Santa Clara Family Health Plan
Cal MediConnect Formulary

List of Prior Authorization Requirements

Effective: 09/01/2019

ABALOPARATIDE

Products Affected

- TYMLOS

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	ONE OF THE FOLLOWING: (1) HIGH RISK FOR FRACTURES DEFINED AS ONE OF THE FOLLOWING: HISTORY OF OSTEOPOROTIC (I.E., FRAGILITY, LOW TRAUMA) FRACTURE(S). 2 OR MORE RISK FACTORS FOR FRACTURE (E.G., HISTORY OF MULTIPLE RECENT LOW TRAUMA FRACTURES, BMD T-SCORE LESS THAN OR EQUAL TO -2.5, CORTICOSTEROID USE, OR USE OF GNRH ANALOGS SUCH AS NAFARELIN, ETC.). NO PRIOR TREATMENT FOR OSTEOPOROSIS AND FRAX SCORE OF AT LEAST 20% FOR ANY MAJOR FRACTURE OR OF AT LEAST 3% FOR HIP FRACTURE. (2) UNABLE TO USE ORAL THERAPY (I.E., UPPER GASTROINTESTINAL PROBLEMS UNABLE TO TOLERATE ORAL MEDICATION, LOWER GASTROINTESTINAL PROBLEMS UNABLE TO ABSORB ORAL MEDICATIONS, TROUBLE REMEMBERING TO TAKE ORAL MEDICATIONS OR COORDINATING AN ORAL BISPHOSPHONATE WITH OTHER ORAL MEDICATIONS OR THEIR DAILY ROUTINE). (3) ADEQUATE TRIAL OF, INTOLERANCE TO, OR A CONTRAINDICATION TO BISPHOSPHONATES (E.G., ALENDRONATE, RISEDRONATE, IBANDRONATE).
Age Restrictions	
Prescriber Restrictions	

PA Criteria	Criteria Details
Coverage Duration	12 MONTHS
Other Criteria	

ABATACEPT IV

Products Affected

- ORENCIA (WITH MALTOSE)

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS AND POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, KEVZARA, ENBREL. POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL.

ABATACEPT SQ

Products Affected

- ORENCIA
- ORENCIA CLICKJECT

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS AND POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA) PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, KEVZARA, ENBREL. POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL.

ABEMACICLIB

Products Affected

- VERZENIO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	THE PATIENT HAS NOT EXPERIENCED DISEASE PROGRESSION FOLLOWING PRIOR CDK INHIBITOR THERAPY
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	TRIAL OF OR CONTRAINDICATION TO IBRANCE (PALBOCICLIB) REQUIRED WHEN REQUEST IS FOR COMBINATION THERAPY WITH FULVESTRANT FOR HORMONE RECEPTOR (HR)-POSITIVE, HER2-NEGATIVE ADVANCED OR METASTATIC BREAST CANCER.

ABIRATERONE

Products Affected

- ZYTIGA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

ABIRATERONE SUBMICRONIZED

Products Affected

- YONSA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PREVIOUS TRIAL OF OR CONTRAINDICATION TO THE FORMULARY PREFERRED AGENT ZYTIGA (ABIRATERONE ACETATE).

ACALABRUTINIB

Products Affected

- CALQUENCE

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

ACETAMINOPHEN OTC

Products Affected

- *child pain-fever 160 mg/5 ml*
- *children's silapap elixir*
- *cvs child pain rlf 160 mg/5 ml children's, a/f*
- *infant pain rlf 80 mg/0.8 ml a/f*
- *little remedies fever 160 mg/5 a/f,d/f,gluten-free*
- *mapap 160 mg/5 ml liquid*
- *mapap 160 mg/5 ml suspension*
- *non-aspirin child's drops*
- *nortemp 80 mg/0.8 ml drop*
- *pediacare fever reducer susp*
- *ra non-aspirin 160 mg/5 ml children's,cherry*

PA Criteria	Criteria Details
Covered Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	N/A
Other Criteria	RESTRICTED TO INDIVIDUALS YOUNGER THAN 21 YEARS OF AGE FOR THE LIQUID AND DROPS ONLY.

ADALIMUMAB

Products Affected

- HUMIRA
- HUMIRA PEDIATRIC CROHNS START
- HUMIRA PEN
- HUMIRA PEN CROHNS-UC-HS START
- HUMIRA PEN PSOR-UVEITS-ADOL HS
- HUMIRA(CF)
- HUMIRA(CF) PEDI CROHNS STARTER
- HUMIRA(CF) PEN CROHNS-UC-HS
- HUMIRA(CF) PEN PSOR-UV-ADOL HS
- HUMIRA(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS: PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, OR GENITAL AREA. RENEWAL FOR RHEUMATOID ARTHRITIS, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS, PSORIATIC ARTHRITIS, ANKYLOSING SPONDYLITIS, PLAQUE PSORIASIS, HIDRADENITIS SUPPURATIVA, OR UVEITIS: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS, ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSORIASIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST. CROHN'S DISEASE/ULCERATIVE COLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST.

PA Criteria	Criteria Details
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA), AND PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. ANKYLOSING SPONDYLITIS: PREVIOUS TRIAL OF FORMULARY AGENTS NOT REQUIRED. PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE. CROHN'S DISEASE (CD) AND ULCERATIVE COLITIS (UC): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS A CORTICOSTEROID (I.E., BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE.

AFATINIB DIMALEATE

Products Affected

- GILOTRIF

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

ALECTINIB

Products Affected

- ALECENSA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

ALEMTUZUMAB - LEMTRADA

Products Affected

- LEMTRADA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 1 MONTH. RENEWAL: 12 MONTHS.
Other Criteria	RENEWAL REQUESTS FOR ALEMTUZUMAB REQUIRE THAT AT LEAST 12 MONTHS HAVE ELAPSED SINCE THE PATIENT RECEIVED THE MOST RECENT COURSE OF LEMTRADA.

ALIROCUMAB

Products Affected

- PRALUENT PEN

PA Criteria	Criteria Details
Covered Uses	PA Criteria: Pending CMS Approval
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval

ALPELISIB

Products Affected

- PIQRAY ORAL TABLET 200 MG/DAY (200 MG X 1), 250 MG/DAY (200 MG X1-50 MG X1), 300 MG/DAY (150 MG X 2)

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

AMANTADINE

Products Affected

- GOCOVRI ORAL
  CAPSULE,EXTENDED RELEASE
  24HR 137 MG, 68.5 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

ANAKINRA

Products Affected

- KINERET

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	RHEUMATOID ARTHRITIS (RA) RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, KEVZARA, ENBREL.

ANTIHISTAMINES AND DECONGESTANTS

Products Affected

- *ala-hist ir 2 mg tablet*
- ALA-HIST PE 2-10 MG TABLET
- *alavert 10 mg odt*
- *aller-chlor 4 mg tablet*
- *aller-tec 10 mg tablet*
- *allergy 4 mg tablet*
- *allergy relief 10 mg odt non-drowsy*
- *allerhist 1.34 mg tablet*
- *aprodine tablet*
- *cetirizine hcl 1 mg/ml soln children, s/f, grape (otc)*
- *cetirizine hcl 10 mg chew tab outer*
- *cetirizine hcl 10 mg tablet*
- *cetirizine hcl 5 mg chew tab children's,outer,u-d*
- *cetirizine hcl 5 mg tablet indoor & outdoor*
- *child allegra allergy 30 mg/5 ml suspension*
- *child dometuss-da liquid*
- *child loratadine 5 mg/5 ml syr grape, s/f*
- *child triaminic cold-allergy*
- *child wal-itin 5 mg/5 ml soln*
- *child wal-tap cold-allergy elx*
- *child wal-zyr 1 mg/ml solution*
- *child's aller-tec 1 mg/ml soln*
- *child's wal-zyr 10 mg chew tab*
- *children's silfedrine liq*
- *children's wal-fex 30 mg/5 ml*
- CHILDS SUDAFED 15 MG/5 ML LIQ NON-DROWSY,A/F,S/F
- *chlorhist 4 mg tablet*
- *chlorpheniramine er 12 mg tab*
- *cold-allergy-sinus*
- *conex tablet*
- *cvs allergy relief 5 mg/5 ml children's,non-drwsy*
- *cvs child allergy 10 mg chw tb 24 hr,indoor/outdoor*
- *cvs child allergy rlf 30 mg/5*
- *cvs cold & cough nighttime liq*
- *cvs motion sickness relief tab chewable tablet*
- DALLERGY 1-5 MG TABLET
- *dayhist allergy 1.34 mg tablet 12 hr relief*
- *dexbromphenir-phenyleph 2-10 mg*
- *dimaphen elixir a/f, grape, gluten-f*
- *dimetapp cold & congest liquid*
- *dramamine less drowsy 25 mg tb*
- *ed a-hist liquid (otc)*
- *ed chlorped drops*
- *ed chlorped jr syrup*
- *ed-a-hist 4 mg-10 mg tablet*
- *eql allergy 4 mg tablet*
- *fexofenadine hcl 180 mg tablet 24hr,original str (otc)*
- *fexofenadine hcl 30 mg/5 ml*
- *fexofenadine hcl 60 mg tablet indoor/outdoor (otc)*
- *glenmax peb liquid*
- *histex-pe syrup*
- *kro child nite time cold & cgh*
- *lohist-d liquid*
- *loradamed 10 mg tablet outer*
- *loratadine 10 mg tablet*
- *meclizine 12.5 mg caplet caplet (otc)*
- *meclizine 25 mg tablet (otc)*
- PEDIAVENT 1 MG TABLET CHEW
- PEDIAVENT 2 MG/5 ML SYRUP
- *phenylephrine-pyrilamine 10-25*
- *promethazine-codeine syrup*
- *promethazine-dm solution*
- *promethazine-pe-codeine syrup*
- *pseudoephed 30 mg/5 ml soln*
- *pseudoephedrine 30 mg tablet*
- *pseudoephedrine 60 mg tablet ex-str, non drowsy (otc)*
- *ra motion sickness rlf tb chew raspberry flavor*
- *ritifed syrup*
- RYMED TABLET
- *rynex pse liquid*
- *sm adult nasal decongestant lq*
- *sm allergy relief 1.34 mg tab*

- STAHIST LIQUID
- *sudogest 30 mg tablet boxed*
- *sudogest 60 mg tablet*
- *sudogest sinus and allergy tab*
- *suphedrin liquid*
- *travel sickness 25 mg tab chew*
- *travel-ease 25 mg tablet*
- *trymine d liquid*
- *valu-tapp decongestant drop*
- *vazotab 10-25 mg tablet*
- *vicks qlearquil allergy 10 mg*
- *wal-act d cold & allergy tab*
- *wal-dram-2 25 mg tablet*
- *wal-fex allergy 180 mg tablet*
- *wal-fex allergy 60 mg tablet*
- *wal-finate 4 mg tablet*
- *wal-finate-d tablet*
- *wal-itin 10 mg tablet non-drowsy,24 hr rlf*
- *wal-phed 30 mg tablet non-drowsy*
- *wal-phed pe sinus-allergy tab*
- *wal-phed sinus and allergy tab*
- *wal-tap elixir*
- *wal-zyr 10 mg tablet*
- *zephrex-d 30 mg tablet*

PA Criteria	Criteria Details
Covered Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	N/A
Other Criteria	RESTRICTED TO INDIVIDUALS 2 YEARS OF AGE AND OLDER.

ANTIHISTAMINES AND DECONGESTANTS - DIPHENHYDRAMINE

Products Affected

- *aler-caps 25 mg capsule*
- *alka-seltzer plus allergy tab*
- *banophen 25 mg capsule*
- *banophen 25 mg tablet*
- *banophen 50 mg capsule*
- *banophen allergy 12.5 mg/5 ml a/f*
- BENADRYL ALLERGY 25 MG ULTRATB
- *child's wal-dryl 12.5 mg/5 ml children,a/f,cherry*
- *compoz 25 mg gelcap*
- *cvs allergy 25 mg capsule*
- *diphedryl 12.5 mg/5 ml elixir*
- *diphenhist 12.5 mg/5 ml soln*
- *diphenhist 25 mg capsule*
- *diphenhist 25 mg captab captab*
- *diphenhydramine 25 mg capsule (otc)*
- *diphenhydramine 50 mg capsule (otc)*
- *eql allergy 25 mg tablet*
- *geri-dryl 12.5 mg/5 ml liquid*
- *hm z-sleep 25 mg softgel*
- *nytol 25 mg quickcaps caplet caplet*
- *ra allergy med 25 mg capsule*
- *ra allergy med 25 mg tablet*
- *ra allergy med 25 mg tablet coated minitabs*
- *ra sleep tablet*
- *ra sleep-aid softgel*
- *siladryl 12.5 mg/5 ml liquid*
- *simply sleep 25 mg caplet*
- *total allergy 25 mg tablet*
- *unisom 50 mg sleepgels softgel*
- *wal-dryl allergy 12.5 mg/5 ml*
- *wal-dryl allergy 25 mg capsule*
- *wal-dryl allergy 25 mg minitab minitab, coated*
- *wal-sleep z 25 mg softgel*
- *wal-som 50 mg softgel softgel*

PA Criteria	Criteria Details
Covered Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	N/A

PA Criteria	Criteria Details
Other Criteria	RESTRICTED TO USE IN THE TREATMENT OF ALLERGIES OR ALLERGIC CONDITIONS ONLY AND TO INDIVIDUALS 2 YEARS OF AGE AND OLDER.

ANTI-OBESITY AGENTS -PHENTERMINE

Products Affected

- *lomaira 8 mg tablet*
- *phentermine 15 mg capsule*
- *phentermine 30 mg capsule pelletized*
- *phentermine 37.5 mg capsule*
- *phentermine 37.5 mg tablet*

PA Criteria	Criteria Details
Covered Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	N/A
Other Criteria	REQUEST FOR PHENTERMINE FOR THE MANAGEMENT OF WEIGHT LOSS OR WEIGHT MANAGEMENT IS RESTRICTED TO INDIVIDUALS 17 YEARS OF AGE OR OLDER. COVERED USES ONLY FOR FDA APPROVED INDICATIONS. CRITERIA TO BE MET INCLUDE ONE OF THE FOLLOWING: A BODY MASS INDEX (BMI) OF 30 KG/M2 OR GREATER OR A BMI OF 27 KG/M2 OR GREATER AND AT LEAST ONE WEIGHT-RELATED CO-MORBIDITY SUCH AS HYPERTENSION, TYPE 2 DIABETES MELLITUS, OR HYPERLIPIDEMIA.

APALUTAMIDE

Products Affected

- ERLEADA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	NON METASTATIC CASTRATION RESISTANT PROSTATE CANCER: THE PATIENT HAS HIGH RISK PROSTATE CANCER (I.E. RAPIDLY INCREASING PROSTATE SPECIFIC ANTIGEN [PSA] LEVELS) AND MEETS ONE OF THE FOLLOWING: (1) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) AGONIST OR ANTAGONIST OR (2) PREVIOUSLY RECEIVED A BILATERAL ORCHIECTOMY.

APREMILAST

Products Affected

- OTEZLA
- OTEZLA STARTER

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS: PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, OR GENITAL AREA. RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSORIASIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL. PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, SKYRIZI.

ASFOTASE

Products Affected

- STRENSIQ

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	NON-SPECIFIC ALKALINE PHOSPHATASE (TNSALP) (ALPL) GENE MUTATION, SERUM ALKALINE PHOSPHATASE (ALP) LEVEL, SERUM PYRIDOXAL-5'-PHOSPHATE (PLP) LEVELS, URINE PHOSPHOETHANOLAMINE (PEA) LEVEL, RADIOGRAPHIC EVIDENCE OF HYPOPHOSPHATASIA (HPP)
Age Restrictions	PERINATAL/INFANTILE-ONSET HYPOPHOSPHATASIA (HPP): 6 MONTHS OF AGE OR YOUNGER AT HYPOPHOSPHATASIA (HPP) ONSET. JUVENILE-ONSET HYPOPHOSPHATASIA (HPP): 18 YEARS OF AGE OR YOUNGER AT HYPOPHOSPHATASIA (HPP) ONSET.
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN ENDOCRINOLOGIST, A GENETICIST, OR A METABOLIC SPECIALIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	INITIAL: FOR PATIENTS WITH PERINATAL/INFANTILE-ONSET HYPOPHOSPHATASIA (HPP), ALL OF THE FOLLOWING CRITERIA MUST BE MET: POSITIVE FOR A TISSUE NON-SPECIFIC ALKALINE PHOSPHATASE (TNSALP) (ALPL) GENE MUTATION AS CONFIRMED BY GENETIC TESTING OR MEETS AT LEAST TWO OF THE FOLLOWING CRITERIA: 1.) SERUM ALKALINE PHOSPHATASE (ALP) LEVEL BELOW THAT OF NORMAL RANGE FOR PATIENT AGE 2.) SERUM PYRIDOXAL-5'-PHOSPHATE (PLP) LEVELS ELEVATED AND PATIENT HAS NOT RECEIVED VITAMIN B6 SUPPLEMENTATION IN THE PREVIOUS WEEK 3.) URINE PHOSPHOETHANOLAMINE (PEA) LEVEL ABOVE THAT OF NORMAL RANGE FOR PATIENT AGE 4.) RADIOGRAPHIC EVIDENCE OF HYPOPHOSPHATASIA (HPP) (E.G., FLARED AND FRAYED METAPHYSES, OSTEOPENIA, WIDENED GROWTH PLATES, AREAS OF RADIOLUCENCY OR SCLEROSIS) 5.) PRESENCE OF TWO OR MORE OF THE FOLLOWING: RACHITIC CHEST DEFORMITY, CRANIOSYNOSTOSIS (PREMATURE CLOSURE OF SKULL BONES), DELAY IN SKELETAL GROWTH RESULTING IN DELAY OF MOTOR DEVELOPMENT, HISTORY OF VITAMIN B6 DEPENDENT SEIZURES, NEPHROCALCINOSIS, OR HISTORY OF ELEVATED SERUM CALCIUM. HISTORY OR PRESENCE OF NON-TRAUMATIC POSTNATAL FRACTURE AND DELAYED FRACTURE HEALING. FOR PATIENTS WITH JUVENILE-ONSET HYPOPHOSPHATASIA (HPP), ALL OF THE FOLLOWING CRITERIA MUST BE MET: POSITIVE FOR A TISSUE NON-SPECIFIC ALKALINE PHOSPHATASE (TNSALP) (ALPL) GENE MUTATION AS CONFIRMED BY GENETIC TESTING OR MEETS AT LEAST TWO OF THE FOLLOWING CRITERIA: 1.) SERUM ALKALINE PHOSPHATASE (ALP) LEVEL BELOW THAT OF NORMAL RANGE FOR PATIENT AGE 2.) SERUM PYRIDOXAL-5'-

PA Criteria	Criteria Details
	PHOSPHATE (PLP) LEVELS ELEVATED AND PATIENT HAS NOT RECEIVED VITAMIN B6 SUPPLEMENTATION IN THE PREVIOUS WEEK 3.)URINE PHOSPHOETHANOLAMINE (PEA) LEVEL ABOVE THAT OF NORMAL RANGE FOR PATIENT AGE 4.)RADIOGRAPHIC EVIDENCE OF HYPOPHOSPHATASIA (HPP) (E.G., FLARED AND FRAYED METAPHYSES, OSTEOPENIA, OSTEOMALACIA, WIDENED GROWTH PLATES, AREAS OF RADIOLUCENCY OR SCLEROSIS) 5.)PRESENCE OF TWO OR MORE OF THE FOLLOWING:RACHITIC DEFORMITIES (RACHITIC CHEST, BOWED LEGS, KNOCK-KNEES),PREMATURE LOSS OF PRIMARY TEETH PRIOR TO 5 YEARS OF AGE, DELAY IN SKELETAL GROWTH RESULTING IN DELAY OF MOTOR DEVELOPMENT, OR HISTORY OR PRESENCE OF NON-TRAUMATIC FRACTURES OR DELAYED FRACTURE HEALING. STRENSIQ WILL NOT BE APPROVED FOR THE FOLLOWING PATIENTS: PATIENTS CURRENTLY RECEIVING TREATMENT WITH A BISPHOSPHONATE [E.G., BONIVA (IBANDRONATE), FOSAMAX (ALENDRONATE), ACTONEL (RISEDRONATE)], PATIENTS WITH SERUM CALCIUM OR PHOSPHATE LEVELS BELOW THE NORMAL RANGE, PATIENTS WITH A TREATABLE FORM OF RICKETS. RENEWAL: PATIENT HAS EXPERIENCED AN IMPROVEMENT IN THE SKELETAL CHARACTERISTICS OF HYPOPHOSPHATASIA (HPP) (E.G., IMPROVEMENT OF THE IRREGULARITY OF THE PROVISIONAL ZONE OF CALCIFICATION, PHYSEAL WIDENING, METAPHYSEAL FLARING, RADIOLUCENCIES, PATCHY OSTEOSCLEROSIS, RATIO OF MID-DIAPHYSEAL CORTEX TO BONE THICKNESS, GRACILE BONES, BONE FORMATION AND FRACTURES.

