500MG, 800MG
- Arsenic Trioxide INJ
- Arzerra
- Azacitidine
- Bendeka
- Bicnu
- Bleomycin
- Bleomycin Sulfate INJ
- Budesonide SUSP
- Busulfan
- Busulfex
- Carboplatin INJ 150MG/15ML, 450MG/45ML, 50MG/5ML, 600MG/60ML
- Carmustine
- Cerezyme
- Cisplatin INJ 100MG/100ML, 200MG/200ML, 50MG/50ML
- Cladribine
- Clinimix 2.75%/dextrose 5%
- Clinimix 4.25%/dextrose 10%
- Clinimix 4.25%/dextrose 20%
- Clinimix 4.25%/dextrose 25%
- Clinimix 4.25%/dextrose 5%
- Clinimix 5%/dextrose 15%
- Clinimix 5%/dextrose 20%
- Clinimix 5%/dextrose 25%
- Clinimix E 2.75%/dextrose 10%
- Clinimix E 4.25%/dextrose 10%
- Clinimix E 4.25%/dextrose 25%
- Clinimix E 5%/dextrose 25%
- Clinimix N9g15e
- Clinisol Sf 15%
- Clofarabine
- Cromolyn Sodium NEBU
- Cyclophosphamide CAPS
- Cyclophosphamide INJ
- Cytarabine INJ 100MG/ML, 20MG/ML
- Cytarabine Aqueous
- Dacarbazine INJ 100MG, 200MG
- Dactinomycin
- Daptomycin
- Daunorubicin Hcl INJ 20MG/4ML
- Daunorubicin Hydrochloride
- Dexrazoxane
- Dextrose INJ
- Dextrose 10%/nacl 0.45%
- Dextrose 5% /electrolyte #48 Viaflex
- Dextrose 10%
- Dextrose 10%/nacl 0.2%
- Dextrose 2.5%/nacl 0.45%
- Dextrose 20%
- Dextrose 25% INJ 250MG/ML
- Dextrose 30%
- Dextrose 40%
- Dextrose 5%/lactated Ringers
- Dextrose 50%
- Docefrez INJ 20MG

- Docetaxel INJ 140MG/7ML, 160MG/16ML, 160MG/8ML, 200MG/10ML, 200MG/20ML, 20MG/2ML, 20MG/ML, 80MG/4ML, 80MG/8ML
- Doxorubicin Hcl INJ 10MG, 2MG/ML, 50MG
- Doxorubicin Hcl Liposome
- Doxorubicin Hydrochloride Liposomal
- Duramorph
- Elitek
- Emend SUSR
- Engerix-b
- Epirubicin Hcl INJ 200MG/100ML, 50MG/25ML
- Erwinaze
- Ethyol
- Etoposide INJ 100MG/5ML, 1GM/50ML, 500MG/25ML
- Fabrazyme
- Faslodex INJ 250MG/5ML
- Fentanyl Citrate INJ 1000MCG/20ML, 100MCG/2ML, 2500MCG/50ML, 250MCG/5ML
- Firmagon
- Fludarabine Phosphate
- Fluorouracil INJ 1GM/20ML, 2.5GM/50ML, 500MG/10ML, 5GM/100ML
- Folotyn
- Freamine Hbc 6.9%
- Freamine III INJ 89MEQ/L; 710MG/100ML; 950MG/100ML; 3MEQ/L; 24MG/100ML; 1400MG/100ML; 280MG/100ML; 690MG/100ML; 910MG/100ML; 730MG/100ML; 530MG/100ML; 560MG/100ML; 10MMOLE/L; 120MG/100ML; 1120MG/100ML; 590MG/100ML; 10MEQ/L; 400MG/100ML; 150MG/100ML; 660MG/100ML
- Gammaked
- Gamunex-c
- Ganciclovir INJ 500MG, 500MG/10ML
- Gemcitabine
- Gemcitabine Hcl
- Gemcitabine Hydrochloride
- Granisetron Hcl INJ 0.1MG/ML, 1MG/ML
- Granisetron Hcl TABS
- Granisetron Hydrochloride
- Hepatamine
- Heplisav-b
- Herceptin INJ 150MG
- Idarubicin Hcl INJ 10MG/10ML
- Idarubicin Hydrochloride INJ 10MG/10ML
- Ifosfamide
- Imovax Rabies (h.d.c.v.)
- Intralipid INJ 20GM/100ML, 30GM/100ML
- Ipratropium Bromide INHALATION SOLN 0.02%
- Ipratropium Bromide/albuterol Sulfate
- Irinotecan
- Irinotecan Hcl
- Irinotecan Hydrochloride
- Ixempra Kit
- Kabiven
- Kcl 0.075%/d5w/nacl 0.45%
- Kcl 0.15%/d5w/nacl 0.2%
- Kcl 0.15%/d5w/nacl 0.225% INJ 5%; 20MEQ/L; 0.225%
- Kcl 0.15%/d5w/nacl 0.45%
- Kcl 0.15%/d5w/nacl 0.9%
- Kcl 0.3%/d5w/nacl 0.45%
- Kcl 0.3%/d5w/nacl 0.9%
- Kyprolis
- Lactated Ringers INJ 3MEQ/L; 109MEQ/L; 28MEQ/L; 4MEQ/L; 130MEQ/L
- Lactated Ringers Viaflex
- Lipodox
- Lipodox 50
- Liposyn III INJ 1.2GM/100ML; 2.5GM/100ML; 10GM/100ML, 1.2GM/100ML; 2.5GM/100ML; 20GM/100ML