ASPARAGINASE

Products Affected

- ONCASPAR

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 MONTHS
Other Criteria	

ATEZOLIZUMAB

Products Affected

- TECENTRIQ

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

AVATROMBOPAG

Products Affected

- DOPTELET (10 TAB PACK)
- DOPTELET (15 TAB PACK)

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	PATIENT HAS A PLANNED PROCEDURE 10 TO 13 DAYS AFTER INITIATION OF DOPTELET. PATIENT IS NOT RECEIVING OTHER THROMBOPOIETIN RECEPTOR AGONISTS (E.G. ROMIPLOSTIM, ELTROMBOPAG, ETC.).
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST, GASTROENTEROLOGIST, HEPATOLOGIST, IMMUNOLOGIST, OR ENDOCRINOLOGIST.
Coverage Duration	1 MONTH
Other Criteria	

AVELUMAB

Products Affected

- BAVENCIO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

AXITINIB

Products Affected

- INLYTA ORAL TABLET 1 MG, 5 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	TRIAL OF AT LEAST ONE SYSTEMIC THERAPY FOR THE TREATMENT OF RCC SUCH AS NEXAVAR (SORAFENIB), TORISEL (TEMSIROLIMUS), SUTENT (SUNITINIB), VOTRIENT (PAZOPANIB), OR AVASTIN (BEVACIZUMAB) IN COMBINATION WITH INTERFERON.

BARICITINIB

Products Affected

- OLUMIANT

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL (RA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, KEVZARA, ENBREL.

BEDAQUILINE FUMARATE

Products Affected

- SIRTURO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	18 YEARS OF AGE AND OLDER.
Prescriber Restrictions	
Coverage Duration	24 WEEKS
Other Criteria	SIRTURO USED IN COMBINATION WITH AT LEAST 3 OTHER ANTIBIOTICS FOR THE TREATMENT OF PULMONARY MULTI-DRUG RESISTANT TUBERCULOSIS.

BELIMUMAB

Products Affected

- BENLYSTA INTRAVENOUS
- BENLYSTA SUBCUTANEOUS

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	AUTOANTIBODY POSITIVE LUPUS TEST.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: MEMBER IS CURRENTLY TAKING CORTICOSTEROIDS, ANTIMALARIALS, NSAIDS, OR IMMUNOSUPPRESSIVE AGENTS. NO APPROVAL FOR DIAGNOSIS OF SEVERE ACTIVE LUPUS NEPHRITIS, SEVERE CENTRAL NERVOUS SYSTEM LUPUS OR CONCURRENT USE OF BIOLOGIC AGENTS OR INTRAVENOUS CYCLOPHOSPHAMIDE. RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.

BELINOSTAT

Products Affected

- BELEODAQ

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

BENDAMUSTINE

Products Affected

- BENDEKA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

BENRALIZUMAB

Products Affected

- FASENRA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	CONCURRENT USE OF XOLAIR
Required Medical Information	BLOOD EOSINOPHIL LEVEL IS GREATER THAN OR EQUAL TO 150 CELLS/MCL WITHIN THE LAST 4 WEEKS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE.
Coverage Duration	INITIAL: 24 WEEKS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: PATIENT IS CURRENTLY TREATED WITH A MAXIMALLY TOLERATED DOSE OF INHALED CORTICOSTEROIDS AND AT LEAST ONE OTHER MAINTENANCE MEDICATION WHICH INCLUDES ANY OF THE FOLLOWING: LONG-ACTING INHALED BETA2-AGONIST, LONG-ACTING MUSCARINIC ANTAGONIST, A LEUKOTRIENE RECEPTOR ANTAGONIST, THEOPHYLLINE, OR ORAL CORTICOSTEROID. RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT HAS EXPERIENCED IMPROVEMENT IN ASTHMA EXACERBATIONS FROM BASELINE AND A REDUCTION IN ORAL CORTICOSTEROID DOSE (IF THE PATIENT WAS ON A MAINTENANCE REGIMEN OF ORAL CORTICOSTEROIDS AT THE INITIATION OF TREATMENT).

BEVACIZUMAB

Products Affected

- AVASTIN

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

BEVACIZUMAB-AWWB

Products Affected

- MVASI

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

BEXAROTENE

Products Affected

- *bexarotene*
- TARGRETIN TOPICAL

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

BINIMETINIB

Products Affected

- MEKTOVI

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

BLINATUMOMAB

Products Affected

- BLINCYTO INTRAVENOUS KIT

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: RELAPSED OR REFRACTORY B-CELL: 3 MOS. MRD-POSITIVE B-CELL: 2 MOS. RENEWAL: 12 MOS.

PA Criteria	Criteria Details
Other Criteria	INITIAL: RELAPSED OR REFRACTORY B-CELL PRECURSOR ALL: APPROVAL IS FOR 2 CYCLES, MAY APPROVE FOR 1 ADDITIONAL CYCLE DUE TO TREATMENT INTERRUPTION FOR DOSE MODIFICATION. RENEWAL: FOR DIAGNOSIS OF RELAPSED OR REFRACTORY B-CELL PRECURSOR ACUTE LYMPHOBLASTIC LEUKEMIA (ALL), RENEWAL IS APPROVED FOR PATIENTS WHO HAVE ACHIEVED COMPLETE REMISSION (CR) OR CR WITH PARTIAL HEMATOLOGICAL RECOVERY OF PERIPHERAL BLOOD COUNTS AFTER 2 CYCLES OF TREATMENT. RENEWAL IS NOT APPROVED FOR PATIENTS WHO RECEIVED AN ALLOGENEIC HEMATOPOIETIC STEM-CELL TRANSPLANT. FOR DIAGNOSIS OF MINIMAL RESIDUAL DISEASE (MRD)-POSITIVE B-CELL PRECURSOR ACUTE LYMPHOBLASTIC LEUKEMIA (ALL), RENEWAL IS APPROVED FOR PATIENTS WHO HAVE ACHIEVED UNDETECTABLE MINIMAL RESIDUAL DISEASE (MRD) WITHIN ONE CYCLE OF BLINCYTO TREATMENT AND IS RELAPSE-FREE (I.E., HEMATOLOGICAL OR EXTRAMEDULLARY RELAPSE, OR SECONDARY LEUKEMIA).

BORTEZOMIB

Products Affected

- BORTEZOMIB
- VELCADE

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

BOSUTINIB

Products Affected

- BOSULIF ORAL TABLET 100 MG, 400 MG, 500 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	CML: BCR-ABL MUTATIONAL ANALYSIS CONFIRMING THAT BOTH T315I AND V299L MUTATIONS ARE NOT PRESENT.

BRIGATINIB

Products Affected

- ALUNBRIG ORAL TABLET 180 MG, 30 MG, 90 MG
- ALUNBRIG ORAL TABLETS,DOSE PACK

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

BRODALUMAB

Products Affected

- SILIQ

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS: PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, OR GENITAL AREA. RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, SKYRIZI. PATIENT HAS BEEN COUNSELED ON AND EXPRESSES UNDERSTANDING OF THE RISK OF SUICIDAL IDEATION AND BEHAVIOR. RENEWAL: PATIENT HAS NOT DEVELOPED OR REPORTED WORSENING DEPRESSIVE SYMPTOMS OR SUICIDAL IDEATION AND BEHAVIORS WHILE ON TREATMENT WITH SILIQ.

C1 ESTERASE INHIBITOR-CINRYZE, BERINERT

Products Affected

- CINRYZE

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST, IMMUNOLOGIST, OR ALLERGIST.
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.

C1 ESTERASE INHIBITOR-HAEGARDA, RUCONEST

Products Affected

- HAEGARDA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST, IMMUNOLOGIST, OR ALLERGIST.
Coverage Duration	12 MONTHS
Other Criteria	

CABOZANTINIB

Products Affected

- COMETRIQ

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

CABOZANTINIB S-MALATE - CABOMETYX

Products Affected

- CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

CANAKINUMAB

Products Affected

- ILARIS (PF) SUBCUTANEOUS RECON SOLN 150 MG/ML
- ILARIS (PF) SUBCUTANEOUS SOLUTION

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST, DERMATOLOGIST, OR AN IMMUNOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	

CANNABIDIOL

Products Affected

- EPIDIOLEX

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	LENNOX-GASTAUT SYNDROME: TRIAL OF OR CONTRAINDICATION TO TOPIRAMATE OR LAMOTRIGINE AND CLOBAZAM (TABLET OR SUSPENSION).

CANNABINOIDS

Products Affected

- *dronabinol*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 MONTHS
Other Criteria	B VS D COVERAGE CONSIDERATION. PART D COVERAGE CONSIDERATION FOR A DIAGNOSIS OF NAUSEA AND VOMITING ASSOCIATED WITH CANCER CHEMOTHERAPY REQUIRES A TRIAL OF OR CONTRAINDICATION TO CONVENTIONAL ANTIEMETIC THERAPIES SUCH AS ONDANSETRON, STEROIDS INDICATED FOR EMESIS OR EMEND. NO ADDITIONAL REQUIREMENTS FOR A DIAGNOSIS OF ANOREXIA ASSOCIATED WITH WEIGHT LOSS IN PATIENTS WITH AIDS.

CAPLACIZUMAB YHDP

Products Affected

- CABLIVI INJECTION KIT

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

CARFILZOMIB

Products Affected

- KYPROLIS

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

CEMIPLIMAB

Products Affected

- LIBTAYO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

CERITINIB

Products Affected

- ZYKADIA ORAL CAPSULE
- ZYKADIA ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

CERTOLIZUMAB PEGOL

Products Affected

- CIMZIA
- CIMZIA POWDER FOR RECONST

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS: PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, OR GENITAL AREA. NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS: PATIENT HAS ONE OF THE FOLLOWING OBJECTIVE SIGNS OF INFLAMMATION: 1) C-REACTIVE PROTEIN (CRP) LEVELS ABOVE THE UPPER LIMIT OF NORMAL OR 2) SACROILIITIS ON MAGNETIC RESONANCE IMAGING (MRI). RENEWAL FOR RHEUMATOID ARTHRITIS, PSORIATIC ARTHRITIS, ANKYLOSING SPONDYLITIS, PLAQUE PSORIASIS OR NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS/ANKYLOSING SPONDYLITIS/NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. CROHN'S DISEASE: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST. PLAQUE PSORIASIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST.

PA Criteria	Criteria Details
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, KEVZARA, ENBREL. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL. PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, SKYRIZI. ANKYLOSING SPONDYLITIS (AS): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, COSENTYX, ENBREL. CROHN'S DISEASE (CD): PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA AND STELARA. PATIENTS WHO ARE PREGNANT, BREASTFEEDING, OR TRYING TO BECOME PREGNANT ARE EXCLUDED FROM STEP CRITERIA FOR ALL INDICATIONS.

CLADRIBINE

Products Affected

- MAVENCLAD (10 TABLET PACK)
- MAVENCLAD (4 TABLET PACK)
- MAVENCLAD (5 TABLET PACK)
- MAVENCLAD (6 TABLET PACK)
- MAVENCLAD (7 TABLET PACK)
- MAVENCLAD (8 TABLET PACK)
- MAVENCLAD (9 TABLET PACK)

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT HAS DEMONSTRATED CLINICAL BENEFIT COMPARED TO PRE TREATMENT BASELINE AND THE PATIENT DOES NOT HAVE LYMPHOPENIA.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	48 WEEKS
Other Criteria	

CLOBAZAM

Products Affected

- *clobazam oral suspension*
- *clobazam oral tablet*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	TRIAL OF OR CONTRAINDICATION TO LAMOTRIGINE OR TOPIRAMATE. REQUESTS FOR ORAL SUSPENSION APPROVABLE IF PATIENT IS UNABLE TO SWALLOW OR IS UNDER THE AGE OF 5 YEARS.

CLOBAZAM-SYMPAZAN

Products Affected

- SYMPAZAN

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PHYSICIAN ATTESTATION THAT THE PATIENT IS UNABLE TO TAKE TABLETS OR SUSPENSION. TRIAL OF OR CONTRAINDICATION TO A FORMULARY CLOBAZAM AGENT.

COBIMETINIB FUMARATE

Products Affected

- COTELLIC

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

COPANLISIB DI-HCL

Products Affected

- ALIQOPA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

CRIZOTINIB

Products Affected

- XALKORI

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

DABRAFENIB MESYLATE

Products Affected

- TAFINLAR

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

DACLATASVIR

Products Affected

- DAKLINZA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE AND ADDITIONAL CONSIDERATION FOR COVERAGE CONSISTENT WITH FDA LABELING.
Exclusion Criteria	
Required Medical Information	HCV RNA LEVEL WITHIN PAST 6 MONTHS.
Age Restrictions	
Prescriber Restrictions	GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.
Coverage Duration	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. TRIAL OF A PREFERRED FORMULARY ALTERNATIVE INCLUDING HARVONI, OR EPCLUSA WHEN THESE AGENTS ARE CONSIDERED ACCEPTABLE FOR TREATMENT OF THE SPECIFIC GENOTYPE PER AASLD/IDSA GUIDANCE. NO APPROVALS FOR CONCURRENT USE WITH ANY OF THESE (CONTRAINDICATED OR NOT RECOMMENDED BY THE MANUFACTURER) MEDICATIONS: AMIODARONE, CARBAMAZEPINE, PHENYTOIN, OR RIFAMPIN.

DACOMATINIB

Products Affected

- VIZIMPRO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

DALFAMPRIDINE

Products Affected

- *dalfampridine*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	WALKING DISABILITY SUCH AS MILD TO MODERATE BILATERAL LOWER EXTREMITY WEAKNESS OR UNILATERAL WEAKNESS PLUS LOWER EXTREMITY OR TRUNCAL ATAXIA.
Age Restrictions	
Prescriber Restrictions	NEUROLOGIST
Coverage Duration	INITIAL: 3 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT IN WALKING ABILITY.

DARATUMUMAB

Products Affected

- DARZALEX

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

DASATINIB

Products Affected

- SPRYCEL ORAL TABLET 100 MG, 140 MG, 20 MG, 50 MG, 70 MG, 80 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PREVIOUSLY-TREATED CHRONIC MYELOID LEUKEMIA (CML) REQUIRES BCR-ABL MUTATIONAL ANALYSIS NEGATIVE FOR THE FOLLOWING MUTATIONS: T315I, V299L, T315A, F317L/V/I/C.

DEFERASIROX

Products Affected

- *deferasirox*
- JADENU
- JADENU SPRINKLE

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST OR HEMATOLOGIST/ONCOLOGIST
Coverage Duration	INITIAL: 6 MONTHS RENEWAL: 12 MONTHS
Other Criteria	CHRONIC IRON OVERLOAD DUE TO BLOOD TRANSFUSIONS INITIAL: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 1000 MCG/L. RENEWAL: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 500 MCG/L. NON-TRANSFUSION DEPENDENT THALASSEMIA (NTDT) INITIAL: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 300 MCG/L AND LIVER IRON CONCENTRATION (LIC) OF 5 MG FE/G DRY WEIGHT OR GREATER. RENEWAL: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 300 MCG/L OR LIC OF 3 MG FE/G DRY WEIGHT OR GREATER

DEFERIPRONE

Products Affected

- FERRIPROX

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST OR HEMATOLOGIST/ONCOLOGIST
Coverage Duration	INITIAL: 6 MONTHS RENEWAL: 12 MONTHS
Other Criteria	INITIAL CRITERIA: REQUIRES TRIAL OF EXJADE (DEFERASIROX), JADENU, OR GENERIC DEFEROXAMINE AND ONE OF THE FOLLOWING CRITERIA 1) PHYSICIAN ATTESTATION THAT PATIENT IS EXPERIENCING INTOLERABLE TOXICITIES, CLINICALLY SIGNIFICANT ADVERSE EFFECTS, OR CONTRAINDICATION TO THESE THERAPIES OR 2) INADEQUATE CHELATION DEFINED BY ONE OF THE FOLLOWING: A) SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 2500 MCG/L OR B) EVIDENCE OF CARDIAC IRON ACCUMULATION. RENEWAL: SERUM FERRITIN LEVELS MUST BE CONSISTENTLY ABOVE 500MCG/L

DEFEROXAMINE

Products Affected

- *deferoxamine*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	AT LEAST 3 YEARS OF AGE OR OLDER
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST OR HEMATOLOGIST/ONCOLOGIST
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 1000MCG/L RENEWAL: SERUM FERRITIN LEVELS MUST BE CONSISTENTLY ABOVE 500MCG/L. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.

DEFLAZACORT

Products Affected

- EMFLAZA ORAL SUSPENSION
- EMFLAZA ORAL TABLET 18 MG, 30 MG, 36 MG, 6 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	PHYSICIAN ATTESTATION OF GENETIC TESTING CONFIRMING DMD DIAGNOSIS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL CRITERIA: REQUIRE TRIAL OF PREDNISONE OR PREDNISOLONE AND PATIENT MEETS ONE OF THE FOLLOWING: 1) REQUEST DUE TO ADVERSE EFFECTS OF PREDNISONE OR PREDNISOLONE OR 2) REQUEST DUE TO LACK OF EFFICACY OF PREDNISONE OR PREDNISOLONE AND ALL OF THE FOLLOWING CRITERIA ARE MET: A) PATIENT IS NOT IN STAGE 1 (PRE-SYMPTOMATIC PHASE) B) STEROID MYOPATHY HAS BEEN RULED OUT C) PHYSICIAN ATTESTATION OF DETERIORATION IN AMBULATION, FUNCTIONAL STATUS, OR PULMONARY FUNCTION CONSISTENT WITH ADVANCING DISEASE. RENEWAL CRITERIA: PATIENT HAS MAINTAINED OR DEMONSTRATED A LESS THAN EXPECTED DECLINE IN AMBULATORY ABILITY IN MUSCLE FUNCTION ASSESSMENTS OR OTHER MUSCLE FUNCTION (I.E. PULMONARY OR CARDIAC FUNCTION).

DELAFLOXACIN

Products Affected

- BAXDELA ORAL

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ONE MONTH
Other Criteria	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN INFECTIOUS DISEASE SPECIALIST OR ABSSSI ORGANISM ANTIMICROBIAL SUSCEPTIBILITY TESTING SHOWS SUSCEPTIBILITY TO DELAFLOXACIN AND RESISTANCE TO ONE PREFERRED FORMULARY STANDARD OF CARE AGENT OR IF SENSITIVITY RESULTS ARE UNAVAILABLE: TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED FORMULARY AGENTS: A PENICILLIN, A FLUOROQUINOLONE, A CEPHALOSPORIN, OR A GRAM POSITIVE TARGETING ANTIBIOTIC

DESIRUDIN

Products Affected

- IPRIVASK

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 MONTH
Other Criteria	

DEUTETRABENAZINE

Products Affected

- AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	TARDIVE DYSKINESIA: PATIENT HAS A PRIOR HISTORY OF USING ANTIPSYCHOTIC MEDICATIONS OR METOCLOPRAMIDE PER PHYSICIAN ATTESTATION
Age Restrictions	
Prescriber Restrictions	HUNTINGTON DISEASE: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST OR MOVEMENT DISORDER SPECIALIST. TARDIVE DYSKINESIA: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST, PSYCHIATRIST, OR MOVEMENT DISORDER SPECIALIST
Coverage Duration	12 MONTHS
Other Criteria	

DEXTROMETHORPHAN QUINIDINE

Products Affected

- NUEDEXTA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.

DICHLORPHENAMIDE

Products Affected

- KEVEYIS

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	HEPATIC INSUFFICIENCY, PULMONARY OBSTRUCTION, OR A HEALTH CONDITION THAT WARRANTS CONCURRENT USE OF HIGH-DOSE ASPIRIN
Required Medical Information	
Age Restrictions	18 YEARS AND OLDER
Prescriber Restrictions	
Coverage Duration	INITIAL: 2 MONTHS RENEWAL: 12 MONTHS
Other Criteria	RENEWAL REQUIRES PHYSICIAN ATTESTATION OF IMPROVEMENT.

DICLOFENAC EPOLAMINE

Products Affected

- *diclofenac epolamine*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.

DICLOFENAC TOPICAL

Products Affected

- *diclofenac sodium topical gel 3 %*
- PENNSAID TOPICAL SOLUTION IN METERED-DOSE PUMP

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PENNSAID 2% TOPICAL SOLUTION: TRIAL OF OR CONTRAINDICATION TO FORMULARY DICLOFENAC SODIUM 1% TOPICAL GEL.

DIMETHYL FUMARATE

Products Affected

- TECFIDERA ORAL CAPSULE,DELAYED RELEASE(DR/EC) 120 MG, 120 MG (14)- 240 MG (46), 240 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

DINUTUXIMAB

Products Affected

- UNITUXIN

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

DROXIDOPA

Products Affected

- NORTHERA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	BLOOD PRESSURE READINGS WHILE THE PATIENT IS SITTING AND ALSO WITHIN 3 MINUTES OF STANDING FROM A SUPINE (LYING FACE UP) POSITION AT BASELINE AND RENEWAL.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST OR CARDIOLOGIST.
Coverage Duration	INITIAL: 3 MONTHS RENEWAL: 12 MONTHS
Other Criteria	INITIAL: DIAGNOSIS OF ORTHOSTATIC HYPOTENSION AS DOCUMENTED BY A DECREASE OF AT LEAST 20 MMHG IN SYSTOLIC BLOOD PRESSURE OR 10 MMHG DIASTOLIC BLOOD PRESSURE WITHIN THREE MINUTES AFTER STANDING FROM A SITTING POSITION. RENEWAL: PATIENT HAD AN INCREASE IN SYSTOLIC BLOOD PRESSURE FROM BASELINE OF AT LEAST 10 MMHG UPON STANDING FROM A SUPINE (LYING FACE UP) POSITION.

DUPILUMAB

Products Affected

- DUPIXENT

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	INITIAL: ASTHMA: CONCURRENT USE OF XOLAIR OR ANTI-IL5 BIOLOGIC (E.G., NUCALA, CINQAIR, FASENRA).
Required Medical Information	INITIAL APPROVAL FOR ASTHMA: BLOOD EOSINOPHIL LEVEL GREATER THAN OR EQUAL TO 150 CELLS/MCL WITHIN THE PAST 6 MONTHS (IF EOSINOPHILIC ASTHMA).
Age Restrictions	
Prescriber Restrictions	ATOPIC DERMATITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST, ALLERGIST OR IMMUNOLOGIST. ASTHMA: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN ALLERGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL: ATOPIC DERMATITIS: 6 MONTHS. ASTHMA: 12 MONTHS. RENEWAL: 12 MONTHS (ALL INDICATIONS).

PA Criteria	Criteria Details
Other Criteria	INITIAL APPROVAL FOR ATOPIC DERMATITIS REQUIRES: 1) PREVIOUS TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING: TOPICAL CORTICOSTEROIDS, TOPICAL CALCINEURIN INHIBITORS [E.G., ELIDEL (PIMECROLIMUS), GENERIC TACROLIMUS OINTMENT], OR TOPICAL PDE4 INHIBITOR [E.G., EUCRISA (CRISABOROLE)]. 2) ATOPIC DERMATITIS INVOLVING AT LEAST 10% OF BODY SURFACE AREA (BSA) OR ATOPIC DERMATITIS AFFECTING THE FACE, HEAD, NECK, HANDS, FEET, GROIN, OR INTERTRIGINOUS AREAS. 3) INTRACTABLE PRURITUS OR CRACKING/ OOZING/BLEEDING OF AFFECTED SKIN. INITIAL APPROVAL FOR ASTHMA: 1) PATIENT IS CONCURRENTLY ON A MAXIMALLY TOLERATED DOSE OF AN INHALED CORTICOSTEROID AND AT LEAST ONE OTHER MAINTENANCE MEDICATION (E.G., LONG-ACTING INHALED BETA2-AGONIST, LONG-ACTING MUSCARINIC ANTAGONIST, A LEUKOTRIENE RECEPTOR ANTAGONIST, THEOPHYLLINE). 2) PATIENT HAS EXPERIENCED AT LEAST 2 ASTHMA EXACERBATIONS IN THE PAST 12 MONTHS (DEFINED AS AN ASTHMA-RELATED EVENT REQUIRING HOSPITALIZATION, EMERGENCY ROOM VISIT, OR SYSTEMIC CORTICOSTEROID BURST LASTING AT LEAST 3 DAYS). RENEWAL FOR ATOPIC DERMATITIS AND ASTHMA: PHYSICIAN ATTESTATION OF IMPROVEMENT.

DURVALUMAB

Products Affected

- IMFINZI

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

DUVELISIB

Products Affected

- COPIKTRA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

EDARAVONE

Products Affected

- RADICAVA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

ELAGOLIX SODIUM

Products Affected

- ORILISSA ORAL TABLET 150 MG, 200 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	RENEWAL: MODERATE TO SEVERE PAIN ASSOCIATED WITH ENDOMETRIOSIS: PHYSICIAN ATTESTATION OF IMPROVEMENT IN PAIN ASSOCIATED WITH ENDOMETRIOSIS.
Age Restrictions	18 YEARS OF AGE AND OLDER
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH AN OBSTETRICIAN/GYNECOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: MODERATE TO SEVERE PAIN ASSOCIATED WITH ENDOMETRIOSIS: PREVIOUS TRIAL OF OR CONTRAINDICATION TO NSAID AND PROGESTIN-CONTAINING CONTRACEPTIVE PREPARATION.

ELAPEGADEMASE-LVLR

Products Affected

- REVCOVI

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

ELBASVIR/GRAZOPREVIR

Products Affected

- ZEPATIER

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE AND ADDITIONAL CONSIDERATION FOR COVERAGE CONSISTENT WITH FDA LABELING.
Exclusion Criteria	MODERATE OR SEVERE LIVER IMPAIRMENT (CHILD PUGH B OR C)
Required Medical Information	HCV RNA LEVEL WITHIN PAST 6 MONTHS. FOR GENOTYPE 1A -TESTING FOR NS5A RESISTANCE-ASSOCIATED POLYMORPHISMS.
Age Restrictions	
Prescriber Restrictions	GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.
Coverage Duration	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.

PA Criteria	Criteria Details
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. TRIAL OF A PREFERRED FORMULARY ALTERNATIVE INCLUDING HARVONI OR EPCLUSA WHEN THESE AGENTS ARE CONSIDERED ACCEPTABLE FOR TREATMENT OF THE SPECIFIC GENOTYPE PER AASLD/IDSA GUIDANCE. NO CONCURRENT USE WITH THE FOLLOWING AGENTS: PHENYTOIN, CARBAMAZEPINE, RIFAMPIN, EFAVIRENZ, ATAZANAVIR, DARUNAVIR, LOPINAVIR, SAQUINAVIR, TIPRANAVIR, CYCLOSPORINE, NAFCILLIN, KETOCONAZOLE, MODAFINIL, BOSENTAN, ETRAVIRINE, ELVITEGRAVIR/COBICISTAT/EMTRICITABINE/TENOFOVIR, ATORVASTATIN AT DOSES GREATER THAN 20MG PER DAY OR ROSUVASTATIN AT DOSES GREATER THAN 10MG PER DAY.

ELIGLUSTAT TARTRATE

Products Affected

- CERDELGA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

ELOSULFASE ALFA

Products Affected

- VIMIZIM

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	LIFETIME OF MEMBERSHIP IN PLAN.
Other Criteria	

ELOTUZUMAB

Products Affected

- EMPLICITI

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

ELTROMBOPAG

Products Affected

- PROMACTA ORAL POWDER IN PACKET
- PROMACTA ORAL TABLET 12.5 MG, 25 MG, 50 MG, 75 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ITP:INITIAL: 2MO.RENEW:12MO.HCV:12MO.SEVERE APLASTIC ANEMIA:12MO
Other Criteria	CHRONIC IMMUNE (IDIOPATHIC) THROMBOCYTOPENIA PURPURA (ITP): INITIAL: TRIAL OF OR CONTRAINDICATION TO CORTICOSTEROIDS, IMMUNOGLOBULINS, OR AN INSUFFICIENT RESPONSE TO SPLENECTOMY. ITP: RENEWAL: PHYSICIAN ATTESTATION OF A CLINICAL RESPONSE.

ENASIDENIB

Products Affected

- IDHIFA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

ENCORAFENIB

Products Affected

- BRAFTOVI ORAL CAPSULE 50 MG, 75 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

ENDOTHELIN RECEPTOR ANTAGONISTS

Products Affected

- *ambrisentan*
- LETAIRIS
- OPSUMIT
- TRACLEER ORAL TABLET
- TRACLEER ORAL TABLET FOR SUSPENSION

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS
Other Criteria	INITIAL: MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG OR GREATER, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS. LETAIRIS (AMBRISENTAN): PATIENT DOES NOT HAVE IDIOPATHIC PULMONARY FIBROSIS (IPF). TRACLEER: PATIENT DOES NOT HAVE ELEVATED LIVER ENZYMES (ALT, AST) MORE THAN 3 TIMES UPPER LIMIT OF NORMAL (ULN) OR INCREASES IN BILIRUBIN BY 2 OR MORE TIMES ULN. PATIENT IS NOT CONCURRENTLY TAKING CYCLOSPORINE A OR GLYBURIDE. RENEWAL: PATIENT SHOW IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR PATIENT HAS A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/IMPROVED WHO FUNCTIONAL CLASS.

ENZALUTAMIDE

Products Affected

- XTANDI

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	DIAGNOSIS OF CASTRATION RESISTANT PROSTATE CANCER AND MEET ONE OF THE FOLLOWING: 1) METASTATIC CASTRATION RESISTANT PROSTATE CANCER, OR 2) NON METASTATIC CASTRATION RESISTANT PROSTATE CANCER: THE PATIENT HAS HIGH RISK PROSTATE CANCER (I.E. RAPIDLY INCREASING PROSTATE SPECIFIC ANTIGEN [PSA] LEVELS).

EPOPROSTENOL IV

Products Affected

- *epoprostenol (glycine)*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	COVERED UNDER LOCAL COVERAGE POLICY OF APPLICABLE MEDICARE DMERC.
Required Medical Information	FORMULARY DRUG ADMINISTERED IN A LONG TERM CARE FACILITY TO A PATIENT WHOSE PART A COVERAGE HAS EXPIRED OR FORMULARY DRUG NOT ADMINISTERED VIA AN IMPLANTABLE PUMP OR AN EXTERNAL PUMP OR DRUG ADMINISTERED VIA AN IMPLANTABLE PUMP/AN EXTERNAL PUMP. DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS III-IV SYMPTOMS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS
Other Criteria	INITIAL: MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG OR GREATER, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS. RENEWAL: PATIENT HAS SHOWN IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR PATIENT HAS A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/ IMPROVED WHO FUNCTIONAL CLASS.

ERDAFITINIB

Products Affected

- BALVERSA ORAL TABLET 3 MG, 4 MG, 5 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

ERENUMAB-AOOE

Products Affected

- AIMOVIG AUTOINJECTOR
- AIMOVIG AUTOINJECTOR (2 PACK)

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	RENEWAL: THE PATIENT HAS EXPERIENCED A REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY OF AT LEAST 2 DAYS PER MONTH OR A REDUCTION IN MIGRAINE SEVERITY OR MIGRAINE DURATION WITH AIMOVIG THERAPY.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE FORMULARY ALTERNATIVE FOR PREVENTIVE MIGRAINE TREATMENT SUCH AS DIVALPROEX SODIUM, TOPIRAMATE, PROPRANOLOL, OR TIMOLOL.

ERLOTINIB

Products Affected

- *erlotinib oral tablet 100 mg, 150 mg, 25 mg*
- TARCEVA ORAL TABLET 100 MG, 150 MG, 25 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

ERYTHROPOIESIS STIMULATING AGENTS - EPOETIN ALFA

Products Affected

- EPOGEN INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML
- PROCRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML, 40,000 UNIT/ML

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. ADDITIONAL OFF LABEL ANEMIA IN HEPATITIS C BEING TREATED IN COMBINATION WITH RIBAVIRIN AND INTERFERON ALFA OR PEGINTERFERON ALFA.
Exclusion Criteria	

PA Criteria	Criteria Details
Required Medical Information	INITIAL: CHRONIC RENAL FAILURE (CRF) AND ANEMIA RELATED TO ZIDOVUDINE THERAPY REQUIRES A HEMOGLOBIN LEVEL OF LESS THAN 10G/DL. CANCER CHEMOTHERAPY REQUIRES A HEMOGLOBIN LEVEL OF LESS THAN 10G/DL ANEMIA DUE TO CONCURRENT HEPATITIS C TREATMENT WITH RIBAVIRIN PLUS INTERFERON ALFA/PEGINTERFERON ALFA REQUIRES A HEMOGLOBIN LEVEL LESS THAN 10G/DL AND RIBAVIRIN DOSE REDUCTION (UNLESS CONTRAINDICATED).ELECTIVE NON-CARDIAC OR NON-VASCULAR SURGERY REQUIRES A HEMOGLOBIN LEVEL LESS THAN 13G/DL. RENEWAL: CHRONIC RENAL FAILURE REQUIRES THAT THE PATIENT MEETS ONE OF THE FOLLOWING: IF THE PATIENT IS CURRENTLY RECEIVING DIALYSIS TREATMENT: 1) HEMOGLOBIN LEVEL OF LESS THAN 11G/DL OR 2) HEMOGLOBIN LEVEL THAT HAS REACHED 11G/DL AND DOSE REDUCTION/INTERRUPTION IS REQUIRED TO REDUCE THE NEED FOR BLOOD TRANSFUSIONS. IF THE PATIENT IS NOT RECEIVING DIALYSIS TREATMENT: 1) HEMOGLOBIN LEVEL OF LESS THAN 10G/DL OR 2) HEMOGLOBIN LEVEL THAT HAS REACHED 10G/DL AND DOSE REDUCTION/INTERRUPTION IS REQUIRED TO REDUCE THE NEED FOR BLOOD TRANSFUSIONS. ANEMIA DUE TO CONCURRENT HEPATITIS C TREATMENT WITH RIBAVIRIN PLUS INTERFERON ALFA/PEGINTERFERON ALFA, OR ANEMIA DUE TO ZIDOVUDINE THERAPY REQUIRES HEMOGLOBIN LEVELS BETWEEN 10G/DL AND 12G/DL. ANEMIA DUE TO EFFECT OF CONCOMITANTLY ADMINISTERED CANCER CHEMOTHERAPY REQUIRES A HEMOGLOBIN LEVEL OF LESS THAN 10 G/DL OR THAT THE HEMOGLOBIN LEVEL DOES NOT EXCEED A LEVEL NEEDED TO AVOID RBC TRANSFUSION.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ANEMIA FROM MYELOSUPPRESSIVE CHEMO/CKD WITHOUT DIALYSIS/ZIDOVUDINE:12 MONTHS.SURGERY:1 MO.HCV:6 MOS.

PA Criteria	Criteria Details
Other Criteria	ALL INDICATIONS: TRIAL OF PROCRIT. PART D MEMBER RECEIVING DIALYSIS OR IDENTIFIED AS A PART D END STAGE RENAL DISEASE MEMBER: PAYS UNDER PART B.

ERYTHROPOIESIS STIMULATING AGENTS - EPOETIN ALFA-EPBX

Products Affected

- RETACRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML, 40,000 UNIT/ML

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. ADDITIONAL OFF LABEL ANEMIA IN HEPATITIS C BEING TREATED IN COMBINATION WITH RIBAVIRIN AND INTERFERON ALFA OR PEGINTERFERON ALFA.
Exclusion Criteria	
Required Medical Information	INITIAL: ANEMIA RELATED TO ZIDOVUDINE THERAPY REQUIRES A HEMOGLOBIN LEVEL OF LESS THAN 10G/DL. ANEMIA DUE TO CONCURRENT HEPATITIS C TREATMENT WITH RIBAVIRIN PLUS INTERFERON ALFA/PEGINTERFERON ALFA REQUIRES A HEMOGLOBIN LEVEL LESS THAN 10G/DL AND RIBAVIRIN DOSE REDUCTION (UNLESS CONTRAINDICATED). RENEWAL: CHRONIC KIDNEY DISEASE REQUIRES THAT THE PATIENT IS NOT RECEIVING DIALYSIS TREATMENT AND MEETS ONE OF THE FOLLOWING: 1) HEMOGLOBIN LEVEL OF LESS THAN 10G/DL OR 2) HEMOGLOBIN LEVEL THAT HAS REACHED 10G/DL AND DOSE REDUCTION/INTERRUPTION IS REQUIRED TO REDUCE THE NEED FOR BLOOD TRANSFUSIONS. ANEMIA DUE TO CONCURRENT HEPATITIS C TREATMENT WITH RIBAVIRIN PLUS INTERFERON ALFA/PEGINTERFERON ALFA, OR ANEMIA DUE TO ZIDOVUDINE THERAPY REQUIRES HEMOGLOBIN LEVELS BETWEEN 10G/DL AND 12G/DL. ANEMIA DUE TO EFFECT OF CONCOMITANTLY ADMINISTERED CANCER CHEMOTHERAPY REQUIRES A HEMOGLOBIN LEVEL OF LESS THAN 10 G/DL OR THAT THE HEMOGLOBIN LEVEL DOES NOT EXCEED A LEVEL NEEDED TO AVOID RBC TRANSFUSION.

PA Criteria	Criteria Details
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ANEMIA FROM MYELOSUPPRESSIVE CHEMO/CKD WITHOUT DIALYSIS/ZIDOVUDINE:12 MOS.SURGERY:1 MO.HCV:6 MOS.
Other Criteria	PART D MEMBER RECEIVING DIALYSIS OR IDENTIFIED AS A PART D END STAGE RENAL DISEASE MEMBER: PAYS UNDER PART B.