- Magnesium Sulfate INJ 20GM/500ML, 2GM/50ML, 40GM/1000ML, 4GM/100ML, 4GM/50ML, 50%
- Magnesium Sulfate In D5w INJ 5%; 1GM/100ML
- Melphalan Hydrochloride
- Mesna
- Mitomycin INJ 20MG, 40MG, 5MG
- Mitoxantrone Hcl INJ 2MG/ML
- Morphine Sulfate INJ 0.5MG/ML, 10MG/ML, 150MG/30ML, 15MG/ML, 1MG/ML, 25MG/ML, 2MG/ML, 4MG/ML, 50MG/ML, 5MG/ML, 8MG/ML
- Mustargen
- Nebupent
- Nephramine
- Nipent
- Normosol -r
- Normosol-m In D5w
- Normosol-r
- Normosol-r In D5w
- Nutrilipid
- Nutrilyte INJ 2.03MEQ/ML; 0.25MEQ/ML; 1.68MEQ/ML; 0.25MEQ/ML; 0.4MEQ/ML; 2.03MEQ/ML; 1.25MEQ
- Nutrilyte II
- Oncaspar
- Ondansetron Hcl ORAL SOLN
- Ondansetron Hcl TABS
- Ondansetron Odt
- Oxaliplatin
- Paclitaxel INJ 100MG/16.7ML, 150MG/25ML, 300MG/50ML, 30MG/5ML
- Pamidronate Disodium
- Perforomist
- Perikabiven
- Plenamine
- Potassium Chloride INJ 10MEQ/100ML, 20MEQ/100ML, 2MEQ/ML, 40MEQ/100ML
- Potassium Chloride /sodium Chloride
- Potassium Chloride/dextrose INJ 5%; 20MEQ/L, 5%; 40MEQ/L
- Potassium Chloride/dextrose/lactated Ringers
- Potassium Chloride/dextrose/sodium Chloride
- Potassium Chloride/sodium Chloride INJ 20MEQ/L; 0.45%, 20MEQ/L; 0.9%, 40MEQ/L; 0.9%
- Premasol
- Procalamine
- Prolastin-c INJ 1000MG
- Proleukin
- Prosol
- Pulmozyme
- Rabavert
- Recombivax Hb
- Remodulin
- Ribavirin SOLR
- Ringers Injection INJ 4.5MEQ/L; 156MEQ/L; 4MEQ/L; 147MEQ/L
- Simulect
- Sodium Lactate INJ 5MEQ/ML
- Temsirolimus
- Thymoglobulin
- Tobramycin NEBU
- Toposar INJ 100MG/5ML, 1GM/50ML, 500MG/25ML
- Torisel
- Tpn Electrolytes
- Travasol INJ 52MEQ/L; 1760MG/100ML; 880MG/100ML; 34MEQ/L; 1760MG/100ML; 372MG/100ML; 406MG/100ML; 526MG/100ML; 492MG/100ML; 492MG/100ML; 526MG/100ML; 356MG/100ML; 500MG/100ML; for Traveler's Diarrhea: 1 month. All 1 month. All other indi
- Treanda
- Trisenox
- Trogarzo
- Trophamine
- Uvadex
- Vinblastine Sulfate INJ 1MG/ML

- Vincasar Pfs
- Vincristine Sulfate INJ
- Vinorelbine Tartrate
- Vyxeos
- Zanosar
- Zemaira
- Zoledronic Acid INJ 4MG, 4MG/5ML, 5MG/100ML

Details

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

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