ESKETAMINE

Products Affected

- SPRAVATO NASAL SPRAY,NON-AEROSOL 56 MG (28 MG X 2), 84 MG (28 MG X 3)

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

ETANERCEPT

Products Affected

- ENBREL
- ENBREL SURECLICK

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING AT LEAST 5% BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE OR GENITAL AREA. RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS, PSORIATIC ARTHRITIS: 18 YEARS OR OLDER
Prescriber Restrictions	RHEUMATOID ARTHRITIS, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS, ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PLAQUE PSORIASIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA.

ETEPLIRSEN

Products Affected

- EXONDYS 51

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	PHYSICIAN ATTESTATION OF GENETIC TESTING CONFIRMING THAT MUTATION IN DUCHENNE MUSCULAR DYSTROPHY (DMD) GENE IS AMENABLE TO EXON 51 SKIPPING.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL: 24 WEEKS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL CRITERIA: PATIENT IS AMBULATORY AND IS CURRENTLY RECEIVING TREATMENT WITH OR HAS A CONTRAINDICATION TO CORTICOSTEROIDS. RENEWAL CRITERIA: PATIENT HAS MAINTAINED OR DEMONSTRATED A LESS THAN EXPECTED DECLINE IN AMBULATORY ABILITY IN MUSCLE FUNCTION ASSESSMENTS OR OTHER MUSCLE FUNCTION (I.E. PULMONARY OR CARDIAC FUNCTION) DURING THE PAST 24 WEEKS. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.

EVEROLIMUS

Products Affected

- AFINITOR DISPERZ
- AFINITOR ORAL TABLET 10 MG, 2.5 MG, 5 MG, 7.5 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	ADVANCED RENAL CELL CARCINOMA (RCC): TRIAL OF OR CONTRAINDICATION TO SUTENT OR NEXAVAR.

EVOLOCUMAB

Products Affected

- REPATHA PUSHTRONEX
- REPATHA SURECLICK
- REPATHA SYRINGE

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	CARDIOLOGIST, ENDOCRINOLOGIST OR LIPIDOLOGIST
Coverage Duration	12 MONTHS

PA Criteria	Criteria Details
Other Criteria	PRIMARY HYPERLIPIDEMIA (E.G., HETEROZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HEFH)): DIAGNOSIS DETERMINED BY (1) DEFINITE SIMON BROOME DIAGNOSTIC (SBD) CRITERIA FOR FH, OR (2) DUTCH LIPID NETWORK (DLN) CRITERIA SCORE OF 6 OR GREATER. HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HOFH): DIAGNOSIS DETERMINED BY (1) DEFINITE SBD CRITERIA, (2) DLN CRITERIA SCORE OF 8 OR GREATER, OR (3) A CLINICAL DIAGNOSIS BASED ON A HISTORY OF AN UNTREATED LDL-C CONCENTRATION GREATER THAN 500 MG/DL TOGETHER WITH EITHER XANTHOMA BEFORE 10 YEARS OF AGE, OR EVIDENCE OF HEFH IN BOTH PARENTS. LDL-C LEVEL GREATER THAN OR EQUAL TO 70MG/DL WHILE ON MAXIMAL DRUG TREATMENT. MEETS ONE OF THE FOLLOWING: (1) TAKING A HIGH-INTENSITY STATIN (I.E., ATORVASTATIN 40-80MG DAILY, ROSUVASTATIN 20-40MG DAILY) FOR A DURATION OF AT LEAST 8 WEEKS, (2) TAKING A MAXIMALLY TOLERATED DOSE OF ANY STATIN FOR A DURATION OF AT LEAST 8 WEEKS GIVEN THAT THE PATIENT CANNOT TOLERATE A HIGH-INTENSITY STATIN, (3) ABSOLUTE CONTRAINDICATION TO STATIN THERAPY (E.G., ACTIVE DECOMPENSATED LIVER DISEASE, NURSING FEMALE, PREGNANCY OR PLANS TO BECOME PREGNANT, HYPERSENSITIVITY REACTIONS), (4) PHYSICIAN ATTESTATION OF STATIN INTOLERANCE, OR (5) PATIENT HAS TRIED ROSUVASTATIN, ATORVASTATIN, OR STATIN THERAPY AT ANY DOSE AND HAS EXPERIENCED SKELETAL-MUSCLE RELATED SYMPTOMS (E.G., MYOPATHY).

FENTANYL NASAL SPRAY

Products Affected

- LAZANDA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	CANCER: CURRENTLY ON A MAINTENANCE DOSE OF CONTROLLED-RELEASE OPIOID PAIN MEDICATION (SUCH AS MORPHINE SULFATE ER, OXYCODONE ER, OR FENTANYL). EITHER A TRIAL OR CONTRAINDICATION TO AT LEAST ONE (1) IMMEDIATE-RELEASE ORAL OPIOID PAIN AGENT (SUCH AS MORPHINE SULFATE IR, OXYCODONE/ASPIRIN, OXYCODONE/ACETAMINOPHEN, CODEINE/ACETAMINOPHEN, HYDROMORPHONE, OR MEPERIDINE) OR MEMBER HAS DIFFICULTY SWALLOWING TABLETS/CAPSULES AND TRIAL OR CONTRAINDICATION TO GENERIC FENTANYL CITRATE LOZENGE. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.

FENTANYL TRANSMUCOSAL AGENTS - FENTANYL CITRATE

Products Affected

- *fentanyl citrate buccal lozenge on a handle*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	CANCER: CURRENTLY ON A MAINTENANCE DOSE OF CONTROLLED-RELEASE OPIOID PAIN MEDICATION (SUCH AS MORPHINE SULFATE ER, OXYCODONE ER, OR FENTANYL). EITHER A TRIAL OR CONTRAINDICATION TO AT LEAST ONE (1) IMMEDIATE-RELEASE ORAL OPIOID PAIN AGENT (SUCH AS MORPHINE SULFATE IR, OXYCODONE/ASPIRIN, OXYCODONE/ACETAMINOPHEN, CODEINE/ACETAMINOPHEN, HYDROMORPHONE, OR MEPERIDINE) OR MEMBER HAS DIFFICULTY SWALLOWING TABLETS/CAPSULES. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.

FINGOLIMOD

Products Affected

- GILENYA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

FOLIC ACID OTC

Products Affected

- *folic acid 0.4 mg tablet*

PA Criteria	Criteria Details
Covered Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	N/A
Other Criteria	RESTRICTED TO FEMALES, AGES 14 THROUGH 45 YEARS, TO PREVENT NEURAL TUBE DEFECTS IN CURRENT AND FUTURE PREGNANCIES ONLY.

FOSTAMATINIB

Products Affected

- TAVALISSE

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION OF A CLINICAL RESPONSE.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST, IMMUNOLOGIST, OR RHEUMATOLOGIST.
Coverage Duration	INITIAL: 3 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	

FREMANEZUMAB-VFRM

Products Affected

- AJOVY

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	RENEWAL: THE PATIENT HAS EXPERIENCED A REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY OF AT LEAST 2 DAYS PER MONTH OR A REDUCTION IN MIGRAINE SEVERITY OR MIGRAINE DURATION WITH AJOVY THERAPY.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE FORMULARY ALTERNATIVE FOR PREVENTIVE MIGRAINE TREATMENT SUCH AS DIVALPROEX SODIUM, TOPIRAMATE, PROPRANOLOL, OR TIMOLOL.

GALCANEZUMAB-GNLM

Products Affected

- EMGALITY PEN
- EMGALITY SYRINGE SUBCUTANEOUS SYRINGE 120 MG/ML

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	RENEWAL FOR MIGRAINES: THE PATIENT HAS EXPERIENCED A REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY OF AT LEAST 2 DAYS PER MONTH OR A REDUCTION IN MIGRAINE SEVERITY OR MIGRAINE DURATION WITH EMGALITY THERAPY.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	MIGRAINES: INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS. CLUSTER HEADACHE: 12 MONTHS
Other Criteria	INITIAL FOR MIGRAINES: PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE FORMULARY ALTERNATIVE FOR PREVENTIVE MIGRAINE TREATMENT SUCH AS DIVALPROEX SODIUM, TOPIRAMATE, PROPRANOLOL, OR TIMOLOL.

GEFITINIB

Products Affected

- IRESSA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

GEMTUZUMAB OZOGAMICIN

Products Affected

- MYLOTARG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

GILTERITINIB

Products Affected

- XOSPATA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

GLASDEGIB

Products Affected

- DAURISMO ORAL TABLET 100 MG, 25 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

GLATIRAMER ACETATE

Products Affected

- COPAXONE SUBCUTANEOUS SYRINGE 20 MG/ML, 40 MG/ML
- *glatiramer subcutaneous syringe 20 mg/ml, 40 mg/ml*
- *glatopa subcutaneous syringe 20 mg/ml, 40 mg/ml*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

GLECAPREVIR/PIBRENTASVIR

Products Affected

- MAVYRET

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE.
Exclusion Criteria	MODERATE OR SEVERE HEPATIC IMPAIRMENT (CHILD PUGH B OR C)
Required Medical Information	HCV RNA LEVEL WITHIN PAST 6 MONTHS
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH: GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.
Coverage Duration	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.

PA Criteria	Criteria Details
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. TRIAL OF A PREFERRED FORMULARY ALTERNATIVE INCLUDING HARVONI OR EPCLUSA WHEN THESE AGENTS ARE CONSIDERED ACCEPTABLE FOR TREATMENT OF THE SPECIFIC GENOTYPE PER AASLD/IDSA GUIDANCE. PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS NOT RECOMMENDED OR CONTRAINDICATED BY THE MANUFACTURER: CARBAMAZEPINE, RIFAMPIN, ETHINYL ESTRADIOL-CONTAINING MEDICATION, ATAZANAVIR,DARUNAVIR, LOPINAVIR, RITONAVIR, EFAVIRENZ, ATORVASTATIN, LOVASTATIN, SIMVASTATIN, ROSUVASTATIN AT DOSES GREATER THAN 10MG, OR CYCLOSPORINE AT DOSES GREATER THAN 100MG PER DAY. PATIENT MUST NOT HAVE PRIOR FAILURE OF A DAA REGIMEN WITH NS5A INHIBITOR AND HCV PROTEASE INHIBITOR.

GLUCOSE TEST STRIPS AND LANCETS

Products Affected

- 1ST TIER COMFORTOUCH 28G LANCT
- 1ST TIER COMFORTOUCH 30G LANCT
- ACCU-CHEK FASTCLIX LANCET DRUM
- ACCU-CHEK MULTICLIX LANCETS
- ACCU-CHEK SAFE-T-PRO 23G LANCT
- ACCU-CHEK SAFE-T-PRO PLUS 23G
- ACCU-CHEK SOFTCLIX LANCETS
- ACTI-LANCE LITE 28G LANCETS
- ACTI-LANCE SPECIAL 17G LANCETS
- ACTI-LANCE UNIVERS 23G LANCETS
- ADVANCED TRAVEL 28G LANCETS 28G,SINGLE-USE,STRL
- ADVANCED TRAVEL 30G LANCETS
- ADVOCATE 26G LANCETS 26 G,STERILE
- ADVOCATE 26G LANCETS STERILE
- ADVOCATE 30G LANCETS TWIST TOP
- ALTERNATE SITE 26G LANCETS RECAPPABLE
- ASSURE HAEMOLANCE PLUS 18G
- ASSURE HAEMOLANCE PLUS 21G
- ASSURE HAEMOLANCE PLUS 25G
- ASSURE HAEMOLANCE PLUS 28G
- ASSURE LANCE 25G LANCETS
- ASSURE LANCE 28G LANCETS
- ASSURE LANCE PLUS 21G LANCETS
- ASSURE LANCE PLUS 25G LANCETS
- ASSURE LANCE PLUS 30G LANCETS
- BD MICROTAINER 21G LANCETS
- BD MICROTAINER 30G LANCETS
- BD ULTRA-FINE 33G LANCETS
- BD ULTRA-FINE II 30G LANCETS
- BLOOD LANCETS 30G EASY TWIST
- BULLSEYE MINI SAFETY 21G
- BULLSEYE MINI SAFETY 25G LANCT
- BULLSEYE MINI SAFETY 28G LANCT
- CAREONE ULTRA THIN LANCET
- CARESENS ULTRA THIN 30G LANCET
- CARETOUCH TWIST 28G LANCET
- CARETOUCH TWIST 30G LANCET
- CLEVER CHEK ULTRA THIN 30G
- COAGUCHEK LANCETS
- COMFORT EZ SAFETY 21G LANCETS
- COMFORT EZ SAFETY 23G LANCETS
- COMFORT EZ SAFETY 28G LANCETS
- COMFORT LANCETS
- CVS MICRO THIN 33G LANCETS
- CVS THIN 26G LANCETS
- CVS ULTRA THIN 30G LANCETS
- DROPLET 30G LANCETS
- E-Z JECT LANCETS
- E-ZJECT COLOR 32G LANCETS
- E-ZJECT SUPER THIN 30G LANCETS SUPER THIN
- E-ZJECT THIN LANCETS 26 GAUGE
- EASY COMFORT 30G LANCETS 30G,TWIST TOP,STRL
- EASY TOUCH 28G LANCETS 28G,PULL TOP,STERILE
- EASY TOUCH SAFETY 21G LANCETS
- EASY TOUCH SAFETY 23G LANCETS
- EASY TOUCH SAFETY 26G LANCETS
- EASY TOUCH TWIST 28G LANCETS
- EASY TOUCH TWIST 30G LANCETS
- EASY TOUCH TWIST 32G LANCETS
- EASY TOUCH TWIST 33G LANCETS

- EASY TWIST & CAP 28G LANCETS
- EMBRACE 30G LANCETS
- EZ SMART 28G LANCETS
- FIFTY50 SAFETY SEAL 30G LANCET
- FIFTY50 SAFETY SEAL 32G LANCET
- FINE 30 UNIVERSAL 30G LANCETS
- FINGERSTIX LANCETS
- FORA 30G LANCETS TWIST OFF,SINGLE USE
- FORACARE 30G LANCETS
- FREESTYLE 28G LANCETS
- FREESTYLE INSULINX TEST STRIP NO CODE
- FREESTYLE INSULINX TEST STRIPS
- FREESTYLE LITE TEST STRIP
- FREESTYLE PREC NEO TEST STRIPS
- FREESTYLE TEST STRIPS
- FREESTYLE UNISTIK 2 LANCETS
- GLUCOCOM 28G LANCETS
- GLUCOCOM 30G LANCETS
- GLUCOCOM 33G LANCETS
- GNP UNIVERSAL 1 STANDARD 21G
- GNP UNIVERSAL 1 SUPER THIN 30G
- HEALTHY ACCENTS UNILET 30G
- INCONTROL SUPER THIN 30G LANCT
- INCONTROL ULTRA THIN 28G LANCT
- INJECT EASE 28G LANCETS
- INJECT EASE 30G LANCETS
- INVACARE 30G LANCETS
- KRO UNIVERSAL 1 THIN 26G LANCT
- KROGER SUPER THIN LANCETS
- LANCETS 33G
- LANCETS THIN 23G
- LANCETS ULTRA FINE 28G
- LANCETS ULTRA THIN 26G
- LITE TOUCH 28G LANCETS
- LITE TOUCH 30G LANCETS
- LITE TOUCH 33G LANCETS
- LONGS THIN LANCETS 26G 26G
- MEDISENSE THIN 28G LANCETS
- MEDLANCE PLUS 21G LANCETS UNIVERSAL
- MEDLANCE PLUS 30G LANCETS SUPERLITE, 1.2MM
- MEDLANCE PLUS LITE 25G LANCETS STERILE
- MICROLET LANCETS
- MONOLET 21G LANCETS
- MONOLET THIN 28G LANCETS
- MYGLUCOHEALTH 30G LANCETS
- NOVA SAFETY 23G LANCETS
- NOVA SAFETY 28G LANCETS
- NOVA SUREFLEX THIN LANCETS
- ON CALL 30G LANCET
- ON CALL PLUS 30G LANCET
- ON-THE-GO 30G LANCETS GENTLE, 1.5MM
- ONETOUCH DELICA 30G LANCETS
- ONETOUCH DELICA 33G LANCETS
- ONETOUCH DELICA PLUS 33G LANCT
- ONETOUCH SURESOFT 18G LANC DEV
- ONETOUCH ULTRASOFT LANCETS
- PHARMACIST CHOICE 30G LANCETS ULTRA THIN
- PRECISION XTRA TEST STRIPS
- PRESSURE ACTIVATED 21G LANCETS
- PRESSURE ACTIVATED 28G LANCETS
- PRO COMFORT 30G LANCETS
- PRO COMFORT 31G LANCET
- PRODIGY PRESSURE ACTIVATED 28G
- PRODIGY SAFETY 26G LANCETS
- PRODIGY TWIST TOP 28G LANCET
- PUSH BUTTON SAFETY 21G LANCET
- PUSH BUTTON SAFETY 28G LANCET
- RA E-ZJECT 26G LANCETS
- RA E-ZJECT 28G LANCETS
- RA E-ZJECT COLOR 33G LANCETS
- READYLANCE 21G SAFETY LANCETS
- READYLANCE 23G SAFETY

LANCETS
- READYLANCE 26G SAFETY LANCETS
- READYLANCE 28G SAFETY LANCETS
- READYLANCE 30G SAFETY LANCETS
- RELIAMED 30G LANCETS
- RELIAMED SAFETY 23G LANCETS
- RELIAMED SAFETY 28G LANCETS LATEX-FREE
- RELIAMED SAFETY SEAL 28G LANCT
- RELIAMED SAFETY SEAL 30G LANCT
- RELION MICRO THIN 33G LANCET
- RELION THIN 26G LANCETS
- RELION ULTRA THIN PLUS 33G
- RELION ULTRA THIN PLUS LANCETS
- RIGHTEST GL300 30G LANCETS
- SAFETY 21G LANCETS LATEX-FREE
- SAFETY 28G LANCETS LATEX-FREE
- SAFETY LANCETS 26G
- SAFETY SEAL 28G LANCETS
- SAFETY SEAL 30G LANCETS
- SAFETY-LET 30G LANCETS
- SINGLE-LET LANCETS
- SM COLOR LANCETS 21G
- SM LANCETS 21G
- SM THIN LANCETS 26G
- SMART SENSE COLOR 33G LANCETS
- SMART SENSE STANDARD 21G
- SMART SENSE THIN 26G LANCETS
- SMARTEST LANCET
- SOFT TOUCH LANCETS
- SOLUS V2 28G LANCETS
- SOLUS V2 30G TWIST LANCETS
- STERILANCE TL TWIST 30G LANCET
- STERILANCE TL TWIST 32G LANCET
- SUPER THIN 28G LANCETS STERILE
- SUPER THIN 30G LANCETS
- SURE COMFORT 18G LANCETS
- SURE COMFORT 21G LANCETS
- SURE COMFORT 23G LANCETS
- SURE COMFORT 28G LANCETS
- SURE COMFORT 30G LANCETS
- SURE-LANCE 26G LANCETS
- SURE-LANCE FLAT LANCETS
- SURE-LANCE THIN 28G LANCETS
- SURE-LANCE ULTRA THIN 30G
- SURE-TOUCH LANCET
- TECHLITE 25G LANCETS
- TECHLITE 28G LANCETS
- TECHLITE 30G LANCETS
- TELCARE ULTRA THIN 30G LANCETS
- THIN LANCETS 28G
- TOPCARE UNIVERSAL1 33G LANCETS
- TOPCARE UNIVERSAL1 THIN LANCET ULTRA THIN, 30G
- TRUE COMFORT 30G LANCET
- TRUEPLUS 26G LANCETS
- TRUEPLUS 33G LANCETS
- TRUEPLUS SAFETY 28G LANCETS 28G, STERILE
- TRUEPLUS SUPER THIN 28G LANCET 28G, STERILE
- TRUEPLUS ULTRA THIN 30G LANCET
- TWIST LANCETS 30G
- TWIST LANCETS 32G
- ULTILET 28G LANCETS
- ULTILET 30G LANCETS
- ULTILET 33G LANCETS
- ULTILET BASIC 30G LANCETS
- ULTILET CLASSIC 26G LANCETS
- ULTILET CLASSIC 28G LANCETS
- ULTILET CLASSIC 30G LANCETS
- ULTILET CLASSIC 33G LANCETS
- ULTILET SAFETY 23G LANCETS
- ULTRA FINE 30G LANCETS
- ULTRA THIN 28G LANCETS ULTRA THIN
- ULTRA THIN 31G LANCET
- ULTRA THIN 31G LANCETS

- ULTRA THIN 33G LANCETS
- ULTRA-CARE 30G LANCETS
- ULTRA-THIN II 26G LANCET
- ULTRA-THIN II 28G LANCETS
- ULTRA-THIN II 30G LANCETS
- ULTRALANCE 26G LANCETS
- ULTRALANCE 28G LANCETS
- ULTRATLC LANCETS
- UNILET COMFORTOUCH 26G LANCETS
- UNILET COMFORTOUCH LANCET
- UNILET EXCELITE II LANCET
- UNILET EXCELITE LANCET
- UNILET GP LANCET
- UNILET MICRO THIN 33G LANCET
- UNILET MICRO THIN 33G LANCETS
- UNILET SUPER THIN 30G LANCETS SINGLE-USE,STERILE
- UNILET ULTRA THIN 28G LANCETS SINGLE-USE,STERILE
- UNISTIK 3 COMFORT LANCET
- UNISTIK 3 EXTRA 21G LANCETS
- UNISTIK 3 GENTLE 30G LANCETS
- UNISTIK 3 NORMAL 23G LANCETS
- UNISTIK 3 SAFETY 21G LANCETS
- UNISTIK CZT COMFORT 28G LANCET
- UNISTIK CZT NORMAL 23G LANCETS
- UNISTIK PRO 21G LANCET
- UNISTIK PRO 25G LANCET
- UNISTIK PRO 28G LANCET
- UNISTIK SAFETY 28G LANCET
- UNISTIK SAFETY 30G LANCETS
- UNISTIK TOUCH 21G LANCETS
- UNISTIK TOUCH 23G LANCETS
- UNISTIK TOUCH 28G LANCETS
- UNISTIK TOUCH 30G LANCETS
- UNIVERSAL 1 33G LANCETS
- VIVAGUARD LANCET
- WALGREENS ULTRA THIN LANCETS

PA Criteria	Criteria Details
Covered Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	N/A

PA Criteria	Criteria Details
Other Criteria	COVERAGE OF BLOOD GLUCOSE TEST STRIPS AND LANCETS MAY BE PROVIDED WITH A WRITTEN PRESCRIPTION BY A LICENSED PRACTITIONER TO INPATIENTS RECEIVING NURSING FACILITY LEVEL A (NF-A) SERVICES OR NURSING FACILITY LEVEL B (NF-B) SERVICES, WHETHER OR NOT IN A HOSPITAL SETTING. BLOOD GLUCOSE TEST STRIPS AND LANCETS ARE RESTRICTED TO PATIENTS WITH A DIABETES DIAGNOSIS. BLOOD GLUCOSE TEST STRIPS AND LANCETS PROVIDED TO INPATIENT'S RECEIVING INPATIENT HOSPITAL SERVICES ARE NOT COVERED. REQUESTS THAT DO NOT MEET THE NURSING FACILITY LEVEL A OR LEVEL B CRITERIA WILL BE REVIEWED FOR PART B COVERAGE.

GLYCEROL PHENYLBUTYRATE

Products Affected

- RAVICTI

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	TRIAL OF OR CONTRAINDICATION TO SODIUM PHENYLBUTYRATE (BUPHENYL).

GOLIMUMAB IV

Products Affected

- SIMPONI ARIA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS: PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, KEVZARA, ENBREL. PSORIATIC ARTHRITIS: PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL. ANKYLOSING SPONDYLITIS: PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, COSENTYX, ENBREL.

GOLIMUMAB SQ

Products Affected

- SIMPONI

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	RENEWAL FOR RHEUMATOID ARTHRITIS, PSORIATIC ARTHRITIS, OR ANKYLOSING SPONDYLITIS: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. ULCERATIVE COLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS

PA Criteria	Criteria Details
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, KEVZARA, ENBREL. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL. ANKYLOSING SPONDYLITIS (AS): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, COSENTYX, ENBREL. ULCERATIVE COLITIS (UC): PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA.

GRANULOCYTE COLONY-STIMULATING FACTORS

Products Affected

- GRANIX
- NEUPOGEN
- NIVESTYM

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	A TRIAL OF OR CONTRAINDICATION TO ZARXIO IS REQUIRED EXCEPT WHEN USED TO INCREASE SURVIVAL IN A PATIENT ACUTELY EXPOSED TO MYELOSUPPRESSIVE DOSES OF RADIATION (HEMATOPOIETIC SYNDROME OF ACUTE RADIATION SYNDROME)

GUSELKUMAB

Products Affected

- TREMFYA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	INITIAL: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE OR GENITAL AREA. RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, SKYRIZI.

HIGH RISK DRUGS IN THE ELDERLY - ANTICHOLINERGICS - BENZTROPINE_TRIHEXYPHENIDYL

Products Affected

- *benztropine*
- *trihexyphenidyl*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.

HIGH RISK DRUGS IN THE ELDERLY - ANTICHOLINERGICS - PROMETHAZINE

Products Affected

- *phenadoz*
- *promethazine injection solution*
- *promethazine oral*
- *promethazine rectal*
- *promethegan*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRURITUS/URTICARIA/SEASONAL/PERENNIAL ALLERGY: TRIAL OF OR CONTRAINDICATION TO A NON-SEDATING ANTIHISTAMINE SUCH AS LEVOCETIRIZINE OR PRESCRIBER ACKNOWLEDGEMENT OR AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. NAUSEA AND VOMITING: PRESCRIBER ACKNOWLEDGEMENT OR AWARENESS THAT THE DRUG IS CONSIDERED HIGH-RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS REQUIRE PHYSICIAN ATTESTATION THAT REQUESTED MEDICATION IS USED TO TREAT A DIAGNOSIS UNRELATED TO THE TERMINAL ILLNESS OR RELATED CONDITION, AND ARE APPROVED WITHOUT TRIAL OF FORMULARY ALTERNATIVES NOR REQUIRING PRESCRIBER ACKNOWLEDGEMENT.

HIGH RISK DRUGS IN THE ELDERLY - ANTICHOLINERGICS - PROMETHAZINE VC

Products Affected

- *promethazine-phenylephrine*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.

HIGH RISK DRUGS IN THE ELDERLY - ANTICHOLINERGICS - SCOPOLAMINE

Products Affected

- *scopolamine base*
- TRANSDERM-SCOP

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS REQUIRE PHYSICIAN ATTESTATION THAT REQUESTED MEDICATION IS USED TO TREAT A DIAGNOSIS UNRELATED TO THE TERMINAL ILLNESS OR RELATED CONDITION, AND ARE APPROVED WITHOUT REQUIRING PRESCRIBER ACKNOWLEDGEMENT.

HIGH RISK DRUGS IN THE ELDERLY - ANTI-INFECTIVE

Products Affected

- *nitrofurantoin macrocrystal*
- *nitrofurantoin monohyd/m-cryst*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS. PA REQUIRED FOR PATIENTS 65 YEARS AND OLDER WITH OVER 90 DAYS CUMULATIVE USE OF THE REQUESTED AGENT.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PREVIOUS TRIAL OF OR CONTRAINDICATION TO SULFAMETHOXAZOLE/TRIMETHOPRIM (TMP-SMX) OR TRIMETHOPRIM. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.

HIGH RISK DRUGS IN THE ELDERLY - BARBITURATE COMBINATIONS

Products Affected

- *butalbital-acetaminophen-caff oral tablet 50-325-40 mg*
- *butalbital-aspirin-caffeine*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS ARE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.

HIGH RISK DRUGS IN THE ELDERLY - CARDIOVASCULAR

Products Affected

- *guanfacine oral tablet*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	HYPERTENSION: PREVIOUS TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING GENERIC FORMULARY ALTERNATIVES: ANGIOTENSIN CONVERTING ENZYME INHIBITOR (ACE INHIBITOR), ACE INHIBITOR COMBINATION, ANGIOTENSIN RECEPTOR BLOCKER (ARB), ARB COMBINATION, BETA BLOCKER, BETA BLOCKER COMBINATION, OR CALCIUM CHANNEL BLOCKERS. PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.

HIGH RISK DRUGS IN THE ELDERLY - DIGOXIN

Products Affected

- *digitek oral tablet 125 mcg, 250 mcg*
- *digox oral tablet 125 mcg, 250 mcg*
- *digoxin 125 mcg tablet*
- *digoxin injection syringe*
- DIGOXIN ORAL SOLUTION 50 MCG/ML
- *digoxin oral tablet 125 mcg, 250 mcg*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	APPROVAL FOR MEMBERS STABLE ON DOSES GREATER THAN 125MCG PER DAY WITH PHYSICIAN'S ATTESTATION OF THERAPEUTIC DIGOXIN LEVEL TAKEN WITHIN THE PAST YEAR. HOSPICE PATIENTS ARE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.

HIGH RISK DRUGS IN THE ELDERLY - DIPYRIDAMOLE

Products Affected

- *dipyridamole oral*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.

HIGH RISK DRUGS IN THE ELDERLY - DISOPYRAMIDE

Products Affected

- *disopyramide phosphate oral capsule*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.

HIGH RISK DRUGS IN THE ELDERLY - ENDOCRINE - ESTROGEN

Products Affected

- *amabelz*
- *dotti*
- DUAVEE
- *estradiol oral*
- *estradiol transdermal patch semiweekly*
- *estradiol transdermal patch weekly*
- *estradiol-norethindrone acet oral tablet 0.5-0.1 mg*
- *estropipate*
- *fyavolv*
- *jinteli*
- MENEST
- *mimvey lo*
- *norethindrone ac-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg*
- PREMARIN ORAL
- PREMPHASE
- PREMPRO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	VULVAR/VAGINAL ATROPHY, OSTEOPOROSIS AND VASOMOTOR SYMPTOMS OF MENOPAUSE: PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. ALL OTHER FDA APPROVED INDICATIONS NOT PREVIOUSLY MENTIONED IN THIS SECTION, SUCH AS PALLIATIVE TREATMENT, AND HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.

HIGH RISK DRUGS IN THE ELDERLY - ENDOCRINE - SULFONYLUREAS

Products Affected

- *glyburide*
- *glyburide micronized*
- *glyburide-metformin*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	TRIAL OF GLIMEPIRIDE, GLIPIZIDE, OR PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS ARE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.

HIGH RISK DRUGS IN THE ELDERLY - KETOROLAC

Products Affected

- *ketorolac oral*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	30 DAYS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.

HIGH RISK DRUGS IN THE ELDERLY - NON-BENZODIAZEPINE

Products Affected

- *eszopiclone*
- *zaleplon*
- *zolpidem oral tablet*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS. PA REQUIRED FOR PATIENTS 65 YEARS AND OLDER WITH OVER 90 DAYS CUMULATIVE USE OF NON-BENZODIAZEPINE AGENTS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	TRIAL OF SILENOR AND BELSOMRA OR PRESCRIBER ACKNOWLEDGEMENT/ AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS ARE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.

HIGH RISK DRUGS IN THE ELDERLY - SKELETAL MUSCLE RELAXANTS

Products Affected

- *carisoprodol oral tablet 350 mg*
- *chlorzoxazone oral tablet 500 mg*
- *cyclobenzaprine oral tablet 10 mg, 5 mg*
- *methocarbamol oral*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED A HIGH RISK MEDICATION FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.

HIGH RISK DRUGS IN THE ELDERLY ANTICHOLINERGICS - CYPROHEPTADINE_CARBINOXAMINE

Products Affected

- *cyproheptadine oral syrup*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.

HIGH RISK DRUGS IN THE ELDERLY- ANTICHOLINERGICS- DIPHENHYDRAMINE ELIXIR

Products Affected

- *diphenhydramine hcl oral elixir*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	ANTIHISTAMINIC CONDITIONS (PRURITUS OR URTICARIA): TRIAL OR CONTRAINDICATION TO A NON-SEDATING ANTIHISTAMINE SUCH AS LEVOCETIRIZINE. INSOMNIA: TRIAL OF SILENOR AND BELSOMRA. MOTION SICKNESS AND ANTIPARKINSONISM: PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS CONSIDERED AS HIGH RISK MEDICATION IN THE ELDERLY FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS AND ANAPHYLACTIC REACTIONS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.

HIGH RISK DRUGS IN THE ELDERLY-DIPHENOXYLATE-ATROPINE

Products Affected

- *diphenoxylate-atropine*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.

HIGH RISK DRUGS IN THE ELDERLY-HYDROXYZINE

Products Affected

- *hydroxyzine hcl intramuscular*
- *hydroxyzine hcl oral solution 10 mg/5 ml*
- *hydroxyzine hcl oral tablet*
- *hydroxyzine pamoate*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS REQUIRE PHYSICIAN ATTESTATION THAT REQUESTED MEDICATION IS USED TO TREAT A DIAGNOSIS UNRELATED TO THE TERMINAL ILLNESS OR RELATED CONDITION, AND ARE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.

HIGH RISK DRUGS IN THE ELDERLY-INDOMETHACIN

Products Affected

- *indomethacin oral capsule 25 mg, 50 mg*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.

HIGH RISK DRUGS IN THE ELDERLY-MECLIZINE

Products Affected

- *meclizine oral tablet 12.5 mg, 25 mg*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS

PA Criteria	Criteria Details
Other Criteria	FOR MANAGEMENT OF VERTIGO ASSOCIATED WITH DISEASES AFFECTING THE VESTIBULAR SYSTEM: PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED A HIGH RISK MEDICATION FOR PATIENTS 65 YEARS AND OLDER. FOR NAUSEA, VOMITING, AND DIZZINESS ASSOCIATED WITH MOTION SICKNESS: PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED A HIGH RISK MEDICATION FOR PATIENTS 65 YEARS AND OLDER OR TRIAL OF OR CONTRAINDICATION TO PROCHLORPERAZINE, PROCHLORPERAZINE MALEATE, OR PROCHLORPERAZINE EDISYLATE. HOSPICE PATIENTS REQUIRE PHYSICIAN ATTESTATION THAT REQUESTED MEDICATION IS USED TO TREAT A DIAGNOSIS UNRELATED TO THE TERMINAL ILLNESS OR RELATED CONDITION, AND ARE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.

HIGH RISK DRUGS IN THE ELDERLY-MEGESTROL

Products Affected

- *megestrol oral suspension 400 mg/10 ml (40 mg/ml)*
- *megestrol oral tablet*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.

HIGH RISK DRUGS IN THE ELDERLY-PAROXETINE

Products Affected

- *paroxetine hcl oral tablet*
- PAXIL ORAL SUSPENSION

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.

HIGH RISK DRUGS IN THE ELDERLY- TCA

Products Affected

- *amitriptyline*
- *amoxapine*
- *clomipramine*
- *desipramine*
- *doxepin oral*
- *imipramine hcl*
- *nortriptyline*
- *perphenazine-amitriptyline*
- *protriptyline*
- *trimipramine*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.

HIGH RISK DRUGS IN THE ELDERLY-BENZODIAZEPINE SEDATIVE HYPNOTICS

Products Affected

- *temazepam oral capsule 15 mg, 30 mg*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS. PA REQUIRED FOR PATIENTS 65 YEARS AND OLDER WITH OVER 90 DAYS CUMULATIVE USE OF THE REQUESTED AGENT.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PREVIOUS TRIAL OF OR CONTRAINDICATION TO SILENOR AND BELSOMRA OR PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.

HIGH RISK MEDICATIONS IN THE ELDERLY-PHENOBARBITAL

Products Affected

- *phenobarbital*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	FOR TREATMENT OF EPILEPSY/SEIZURES IN PATIENTS WHO ARE NOT CURRENTLY STABLE ON PHENOBARBITAL: PATIENT HAS NOT RESPONDED TO OTHER ANTICONVULSANTS OR PRESCRIBER ACKNOWLEDGEMENT/AWARENESS THAT THE DRUG IS CONSIDERED HIGH RISK FOR PATIENTS 65 YEARS AND OLDER. PATIENTS WHO ARE STABLE ON PHENOBARBITAL FOR EPILEPSY/SEIZURES ARE APPROVED WITHOUT REQUIRING A TRIAL OF FORMULARY ALTERNATIVES OR PRESCRIBER ACKNOWLEDGEMENT. HOSPICE PATIENTS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA.

HYDROXYPROGESTERONE CAPROATE-DELALUTIN GENERIC

Products Affected

- *hydroxyprogesterone caproate*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.

IBRUTINIB

Products Affected

- IMBRUVICA ORAL CAPSULE 140 MG, 70 MG
- IMBRUVICA ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

IDELALISIB

Products Affected

- ZYDELIG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

IMATINIB MESYLATE

Products Affected

- *imatinib oral tablet 100 mg, 400 mg*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ALL DIAGNOSES: 12 MONTHS. ADJUVANT GASTROINTESTINAL STROMAL TUMOR (GIST) TREATMENT: 36 MONTHS.
Other Criteria	PATIENTS WITH PREVIOUSLY-TREATED CML REQUIRE A BCR-ABL MUTATIONAL ANALYSIS CONFIRMING THAT THE PATIENT IS NEGATIVE FOR THE FOLLOWING MUTATIONS: T315I, V299L, F317L/V/I/C, Y253H, E255K/V, F359V/C/I.

IMIQUIMOD - ALDARA

Products Affected

- *imiquimod topical cream in packet*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	ACTINIC KERATOSIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST. SUPERFICIAL BASAL CELL CARCINOMA: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR AN ONCOLOGIST.
Coverage Duration	4 MONTHS
Other Criteria	EXTERNAL GENITAL WARTS: TRIAL OF PODOFILOX (CONDYLOX) 0.5% TOPICAL SOLUTION. ACTINIC KERATOSIS BRAND DRUG REQUEST: TRIAL OF GENERIC IMIQUIMOD 5% CREAM. SUPERFICIAL BASAL CELL CARCINOMA: LESS THAN 2CM IN SIZE AND NOT ON THE FACE.

INFLIXIMAB

Products Affected

- REMICADE

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS: SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, OR FACE. RENEWAL FOR RHEUMATOID ARTHRITIS, PSORIATIC ARTHRITIS, ANKYLOSING SPONDYLITIS, OR PLAQUE PSORIASIS: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSORIASIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST. CROHN'S DISEASE/ULCERATIVE COLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, KEVZARA, ENBREL. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL. PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, SKYRIZI. ANKYLOSING SPONDYLITIS (AS): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, COSENTYX, ENBREL. CROHN'S DISEASE (CD): PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA AND STELARA. ULCERATIVE COLITIS (UC): PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA.

INFLIXIMAB-ABDA

Products Affected

- RENFLEXIS

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS: SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, OR FACE. RENEWAL FOR RHEUMATOID ARTHRITIS, PSORIATIC ARTHRITIS, ANKYLOSING SPONDYLITIS, OR PLAQUE PSORIASIS: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSORIASIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST. CROHN'S DISEASE/ULCERATIVE COLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, KEVZARA, ENBREL. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL. PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, SKYRIZI. ANKYLOSING SPONDYLITIS (AS): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, COSENTYX, ENBREL. CROHN'S DISEASE (CD): PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA AND STELARA. ULCERATIVE COLITIS (UC): PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA.

INFLIXIMAB-DYYB

Products Affected

- INFLECTRA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS: SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5 PERCENT BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, OR FACE. RENEWAL FOR RHEUMATOID ARTHRITIS, PSORIATIC ARTHRITIS, ANKYLOSING SPONDYLITIS, OR PLAQUE PSORIASIS: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSORIASIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST. CROHN'S DISEASE/ULCERATIVE COLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, KEVZARA, ENBREL. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL. PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL, SKYRIZI. ANKYLOSING SPONDYLITIS (AS): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, COSENTYX, ENBREL. CROHN'S DISEASE (CD): PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA AND STELARA. ULCERATIVE COLITIS (UC): PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA.

INOTUZUMAB OZOGAMICIN

Products Affected

- BESPONSA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

INTERFERON ALFA-2B

Products Affected

- INTRON A INJECTION

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. FOR USE TO TREAT HEPATITIS C, CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE AND ADDITIONAL CONSIDERATION FOR COVERAGE CONSISTENT WITH FDA LABELING.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	HEPATITIS C: GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (E.G. HEPATOLOGIST). NO REQUIREMENT FOR OTHER FDA APPROVED INDICATIONS.
Coverage Duration	6 MONTHS
Other Criteria	LIMITED TO 1 YEAR OF THERAPY EXCEPT 18 MONTHS FOR FOLLICULAR LYMPHOMA. HEPATITIS C GENOTYPE 1, 2, 3, 4, 5, OR 6: REQUIRES A TRIAL OF OR CONTRAINDICATION TO PEGINTERFERON ALFA-2A OR PEGINTERFERON ALFA-2B USED IN COMBINATION WITH RIBAVIRIN UNLESS CONTRAINDICATED.

INTERFERONS FOR MS-AVONEX, PLEGRIDY, REBIF

Products Affected

- AVONEX (WITH ALBUMIN)
- AVONEX INTRAMUSCULAR PEN INJECTOR KIT
- AVONEX INTRAMUSCULAR SYRINGE KIT
- PLEGRIDY
- REBIF (WITH ALBUMIN)
- REBIF REBIDOSE
- REBIF TITRATION PACK

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

INTERFERONS FOR MS-BETASERON, EXTAVIA

Products Affected

- BETASERON SUBCUTANEOUS KIT
- EXTAVIA SUBCUTANEOUS KIT

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	TRIAL WITH TWO OF THE FOLLOWING AGENTS FOR MULTIPLE SCLEROSIS: AUBAGIO, AVONEX, GILENYA, PLEGRIDY, REBIF, TECFIDERA, AND GLATIRAMER
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

IPILIMUMAB

Products Affected

- YERVOY

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: UNRESECT/MET MELANOMA: 4 MO, RCC/CRC: 3 MO. CUTANEOUS MELANOMA: INITIAL AND RENEWAL: 6 MO
Other Criteria	RENEWAL FOR ADJUVANT CUTANEOUS MELANOMA: NO EVIDENCE OF DISEASE RECURRENCE (DEFINED AS THE APPEARANCE OF ONE OR MORE NEW MELANOMA LESIONS: LOCAL, REGIONAL OR DISTANT METASTASIS)

IVACAFTOR

Products Affected

- KALYDECO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	HOMOZYGOUS FOR F508DEL MUTATION IN CFTR GENE.
Required Medical Information	CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CYSTIC FIBROSIS.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

IVACAFTOR - GRANULE PACKETS

Products Affected

- KALYDECO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	HOMOZYGOUS F508DEL MUTATION IN CFTR GENE.
Required Medical Information	CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CYSTIC FIBROSIS.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

IVOSIDENIB

Products Affected

- TIBSOVO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

IXAZOMIB

Products Affected

- NINLARO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

IXEKIZUMAB

Products Affected

- TALTZ AUTOINJECTOR
- TALTZ SYRINGE

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5 PERCENT BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, OR GENITAL AREA. RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	PLAQUE PSORIASIS (PSO): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, COSENTYX, STELARA, ENBREL. PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, COSENTYX, STELARA, ENBREL, SKYRIZI.

LANADELUMAB

Products Affected

- TAKHZYRO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT (I.E., REDUCTIONS IN ATTACK FREQUENCY OR ATTACK SEVERITY) IN HAE ATTACKS WITH ROUTINE PROPHYLAXIS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH AN ALLERGIST/IMMUNOLOGIST OR HEMATOLOGIST.
Coverage Duration	INITIAL: 12 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: DIAGNOSIS OF HEREDITARY ANGIOEDEMA CONFIRMED BY COMPLEMENT TESTING.

LAROTRECTINIB

Products Affected

- VITRAKVI ORAL CAPSULE 100 MG, 25 MG
- VITRAKVI ORAL SOLUTION

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

LEDIPASVIR-SOFOSBUVIR

Products Affected

- HARVONI

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE AND ADDITIONAL CONSIDERATION FOR COVERAGE CONSISTENT WITH FDA LABELING.
Exclusion Criteria	
Required Medical Information	HCV RNA LEVEL WITHIN PAST 6 MONTHS.
Age Restrictions	
Prescriber Restrictions	GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.
Coverage Duration	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING: CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, ROSUVASTATIN, SOFOSBUVIR (AS A SINGLE AGENT), STRIBILD (ELVITEGRAVIR/COBICISTAT/EMTRICITABINE /TENOFOVIR), OR TIPRANAVIR/RITONAVIR.

LEDIPASVIR-SOFOSBUVIR-GENERIC

Products Affected

- *ledipasvir-sofosbuvir*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE AND ADDITIONAL CONSIDERATION FOR COVERAGE CONSISTENT WITH FDA LABELING.
Exclusion Criteria	
Required Medical Information	HCV RNA LEVEL WITHIN PAST 6 MONTHS.
Age Restrictions	
Prescriber Restrictions	GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.
Coverage Duration	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING: CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, ROSUVASTATIN, SOFOSBUVIR (AS A SINGLE AGENT), STRIBILD (ELVITEGRAVIR/COBICISTAT/EMTRICITABINE /TENOFOVIR), OR TIPRANAVIR/RITONAVIR. REQUESTS FOR GENERIC LEDIPASVIR/SOFOSBUVIR REQUIRE TRIAL OF OR CONTRAINDICATION TO BRAND HARVONI.

LENALIDOMIDE

Products Affected

- REVLIMID

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

LENVATINIB MESYLATE

Products Affected

- LENVIMA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

LETERMOVIR

Products Affected

- PREVYMIS INTRAVENOUS SOLUTION 240 MG/12 ML, 480 MG/24 ML
- PREVYMIS ORAL

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	4 MONTHS
Other Criteria	

LEVODOPA

Products Affected

- INBRIJA 42 MG INHALATION CAP
- INBRIJA INHALATION CAPSULE, W/INHALATION DEVICE

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

L-GLUTAMINE

Products Affected

- ENDARI

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST
Coverage Duration	12 MONTHS
Other Criteria	INITIAL CRITERIA FOR ADULTS (18 YEARS OR OLDER): PHYSICIAN ATTESTATION OF ONE OF THE FOLLOWING: (1) AT LEAST 2 SICKLE CELL CRISES IN THE PAST YEAR OR (2) SICKLE-CELL ASSOCIATED SYMPTOMS WHICH ARE INTERFERING WITH ACTIVITIES OF DAILY LIVING OR (3) HISTORY OF OR HAS RECURRENT ACUTE CHEST SYNDROME (ACS). INITIAL REQUESTS FOR PATIENTS BETWEEN THE AGES OF 5-17 WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA. RENEWAL FOR ALL PATIENTS: PHYSICIAN ATTESTATION PATIENT HAS MAINTAINED OR EXPERIENCED REDUCTION IN ACUTE COMPLICATIONS OF SICKLE CELL DISEASE.

LIDOCAINE

Products Affected

- *lidocaine topical adhesive patch,medicated*
- *lidocaine topical ointment*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PATCH: 12 MONTHS. OINTMENT: 3 MONTHS.
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.

LIDOCAINE PRILOCAINE

Products Affected

- *lidocaine-prilocaine topical cream*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG MAY BE EITHER BUNDLED WITH AND COVERED UNDER END STAGE RENAL DISEASE DIALYSIS RELATED SERVICES OR COVERED UNDER MEDICARE D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.

LIDOCAINE TIRF

Products Affected

- ZTLIDO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.

LOMITAPIDE

Products Affected

- JUXTAPID ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG, 5 MG, 60 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	LDL CHOLESTEROL LEVEL, LDL RECEPTOR STATUS.
Age Restrictions	
Prescriber Restrictions	CARDIOLOGIST, ENDOCRINOLOGIST OR LIPIDOLOGIST.
Coverage Duration	12 MONTHS

PA Criteria	Criteria Details
Other Criteria	DIAGNOSIS DETERMINED BY (1) DEFINITE SIMON BROOME DIAGNOSTIC CRITERIA, (2) DUTCH LIPID NETWORK CRITERIA SCORE OF 8 OR GREATER, OR (3) A CLINICAL DIAGNOSIS BASED ON A HISTORY OF AN UNTREATED LDL-C CONCENTRATION GREATER THAN 500 MG/DL TOGETHER WITH EITHER XANTHOMA BEFORE 10 YEARS OF AGE, OR EVIDENCE OF HEFH IN BOTH PARENTS. LDL-C LEVEL GREATER THAN OR EQUAL TO 70MG/DL WHILE ON MAXIMAL DRUG TREATMENT. PREVIOUS TRIAL OF EVOLOCUMAB UNLESS THE PATIENT HAS NON-FUNCTIONING LDL RECEPTORS. MEETS ONE OF THE FOLLOWING: (1) TAKING A HIGH-INTENSITY STATIN (I.E., ATORVASTATIN 40-80MG DAILY, ROSUVASTATIN 20-40MG DAILY) FOR A DURATION OF AT LEAST 8 WEEKS, (2) TAKING A MAXIMALLY TOLERATED DOSE OF ANY STATIN FOR A DURATION OF AT LEAST 8 WEEKS GIVEN THAT THE PATIENT CANNOT TOLERATE A HIGH-INTENSITY STATIN, (3) ABSOLUTE CONTRAINDICATION TO STATIN THERAPY (E.G., ACTIVE DECOMPENSATED LIVER DISEASE, NURSING FEMALE, PREGNANCY OR PLANS TO BECOME PREGNANT, HYPERSENSITIVITY REACTIONS), (4) PHYSICIAN ATTESTATION OF STATIN INTOLERANCE, OR (5) PATIENT HAS TRIED ROSUVASTATIN, ATORVASTATIN, OR STATIN THERAPY AT ANY DOSE AND HAS EXPERIENCED SKELETAL-MUSCLE RELATED SYMPTOMS (E.G., MYOPATHY).

LORLATINIB

Products Affected

- LORBRENA ORAL TABLET 100 MG, 25 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

LUMACAFTOR-IVACAFTOR

Products Affected

- ORKAMBI ORAL GRANULES IN PACKET
- ORKAMBI ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CYSTIC FIBROSIS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PULMONOLOGIST OR CYSTIC FIBROSIS EXPERT.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	RENEWAL: MAINTAINED OR IMPROVEMENT IN FEV1 OR BODY MASS INDEX (BMI), OR REDUCTION IN NUMBER OF PULMONARY EXACERBATIONS.

LUSUTROMBOPAG

Products Affected

- MULPLETA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 MONTHS
Other Criteria	

MEPOLIZUMAB

Products Affected

- NUCALA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	SEVERE ASTHMA: CONCURRENT USE OF XOLAIR.
Required Medical Information	SEVERE ASTHMA: BLOOD EOSINOPHIL LEVEL GREATER THAN OR EQUAL TO 150 CELLS/MCL WITHIN THE LAST 6 WEEKS OR GREATER THAN OR EQUAL TO 300 CELLS/MCL WITHIN THE LAST 12 MONTHS.
Age Restrictions	
Prescriber Restrictions	SEVERE ASTHMA: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN PULMONARY MEDICINE, AN ALLERGIST OR AN IMMUNOLOGIST.
Coverage Duration	INITIAL: SEVERE ASTHMA: 24 WEEKS. EGPA: 12 MONTHS. RENEWAL FOR ALL INDICATIONS: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	INITIAL THERAPY: SEVERE ASTHMA: PATIENT CURRENTLY TREATED WITH A MAXIMALLY TOLERATED DOSE OF INHALED CORTICOSTEROIDS AND AT LEAST ONE OTHER MAINTENANCE MEDICATION WHICH INCLUDES ANY OF THE FOLLOWING: LONG-ACTING INHALED BETA2-AGONIST, LONG-ACTING MUSCARINIC ANTAGONIST, A LEUKOTRIENE RECEPTOR ANTAGONIST, THEOPHYLLINE, OR ORAL CORTICOSTEROID. RENEWAL: SEVERE ASTHMA: REQUIRES DOCUMENTATION THAT THE PATIENT HAS EXPERIENCED IMPROVEMENT IN ASTHMA EXACERBATIONS FROM BASELINE (PHYSICIAN ATTESTATION) AND A REDUCTION IN ORAL CORTICOSTEROID DOSE (IF THE PATIENT WAS ON A MAINTENANCE REGIMEN OF ORAL CORTICOSTEROIDS AT THE INITIATION OF TREATMENT).

METHYLNALTREXONE

Products Affected

- RELISTOR SUBCUTANEOUS SOLUTION
- RELISTOR SUBCUTANEOUS SYRINGE

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	ADVANCED ILLNESS: OPIOID-INDUCED CONSTIPATION.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 MONTHS FOR PATIENTS RECEIVING PALLIATIVE CARE, 12 MONTHS FOR CHRONIC, NON-CANCER PAIN.
Other Criteria	ADVANCED ILLNESS: PATIENT IS RECEIVING PALLIATIVE CARE. CHRONIC NON-CANCER PAIN: PATIENT HAS BEEN TAKING OPIOIDS FOR AT LEAST 4 WEEKS AND HAD A PREVIOUS TRIAL OF OR CONTRAINDICATION TO NALOXEGOL (MOVANTIK) AND LUBIPROSTONE (AMITIZA).

METHYLNALTREXONE ORAL

Products Affected

- RELISTOR ORAL

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PATIENT HAS BEEN TAKING OPIOIDS FOR AT LEAST 4 WEEKS AND HAD A PREVIOUS TRIAL OF OR CONTRAINDICATION TO NALOXEGOL (MOVANTIK) AND LUBIPROSTONE (AMITIZA).

MIDOSTAURIN

Products Affected

- RYDAPT

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ACUTE MYELOID LEUKEMIA: 6 MONTHS. ADVANCED SYSTEMIC MASTOCYTOSIS: 12 MONTHS
Other Criteria	

MIFEPRISTONE

Products Affected

- KORLYM

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

MIGALASTAT HCL

Products Affected

- GALAFOLD

PA Criteria	Criteria Details
Covered Uses	ALL FDA-APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	FABRY DISEASE INITIAL: THE PATIENT IS NOT CONCURRENTLY USING ENZYME REPLACEMENT THERAPY (I.E. FABRAZYME). THE PATIENT IS SYMPTOMATIC OR HAS EVIDENCE OF INJURY FROM GL-3 TO THE KIDNEY, HEART, OR CENTRAL NERVOUS SYSTEM RECOGNIZED BY LABORATORY, HISTOLOGICAL, OR IMAGING FINDINGS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH NEPHROLOGIST, CARDIOLOGIST, OR SPECIALIST IN GENETICS OR INHERITED METABOLIC DISORDERS.
Coverage Duration	INITIAL: 6 MOS. RENEWAL: 12 MOS
Other Criteria	FABRY DISEASE RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT HAS DEMONSTRATED IMPROVEMENT OR STABILIZATION.

MILTEFOSINE

Products Affected

- IMPAVIDO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

MIPOMERSEN

Products Affected

- KYNAMRO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	LDL CHOLESTEROL LEVEL, LDL RECEPTOR STATUS.
Age Restrictions	
Prescriber Restrictions	CARDIOLOGIST, ENDOCRINOLOGIST OR LIPIDOLOGIST
Coverage Duration	12 MONTHS

PA Criteria	Criteria Details
Other Criteria	DIAGNOSIS DETERMINED BY (1) DEFINITE SIMON BROOME DIAGNOSTIC CRITERIA, (2) DUTCH LIPID NETWORK CRITERIA SCORE OF 8 OR GREATER, OR (3) A CLINICAL DIAGNOSIS BASED ON A HISTORY OF AN UNTREATED LDL-C CONCENTRATION GREATER THAN 500 MG/DL TOGETHER WITH EITHER XANTHOMA BEFORE 10 YEARS OF AGE, OR EVIDENCE OF HEFH IN BOTH PARENTS. LDL-C LEVEL GREATER THAN OR EQUAL TO 70MG/DL WHILE ON MAXIMAL DRUG TREATMENT. PREVIOUS TRIAL OF EVOLOCUMAB UNLESS THE PATIENT HAS NON-FUNCTIONING LDL RECEPTORS. MEETS ONE OF THE FOLLOWING: (1) TAKING A HIGH-INTENSITY STATIN (I.E., ATORVASTATIN 40-80MG DAILY, ROSUVASTATIN 20-40MG DAILY) FOR A DURATION OF AT LEAST 8 WEEKS, (2) TAKING A MAXIMALLY TOLERATED DOSE OF ANY STATIN FOR A DURATION OF AT LEAST 8 WEEKS GIVEN THAT THE PATIENT CANNOT TOLERATE A HIGH-INTENSITY STATIN, (3) ABSOLUTE CONTRAINDICATION TO STATIN THERAPY (E.G., ACTIVE DECOMPENSATED LIVER DISEASE, NURSING FEMALE, PREGNANCY OR PLANS TO BECOME PREGNANT, HYPERSENSITIVITY REACTIONS), (4) PHYSICIAN ATTESTATION OF STATIN INTOLERANCE, OR (5) PATIENT HAS TRIED ROSUVASTATIN, ATORVASTATIN, OR STATIN THERAPY AT ANY DOSE AND HAS EXPERIENCED SKELETAL-MUSCLE RELATED SYMPTOMS (E.G., MYOPATHY).

MOGAMULIZUMAB-KPKC

Products Affected

- POTELIGEO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

MOXETUMOMAB PASUDOTOX

Products Affected

- LUMOXITI

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

NARCOLEPSY AGENTS

Products Affected

- *armodafinil*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.

NATALIZUMAB

Products Affected

- TYSABRI

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	CROHN'S DISEASE: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	MULTIPLE SCLEROSIS: 12 MOS. CROHN'S DISEASE: INITIAL: 6 MOS. RENEWAL: 12 MOS.
Other Criteria	MULTIPLE SCLEROSIS INITIAL CRITERIA: PREVIOUS TRIAL OF TWO AGENTS FOR MULTIPLE SCLEROSIS. CROHN'S DISEASE INITIAL CRITERIA: PREVIOUS TRIAL OF HUMIRA AND STELARA. CROHN'S DISEASE RENEWAL CRITERIA: PATIENT HAS RECEIVED AT LEAST 12 MONTHS OF THERAPY WITH TYSABRI WITH PHYSICIAN ATTESTATION THAT THE PATIENT HAS NOT REQUIRED MORE THAN 3 MONTHS OF CORTICOSTEROID USE WITHIN THE PAST 12 MONTHS TO CONTROL THEIR CROHN'S DISEASE WHILE ON TYSABRI, OR PATIENT HAS ONLY RECEIVED 6 MONTHS OF THERAPY WITH TYSABRI WITH PHYSICIAN ATTESTATION THAT THE PATIENT HAS TAPERED OFF CORTICOSTEROIDS DURING THE FIRST 24 WEEKS OF TYSABRI THERAPY. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.

NECITUMUMAB

Products Affected

- PORTRAZZA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

NERATINIB MALEATE

Products Affected

- NERLYNX

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	EARLY-STAGE TUMOR (STAGE I-III) AND TUMOR IS HORMONE-RECEPTOR POSITIVE AND THE MEDICATION IS BEING REQUESTED WITHIN 2 YEARS OF COMPLETING THE LAST TRASTUZUMAB DOSE

NILOTINIB

Products Affected

- TASIGNA ORAL CAPSULE 150 MG, 200 MG, 50 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PREVIOUSLY TREATED CML REQUIRES BCR-ABL MUTATIONAL ANALYSIS NEGATIVE FOR THE FOLLOWING MUTATIONS: T315I, Y253H, E255K/V, AND F359V/C/I.

NINTEDANIB

Products Affected

- OFEV

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	NOT APPROVED FOR PATIENTS WITH OTHER KNOWN CAUSES OF INTERSTITIAL LUNG DISEASE (E.G., CONNECTIVE TISSUE DISEASE, DRUG TOXICITY, ASBESTOS OR BERYLLIUM EXPOSURE, HYPERSENSITIVITY PNEUMONITIS, SYSTEMIC SCLEROSIS, RHEUMATOID ARTHRITIS, RADIATION, SARCOIDOSIS, BRONCHIOLITIS OBLITERANS ORGANIZING PNEUMONIA, HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION, VIRAL HEPATITIS, AND CANCER). NOT APPROVED IF PATIENT DOES NOT HAVE A PREDICTED FORCED VITAL CAPACITY (FVC) OF AT LEAST 50 PERCENT OR HAS NOT OBTAINED LIVER FUNCTION TESTS.
Required Medical Information	A USUAL INTERSTITIAL PNEUMONIA (UIP) PATTERN AS EVIDENCED BY HIGH-RESOLUTION COMPUTED TOMOGRAPHY (HRCT) ALONE OR VIA A COMBINATION OF SURGICAL LUNG BIOPSY AND HRCT.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PULMONOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	

NIRAPARIB TOSYLATE

Products Affected

- ZEJULA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

NITISINONE

Products Affected

- NITYR
- ORFADIN

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DIAGNOSIS OF HEREDITARY TYROSINEMIA TYPE 1 AS CONFIRMED BY ELEVATED URINARY OR PLASMA SUCCINYLACETONE LEVELS OR A MUTATION IN THE FUMARYLACETOACETATE HYDROLASE GENE.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PRESCRIBER SPECIALIZING IN INHERITED METABOLIC DISEASES.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	ORFADIN SUSPENSION: TRIAL OF OR CONTRAINDICATION TO PREFERRED FORMULARY NITISINONE TABLETS OR CAPSULES. RENEWAL: THE PATIENT'S URINARY OR PLASMA SUCCINYLACETONE LEVELS HAVE DECREASED FROM BASELINE WHILE ON TREATMENT WITH NITISINONE.

NIVOLUMAB

Products Affected

- OPDIVO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	MELANOMA: OPDIVO IS NOT APPROVED FOR COMBINATION THERAPY WITH TAFINLAR, MEKINIST (TRAMETINIB), COTELLIC (COBIMETINIB), OR ZELBORAF.

OBETICHOLIC ACID

Products Affected

- OCALIVA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	PATIENTS WITH COMPLETE BILIARY OBSTRUCTION.
Required Medical Information	DIAGNOSIS OF PRIMARY BILIARY CHOLANGITIS AS CONFIRMED BY AT LEAST TWO OF THE FOLLOWING CRITERIA: AN ALKALINE PHOSPHATASE LEVEL OF AT LEAST 1.5 TIMES THE UPPER LIMIT OF NORMAL (ULN), THE PRESENCE OF ANTIMITOCHONDRIAL ANTIBODIES AT A TITER OF 1:40 OR HIGHER, HISTOLOGIC EVIDENCE OF NON-SUPPURATIVE DESTRUCTIVE CHOLANGITIS AND DESTRUCTION OF INTERLOBULAR BILE DUCTS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST OR HEPATOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	INITIAL: USED IN COMBINATION WITH URSODEOXYCHOLIC ACID (E.G., URSODIOL, URSO 250, URSO FORTE) IN ADULTS WITH AN INADEQUATE RESPONSE TO URSODEOXYCHOLIC ACID AT A DOSAGE OF 13-15 MG/KG/DAY FOR AT LEAST 1 YEAR, OR AS MONOTHERAPY IN ADULTS UNABLE TO TOLERATE URSODEOXYCHOLIC ACID. RENEWAL: PATIENT'S ALKALINE PHOSPHATASE LEVELS ARE LESS THAN 1.67-TIMES THE UPPER LIMIT OF NORMAL OR HAVE DECREASED BY AT LEAST 15% FROM BASELINE WHILE ON TREATMENT WITH OBETICHOLIC ACID.

OBINUTUZUMAB

Products Affected

- GAZYVA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 MONTHS
Other Criteria	

OCRELIZUMAB

Products Affected

- OCREVUS

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	RELAPSING FORM OF MULTIPLE SCLEROSIS (MS): THE PATIENT HAD A PREVIOUS TRIAL OF TWO AGENTS INDICATED FOR TREATMENT OF MS. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.

OLAPARIB

Products Affected

- LYNPARZA ORAL CAPSULE
- LYNPARZA ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

OMACETAXINE

Products Affected

- SYNRIBO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INDUCTION: 3 MONTHS. POST INDUCTION/RENEWAL: 3 TO 12 MONTHS.
Other Criteria	CML INDUCTION THERAPY: TRIAL OF OR CONTRAINDICATION TO AT LEAST TWO OF THE FOLLOWING AGENTS: GLEEVEC, SPRYCEL, TASIGNA, BOSULIF, OR ICLUSIG. APPROVAL FOR POST-INDUCTION THERAPY DURATION WILL DEPEND ON THE PATIENT'S HEMATOLOGIC RESPONSE, DEFINED AS (1) AN ABSOLUTE NEUTROPHIL COUNT (ANC) GREATER THAN OR EQUAL TO 1.5 X 10^9/L AND PLATELETS GREATER THAN OR EQUAL TO 100 X 10^9/L WITHOUT BLOOD BLASTS OR (2) THE PATIENT HAS BONE MARROW BLASTS AT LESS THAN 5 PERCENT. APPROVAL IS FOR 12 MONTHS IF HEMATOLOGIC RESPONSE IS MET. IF NOT MET, APPROVAL IS FOR 3 MONTHS.

OMALIZUMAB

Products Affected

- XOLAIR

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	INITIAL CRITERIA FOR ASTHMA: PATIENT MEETS THE CRITERIA OF MODERATE TO SEVERE ASTHMA, POSITIVE SKIN PRICK OR RAST TEST, DEMONSTRATED INADEQUATELY CONTROLLED SYMPTOMS ON INHALED CORTICOSTEROIDS AND SECOND ASTHMA CONTROLLER, BASELINE IGE SERUM LEVEL GREATER THAN OR EQUAL TO 30IU/ML. RENEWAL CRITERIA FOR ASTHMA: PHYSICIAN ATTESTATION OF IMPROVEMENT IN ASTHMA EXACERBATIONS FROM BASELINE OR A REDUCTION IN ORAL OR INHALED CORTICOSTEROID USE.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A SPECIALIST IN ALLERGY, PULMONARY MEDICINE, DERMATOLOGY OR IMMUNOLOGY.
Coverage Duration	INITIAL: ASTHMA: 12 MOS. CHRONIC IDIOPATHIC URTICARIA: 6 MOS. RENEWAL FOR ALL INDICATIONS: 12 MOS.
Other Criteria	FOR CHRONIC IDIOPATHIC URTICARIA: PREVIOUS TRIAL OF OR CONTRAINDICATION TO A MAXIMALLY TOLERATED DOSE OF AN H1 ANTI-HISTAMINE (SUCH AS CLARINEX OR XYZAL) AND PATIENT STILL EXPERIENCES HIVES ON MOST DAYS OF THE WEEK.

OMBITASVIR-PARITAPREVIR-RITONAVIR

Products Affected

- TECHNIVIE

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE AND ADDITIONAL CONSIDERATION FOR COVERAGE CONSISTENT WITH FDA LABELING.
Exclusion Criteria	DECOMPENSATED CIRRHOSIS, MODERATE OR SEVERE LIVER IMPAIRMENT (CHILD-PUGH B OR C).
Required Medical Information	HCV RNA LEVEL WITHIN PAST 6 MONTHS.
Age Restrictions	
Prescriber Restrictions	GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.
Coverage Duration	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.

PA Criteria	Criteria Details
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. TRIAL OF A PREFERRED FORMULARY ALTERNATIVE INCLUDING HARVONI OR EPCLUSA WHEN THESE AGENTS ARE CONSIDERED ACCEPTABLE FOR TREATMENT OF THE SPECIFIC GENOTYPE PER AASLD/IDSA GUIDANCE. MUST BE USED CONCURRENTLY WITH RIBAVIRIN. PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING (CONTRAINDICATED OR NOT RECOMMENDED BY THE MANUFACTURER): ALFUZOSIN, CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, RIFAMPIN, ERGOTAMINE, DIHYDROERGOTAMINE, ERGONOVINE, METHYLERGONOVINE, ETHINYL ESTRADIOL CONTAINING MEDICATIONS (SUCH AS COMBINED ORAL CONTRACEPTIVES, NUVARING, ORTHO EVRA OR XULANE TRANSDERMAL PATCH SYSTEM), LOVASTATIN, SIMVASTATIN, PIMOZIDE, EFAVIRENZ (ATRIPLA, SUSTIVA), REVATIO (SILDENAFIL DOSE OF 20MG AND/OR DOSED THREE TIMES DAILY FOR PAH), TRIAZOLAM, ORAL MIDAZOLAM, LOPINAVIR/RITONAVIR, RILPIVIRINE, SALMETEROL.

OMBITASVIR-PARITAPREVIR-RITONAVIR-DASABUVIR

Products Affected

- VIEKIRA PAK
- VIEKIRA XR

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE AND ADDITIONAL CONSIDERATION FOR COVERAGE CONSISTENT WITH FDA LABELING.
Exclusion Criteria	DECOMPENSATED CIRRHOSIS, MODERATE OR SEVERE LIVER IMPAIRMENT (CHILD-PUGH B OR C).
Required Medical Information	HCV RNA LEVEL WITHIN PAST 6 MONTHS.
Age Restrictions	
Prescriber Restrictions	GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.
Coverage Duration	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.

PA Criteria	Criteria Details
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. TRIAL OF A PREFERRED FORMULARY ALTERNATIVE INCLUDING HARVONI OR EPCLUSA WHEN THESE AGENTS ARE CONSIDERED ACCEPTABLE FOR TREATMENT OF THE SPECIFIC GENOTYPE PER AASLD/IDSA GUIDANCE. PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING: ALFUZOSIN, CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, GEMFIBROZIL, RIFAMPIN, ERGOTAMINE, DIHYDROERGOTAMINE, ERGONOVINE, METHYLERGONOVINE, ETHINYL ESTRADIOL CONTAINING MEDICATIONS (SUCH AS COMBINED ORAL CONTRACEPTIVES, NUVARING, ORTHO EVRA OR XULANE TRANSDERMAL PATCH SYSTEM), ST. JOHN'S WORT, LOVASTATIN, SIMVASTATIN, PIMOZIDE, EFAVIRENZ, REVATIO, TRIAZOLAM, ORAL MIDAZOLAM, DARUNAVIR/RITONAVIR, LOPINAVIR/RITONAVIR, RILPIVIRINE, SALMETEROL.

OSIMERTINIB

Products Affected

- TAGRISSO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	METASTATIC NSCLC WITH EGFR T790M MUTATION: CONCURRENT THERAPY WITH AN EGFR TYROSINE KINASE-INHIBITOR.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

OXYMETHOLONE

Products Affected

- ANADROL-50

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	CARCINOMA OF THE PROSTATE OR BREAST IN MALE PATIENTS, CARCINOMA OF THE BREAST IN FEMALES WITH HYPERCALCEMIA, WOMEN WHO ARE OR MAY BECOME PREGNANT, NEPHROSIS OR THE NEPHROTIC PHASE OF NEPHRITIS, HYPERSENSITIVITY TO THE DRUG AND SEVERE HEPATIC DYSFUNCTION.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

PALBOCICLIB

Products Affected

- IBRANCE

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	THE PATIENT HAS NOT EXPERIENCED DISEASE PROGRESSION FOLLOWING PRIOR CDK INHIBITOR THERAPY
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

PALIVIZUMAB

Products Affected

- SYNAGIS

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	GESTATIONAL AGE
Age Restrictions	LESS THAN 24 MONTHS OF AGE.
Prescriber Restrictions	
Coverage Duration	1 MONTH TO 5 MONTHS. SEE OTHER CRITERIA FOR MORE INFORMATION.
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT RECOMMENDATIONS FROM THE AMERICAN ACADEMY OF PEDIATRICS FOR PALIVIZUMAB PROPHYLAXIS FOR RESPIRATORY SYNCYTIAL VIRUS INFECTIONS. INITIAL: APPROVAL WILL BE FOR AT LEAST 1 MONTH AND NO GREATER THAN 5 MONTHS DEPENDENT UPON REMAINING LENGTH OF RESPIRATORY SYNCYTIAL VIRUS (RSV) SEASON. RENEWAL: ADDITIONAL 1 MONTH OF TREATMENT FOR CARDIOPULMONARY BYPASS SURGERY DURING RSV PROPHYLAXIS SEASON.

PANOBINOSTAT

Products Affected

- FARYDAK

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	RENEWAL: PATIENT HAS TOLERATED THE FIRST 8 CYCLES OF THERAPY WITHOUT UNRESOLVED SEVERE OR MEDICALLY SIGNIFICANT TOXICITY.

PARATHYROID HORMONE

Products Affected

- NATPARA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

PAZOPANIB

Products Affected

- VOTRIENT

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

PDE5 INHIBITORS FOR PULMONARY ARTERIAL HYPERTENSION

Products Affected

- *alyq*
- *sildenafil (antihypertensive) oral tablet*
- *tadalafil (antihypertensive)*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	PATIENT CANNOT CONCURRENTLY OR INTERMITTENTLY BE TAKING ORAL ERECTILE DYSFUNCTION AGENTS (E.G. CIALIS, VIAGRA), ANY ORGANIC NITRATES IN ANY FORM, OR GUANYLATE CYCLASE (GC) STIMULATORS (ADEMPAS).
Required Medical Information	DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS

PA Criteria	Criteria Details
Other Criteria	INITIAL: MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG OR GREATER, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS. REQUEST FOR FORMULARY TADALAFIL 20MG TABLET REQUIRE TRIAL OR CONTRAINDICATION TO REVATIO (SILDENAFIL). RENEWAL: PATIENT SHOWS IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR PATIENT HAS A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/ IMPROVED WHO FUNCTIONAL CLASS. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.

PDE5 INHIBITORS FOR PULMONARY ARTERIAL HYPERTENSION - IV

Products Affected

- *sildenafil (antihypertensive) intravenous*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	PATIENT CANNOT CONCURRENTLY OR INTERMITTENTLY BE TAKING ORAL ERECTILE DYSFUNCTION AGENTS (E.G. CIALIS, VIAGRA), ANY ORGANIC NITRATES IN ANY FORM, OR GUANYLATE CYCLASE (GC) STIMULATORS (ADEMPAS).
Required Medical Information	DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS
Other Criteria	INITIAL: MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG OR GREATER, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS. RENEWAL: PATIENT SHOWS IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR PATIENT HAS A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/ IMPROVED WHO FUNCTIONAL CLASS.

PEDIATRIC VITAMINS

Products Affected

- INFANT-TODDLER TRI-VIT DROP
- *pedia tri-vite drop*
- *tri-vi-sol drops*
- *tri-vite-fluoride 0.25 mg/ml*
- *tri-vite-fluoride 0.5 mg/ml*

PA Criteria	Criteria Details
Covered Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	N/A
Other Criteria	REIMBURSABLE FOR CHILDREN UP TO THE 5TH BIRTHDAY ONLY.

PEG-INTERFERON ALFA-2B-SYLATRON

Products Affected

- SYLATRON

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	OVERALL DURATION OF THERAPY LIMITED TO 5 YEARS.

PEGVALIASE-PQPZ

Products Affected

- PALYNZIQ

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	RENEWAL: REDUCTION IN PHENYLALANINE LEVELS BY AT LEAST 20 PERCENT FROM BASELINE OR TO A LEVEL UNDER 600 MICROMOLES PER LITER.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	

PEMBROLIZUMAB

Products Affected

- KEYTRUDA INTRAVENOUS SOLUTION

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

PENICILLAMINE

Products Affected

- CUPRIMINE
- *penicillamine*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	RHEUMATOID ARTHRITIS: HISTORY OR OTHER EVIDENCE OF RENAL INSUFFICIENCY
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	WILSON'S DISEASE: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEPATOLOGIST. CYSTINURIA: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEPHROLOGIST. RHEUMATOID ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	WILSON'S DISEASE: CONFIRMED DIAGNOSIS OF WILSON'S DISEASE. CYSTINURIA: DIAGNOSIS REQUIRES THE PRESENCE OF NEPHROLITHIASIS AND 1 OR MORE OF THE FOLLOWING: STONE ANALYSIS SHOWING PRESENCE OF CYSTEINE, IDENTIFICATION OF PATHOGNOMONIC HEXAGONAL CYSTINE CRYSTALS ON URINALYSIS, POSITIVE FAMILY HISTORY OF CYSTINURIA WITH POSITIVE CYANIDE-NITROPRUSSIDE SCREEN. REQUESTS FOR CUPRIMINE FOR THE TREATMENT OF WILSON'S DISEASE, CYSTINURIA, AND RHEUMATOID ARTHRITIS REQUIRE A PREVIOUS TRIAL OF OR CONTRAINDICATION TO DEPEN.

PENICILLAMINE-DEPEN

Products Affected

- DEPEN TITRATABS

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	RHEUMATOID ARTHRITIS: HISTORY OR OTHER EVIDENCE OF RENAL INSUFFICIENCY
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	WILSON'S DISEASE: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEPATOLOGIST. CYSTINURIA: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEPHROLOGIST. RHEUMATOID ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	WILSON'S DISEASE: CONFIRMED DIAGNOSIS OF WILSON'S DISEASE. CYSTINURIA: DIAGNOSIS REQUIRES THE PRESENCE OF NEPHROLITHIASIS AND 1 OR MORE OF THE FOLLOWING: STONE ANALYSIS SHOWING PRESENCE OF CYSTEINE, IDENTIFICATION OF PATHOGNOMONIC HEXAGONAL CYSTINE CRYSTALS ON URINALYSIS, POSITIVE FAMILY HISTORY OF CYSTINURIA WITH POSITIVE CYANIDE-NITROPRUSSIDE SCREEN.

PIMAVANSERIN

Products Affected

- NUPLAZID ORAL CAPSULE
- NUPLAZID ORAL TABLET 10 MG, 17 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	18 YEARS OR OLDER
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST, GERIATRICIAN, OR A BEHAVIORAL HEALTH SPECIALIST (SUCH AS A PSYCHIATRIST).
Coverage Duration	INITIAL 12 MONTHS. RENEWAL 12 MONTHS.
Other Criteria	RENEWAL REQUIRES THAT THE PATIENT HAS EXPERIENCED AN IMPROVEMENT IN PSYCHOSIS SYMPTOMS FROM BASELINE AND DEMONSTRATES A CONTINUED NEED FOR TREATMENT.

PIRFENIDONE

Products Affected

- ESBRIET ORAL CAPSULE
- ESBRIET ORAL TABLET 267 MG, 801 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	PATIENTS WITH KNOWN CAUSES OF INTERSTITIAL LUNG DISEASE (E.G., CONNECTIVE TISSUE DISEASE, DRUG TOXICITY, ASBESTOS OR BERYLLIUM EXPOSURE, HYPERSENSITIVITY PNEUMONITIS, SYSTEMIC SCLEROSIS, RHEUMATOID ARTHRITIS, RADIATION, SARCOIDOSIS, BRONCHIOLITIS OBLITERANS ORGANIZING PNEUMONIA, HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION, VIRAL HEPATITIS, AND CANCER). NOT APPROVED IF THE PATIENT HAS NOT OBTAINED LIVER FUNCTION TESTS.
Required Medical Information	PATIENT WITH USUAL INTERSTITIAL PNEUMONIA (UIP) PATTERN AS EVIDENCED BY HIGH-RESOLUTION COMPUTED TOMOGRAPHY (HRCT) ALONE OR VIA A COMBINATION OF SURGICAL LUNG BIOPSY AND HRCT
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PULMONOLOGIST
Coverage Duration	12 MONTHS
Other Criteria	PATIENT HAS A PREDICTED FORCED VITAL CAPACITY (FVC) OF AT LEAST 50%.

POLATUZUMAB VEDOTIN

Products Affected

- POLIVY

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

POMALIDOMIDE

Products Affected

- POMALYST

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

PONATINIB

Products Affected

- ICLUSIG ORAL TABLET 15 MG, 45 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

PRAMLINTIDE

Products Affected

- SYMLINPEN 120
- SYMLINPEN 60

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	TYPE I OR TYPE II DIABETES: REQUIRING INSULIN OR CONTINUOUS INSULIN INFUSION (INSULIN PUMP) FOR GLYCEMIC CONTROL
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

PRENATAL OTC VITAMINS

Products Affected

- *cvs prenatal gummies*
- *cvs prenatal gummy vitamins*
- *cvs prenatal multi-dha softgel*
- *cvs prenatal vitamin tablet*
- *cvs prenatal vitamins tablet (otc)*
- *cvs women's prenatal plus dha*
- *daily prenatal combo pack*
- EXPECTA PRENATAL COMBO PACK
- *kpn tablet*
- *kro prenatal vitamins tablet*
- ONE-A-DAY PRENATAL 1 DHA SFGL
- *perry prenatal capsule*
- *prenatal + dha combo pack*
- *prenatal 19 chewable tablet (otc)*
- *prenatal formula tablet*
- *prenatal gummies*
- *prenatal multivitamin tablet*
- *prenatal multivitamin-dha sfgl*
- *prenatal one tablet*
- *prenatal tablet*
- *prenatal tablet (otc)*
- *prenatal tablet outer (otc)*
- *prenatal vitamin tablet*
- *prenatal vitamins tablet phosphorus free*
- *ra one daily prenatal dha pack 30's tab & 30's cap*
- *ra prenatal tablet*
- *right step prenatal vit tab*
- *sm one daily prenatal combo pk*
- *sm prenatal vitamins tablet*
- STUART ONE CAPSULE
- THERANATAL CORE NUTRITION TAB
- THERANATAL ONE SOFTGEL
- THERANATAL OVAVITE COMBO PACK
- THERANATAL PLUS COMBO PACK
- *vinacal b prenatal combo pack*

PA Criteria	Criteria Details
Covered Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	N/A

PA Criteria	Criteria Details
Other Criteria	RESTRICTED TO USE BY EXPECTANT FEMALES WITH CONFIRMED POSITIVE PREGNANCY TEST CONDUCTED BY HER PHYSICIAN.

PYRIMETHAMINE

Products Affected

- DARAPRIM

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D, ADDITIONAL CONSIDERATION FOR CHRONIC MAINTENANCE THERAPY FOR TOXOPLASMOSIS AND TOXOPLASMOSIS PROPHYLAXIS.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	TOXOPLASMOSIS: INITIAL: 8 WEEKS. RENEWAL: 6 MOS. PROPHYLAXIS: 12 MOS. FOR INITIAL AND RENEWAL.
Other Criteria	INITIAL: PRIMARY PROPHYLAXIS OF TOXOPLASMOSIS IN PATIENTS WITH HIV REQUIRES PREVIOUS TRIAL OF OR CONTRAINDICATION TO BACTRIM (SMX/TMP). RENEWAL: CONTINUED TREATMENT OF TOXOPLASMOSIS REQUIRES ONE OF THE FOLLOWING: 1) PERSISTENT CLINICAL DISEASE (HEADACHE, NEUROLOGICAL SYMPTOMS, OR FEVER) AND PERSISTENT RADIOGRAPHIC DISEASE (ONE OR MORE MASS LESIONS ON BRAIN IMAGING) OR 2) CD4 COUNT LESS THAN 200 CELLS/MM3 AND CURRENT ANTI-RETROVIRAL THERAPY IF HIV POSITIVE. CONTINUATION OF PRIMARY PROPHYLAXIS FOR TOXOPLASMOSIS WITH HIV REQUIRES CD4 COUNT LESS THAN 200 CELLS/MM3 AND CURRENT ANTI-RETROVIRAL THERAPY.

RAMUCIRUMAB

Products Affected

- CYRAMZA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

REGORAFENIB

Products Affected

- STIVARGA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

RESLIZUMAB

Products Affected

- CINQAIR

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	CONCURRENT USE OF XOLAIR.
Required Medical Information	BLOOD EOSINOPHIL LEVEL GREATER THAN OR EQUAL TO 400 CELLS/MCL WITHIN THE LAST 6 MONTHS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN PULMONARY MEDICINE, AN ALLERGIST OR AN IMMUNOLOGIST.
Coverage Duration	INITIAL: 24 WEEKS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL THERAPY: PATIENT CURRENTLY TREATED WITH A MAXIMALLY TOLERATED DOSE OF INHALED CORTICOSTEROIDS. RENEWAL REQUIRES DOCUMENTATION THAT THE PATIENT HAS EXPERIENCED AT LEAST A 25 PERCENT REDUCTION IN ASTHMA EXACERBATIONS (FOR EXAMPLE: HOSPITALIZATIONS, URGENT OR EMERGENT CARE VISITS, USE OF RESCUE MEDICATIONS, ETC.) FROM BASELINE.

RIBOCICLIB

Products Affected

- KISQALI FEMARA CO-PACK ORAL TABLET 200 MG/DAY(200 MG X 1)-2.5 MG, 400 MG/DAY(200 MG X 2)-2.5 MG, 600 MG/DAY(200 MG X 3)-2.5 MG
- KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1), 400 MG/DAY (200 MG X 2), 600 MG/DAY (200 MG X 3)

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	THE PATIENT HAS NOT EXPERIENCED DISEASE PROGRESSION FOLLOWING PRIOR CDK INHIBITOR THERAPY
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

RIFAXIMIN

Products Affected

- XIFAXAN ORAL TABLET 200 MG, 550 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	TRAVELERS' DIARRHEA/HEPATIC ENCEPHALOPATHY: 12 MOS. IBS-D: 12 WKS.
Other Criteria	FOR RIFAXIMIN 550 MG TABLETS ONLY: HEPATIC ENCEPHALOPATHY (HE): PREVIOUS TRIAL OF OR CONTRAINDICATION TO LACTULOSE OR CONCURRENT LACTULOSE THERAPY.

RIOCIGUAT

Products Affected

- ADEMPAS

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	INITIAL FOR PAH: PATIENT IS NOT CONCURRENTLY TAKING NITRATES OR NITRIC OXIDE DONORS (E.G. AMYL NITRATE), PHOSPHODIESTERASE INHIBITORS (E.G. SILDENAFIL, TADALAFIL, OR VARDENAFIL), OR NON-SPECIFIC PDE INHIBITORS (E.G. DIPYRIDAMOLE, THEOPHYLLINE). INITIAL FOR CTEPH: PATIENT IS NOT A CANDIDATE FOR SURGERY OR HAS INOPERABLE CTEPH. PERSISTENT OR RECURRENT DISEASE AFTER SURGICAL TREATMENT. PATIENT IS NOT CONCURRENTLY OR INTERMITTENTLY TAKING NITRATES, NITRIC OXIDE DONORS OR ANY PDE INHIBITORS (E.G.VIAGRA, CIALIS, DIPYRIDAMOLE).
Required Medical Information	DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS. DIAGNOSIS OF PERSISTENT/RECURRENT CHRONIC THROMBOEMBOLIC PULMONARY HYPERTENSION (CTEPH) WHO GROUP 4. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS

PA Criteria	Criteria Details
Other Criteria	INITIAL FOR PAH: MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG OR GREATER, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS. PREVIOUS TRIAL OF OR CONTRAINDICATION TO A PHOSPHODIESTERASE-5 (PDE-5) INHIBITOR, SUCH AS REVATIO (SILDENAFIL) OR ADCIRCA (TADALAFIL). RENEWAL FOR PAH AND CTEPH: PATIENT SHOW IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR PATIENT HAS A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/ IMPROVED WHO FUNCTIONAL CLASS.

RISANKIZUMAB-RZAA

Products Affected

- SKYRIZI

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE OR GENITAL AREA. RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY, SUCH AS PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE

RITUXIMAB

Products Affected

- RITUXAN

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	RENEWAL FOR RA: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. NHL, CLL: ONCOLOGIST.
Coverage Duration	RA: INITIAL: 6 MO, RENEWAL: 12 MONTHS. NHL, PV: 12 MONTHS. CLL: 6 MO. WG, MPA: 3 MONTHS.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, KEVZARA, ENBREL. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.

RITUXIMAB SQ

Products Affected

- RITUXAN HYCELA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THE PATIENT HAS RECEIVED OR WILL RECEIVE AT LEAST ONE FULL DOSE OF A RITUXIMAB PRODUCT BY INTRAVENOUS INFUSION PRIOR TO INITIATION OF RITUXIMAB AND HYALURONIDASE.

ROMOSOZUMAB

Products Affected

- EVENITY 105 MG/1.17 ML SYRINGE
- EVENITY SUBCUTANEOUS SYRINGE 210MG/2.34ML (105MG/1.17MLX2)

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	ONE OF THE FOLLOWING: (1) HIGH RISK FOR FRACTURES DEFINED AS ONE OF THE FOLLOWING: A) HISTORY OF OSTEOPOROTIC (I.E., FRAGILITY, LOW TRAUMA) FRACTURE(S). B) 2 OR MORE RISK FACTORS FOR FRACTURE (E.G., HISTORY OF MULTIPLE RECENT LOW TRAUMA FRACTURES, BMD T-SCORE LESS THAN OR EQUAL TO -2.5, CORTICOSTEROID USE, OR USE OF GNRH ANALOGS SUCH AS NAFARELIN, ETC.). C) NO PRIOR TREATMENT FOR OSTEOPOROSIS AND FRAX SCORE OF AT LEAST 20% FOR ANY MAJOR FRACTURE OR OF AT LEAST 3% FOR HIP FRACTURE. (2) UNABLE TO USE ORAL THERAPY (I.E., UPPER GASTROINTESTINAL PROBLEMS UNABLE TO TOLERATE ORAL MEDICATION, LOWER GASTROINTESTINAL PROBLEMS UNABLE TO ABSORB ORAL MEDICATIONS, TROUBLE REMEMBERING TO TAKE ORAL MEDICATIONS OR COORDINATING AN ORAL BISPHOSPHONATE WITH OTHER ORAL MEDICATIONS OR THEIR DAILY ROUTINE). (3) ADEQUATE TRIAL OF, INTOLERANCE TO, OR A CONTRAINDICATION TO BISPHOSPHONATES.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS

PA Criteria	Criteria Details
Other Criteria	

RUCAPARIB

Products Affected

- RUBRACA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

RUXOLITINIB

Products Affected

- JAKAFI

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	MYELOFIBROSIS RENEWAL: IMPROVEMENT OR MAINTENANCE OF SYMPTOM IMPROVEMENT SUCH AS A 50% OR GREATER REDUCTION IN TOTAL SYMPTOM SCORE ON THE MODIFIED MYELOFIBROSIS SYMPTOM ASSESSMENT FORM (MFSAF) V2.0 OR 50% OR GREATER REDUCTION IN PALPABLE SPLEEN LENGTH, OR REDUCTION OF 35% OR GREATER FROM BASELINE SPLEEN VOLUME AFTER 6 MONTHS OF THERAPY.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	MYELOFIBROSIS INITIAL:6 MONTHS RENEWAL:12 MONTHS. OTHER INDICATIONS:12 MONTHS
Other Criteria	

SAFINAMIDE MESYLATE

Products Affected

- XADAGO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

SARILUMAB

Products Affected

- KEVZARA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: PREVIOUS TRIAL OF OR CONTRAINDICATION TO AT LEAST ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE

SEBELIPASE ALFA

Products Affected

- KANUMA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	BLOOD TEST OR DRIED BLOOD SPOT TEST INDICATING LOW OR ABSENT LYSOSOMAL ACID LIPASE DEFICIENCY (LAL) ENZYME ACTIVITY, OR A GENETIC TEST INDICATING THE PRESENCE OF ALTERED LIPA GENE(S).
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN ENDOCRINOLOGIST, HEPATOLOGIST, GASTROENTEROLOGIST, MEDICAL GENETICIST, LIPIDOLOGIST, OR A METABOLIC SPECIALIST.
Coverage Duration	LAL INITIAL 6 OR 12 MONTHS, SEE OTHER CRITERIA. RENEWAL: 12 MONTHS

PA Criteria	Criteria Details
Other Criteria	INITIAL: DIAGNOSIS OF LYSOSOMAL ACID LIPASE (LAL) DEFICIENCY, AS CONFIRMED BY THE PRESENCE OF CLINICAL FEATURES (E.G., HEPATOMEGALY, ELEVATED SERUM TRANSAMINASES, DYSLIPIDEMIA, SPLENOMEGALY) PLUS ANY OF THE FOLLOWING: A BLOOD TEST INDICATING LOW OR ABSENT LEVELS OF LAL ENZYME ACTIVITY, A DRIED BLOOD SPOT TEST INDICATING LOW OR ABSENT LAL ENZYME ACTIVITY, OR A GENETIC TEST INDICATING THE BI-ALLELIC PRESENCE OF ALTERED LIPA GENE(S). RENEWAL:DIAGNOSIS OF LYSOSOMAL ACID LIPASE (LAL) DEFICIENCY PRESENTING AFTER THE FIRST 6 MONTHS OF LIFE AND NOT CONSIDERED RAPIDLY PROGRESSIVE REQUIRES DOCUMENTED IMPROVEMENT IN ANY ONE OF THE FOLLOWING CLINICAL PARAMETERS ASSOCIATED WITH LYSOSOMAL ACID LIPASE (LAL) DEFICIENCY DURING THE PAST 6 MONTHS: A RELATIVE REDUCTION FROM BASELINE IN ANY ONE OF THE FOLLOWING LIPID LEVELS (LDL-C, NON-HDL-C, OR TRIGLYCERIDES), NORMALIZATION OF ASPARTATE AMINOTRANSFERASE (AST) BASED ON AGE- AND GENDER-SPECIFIC NORMAL RANGES, A DECREASE IN LIVER FAT CONTENT COMPARED TO BASELINE ASSESSED BY ABDOMINAL IMAGING (E.G., MULTI-ECHO GRADIENT ECHO [MEGE] MRI). DIAGNOSIS OF RAPIDLY PROGRESSIVE LYSOSOMAL ACID LIPASE (LAL) DEFICIENCY PRESENTING WITHIN THE FIRST 6 MONTHS OF LIFE: 12 MONTHS. A DIAGNOSIS OF LYSOSOMAL ACID LIPASE (LAL) DEFICIENCY PRESENTING AFTER THE FIRST 6 MONTHS OF LIFE AND NOT CONSIDERED RAPIDLY PROGRESSIVE: INITIAL: 6 MONTHS

SECUKINUMAB

Products Affected

- COSENTYX (2 SYRINGES)
- COSENTYX PEN (2 PENS)

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	PLAQUE PSORIASIS (PSO): MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5 PERCENT BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, OR FACE. RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	PLAQUE PSORIASIS (PSO): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST OR A DERMATOLOGIST. ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS

PA Criteria	Criteria Details
Other Criteria	INITIAL FOR PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION AT LEAST ONE CONVENTIONAL THERAPY SUCH AS PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO AT LEAST ONE DMARD (DISEASE-MODIFYING ANTI-RHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE

SELEXIPAG

Products Affected

- UPTRAVI ORAL TABLET 1,000 MCG, 1,200 MCG, 1,400 MCG, 1,600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG PACK
- UPTRAVI ORAL TABLETS,DOSE

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS
Other Criteria	INITIAL: MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG OR GREATER, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS. RENEWAL: PATIENT SHOWS IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR PATIENT HAS A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/ IMPROVED WHO FUNCTIONAL CLASS.

SELINEXOR

Products Affected

- XPOVIO ORAL TABLET 100 MG/WEEK (20 MG X 5), 160 MG/WEEK (20 MG X 8), 60 MG/WEEK (20 MG X 3), 80 MG/WEEK (20 MG X 4)

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

SILTUXIMAB

Products Affected

- SYLVANT

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

SIPONIMOD

Products Affected

- MAYZENT ORAL TABLET 0.25 MG, 2 MG
- MAYZENT STARTER PACK

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT HAS DEMONSTRATED CLINICAL BENEFIT COMPARED TO PRE TREATMENT BASELINE AND THE PATIENT DOES NOT HAVE LYMPHOPENIA.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

SOFOSBUVIR

Products Affected

- SOVALDI

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE AND ADDITIONAL CONSIDERATION FOR COVERAGE CONSISTENT WITH FDA LABELING.
Exclusion Criteria	PATIENT WITH END STAGE RENAL DISEASE OR REQUIRES DIALYSIS.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL
Coverage Duration	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE

PA Criteria	Criteria Details
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. TRIAL OF A PREFERRED FORMULARY ALTERNATIVE INCLUDING HARVONI OR EPCLUSA WHEN THESE AGENTS ARE CONSIDERED ACCEPTABLE FOR TREATMENT OF THE SPECIFIC GENOTYPE PER AASLD/IDSA GUIDANCE. FOR PATIENTS ON SOVALDI PLUS DAKLINZA REGIMENS THERE WILL BE NO APPROVALS FOR CONCURRENT USE OF ANY OF THESE (CONTRAINDICATED OR NOT RECOMMENDED BY THE MANUFACTURER) MEDICATIONS: AMIODARONE, CARBAMAZEPINE, PHENYTOIN, OR RIFAMPIN. REQUESTS FOR SOVALDI IN COMBINATION WITH DAKLINZA WILL REQUIRE THAT THE PATIENT ALSO MEETS ALL CRITERIA FOR DAKLINZA.

SOFOSBUVIR/VELPATASVIR

Products Affected

- EPCLUSA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE.
Exclusion Criteria	
Required Medical Information	HCV RNA LEVEL.
Age Restrictions	18 YEARS OF AGE AND OLDER.
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH: GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.
Coverage Duration	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. HCV RNA LEVEL WITHIN PAST 6 MONTHS. PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS NOT RECOMMENDED BY THE MANUFACTURER: AMIODARONE, CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, HIV REGIMEN THAT CONTAINS EFAVIRENZ, ROSUVASTATIN AT DOSES ABOVE 10MG, TIPRANAVIR/RITONAVIR OR TOPOTECAN. PATIENT MUST NOT HAVE SEVERE RENAL IMPAIRMENT, ESRD OR ON HEMODIALYSIS. RIBAVIRIN USE REQUIRED FOR PATIENTS WITH DECOMPENSATED CIRRHOSIS.

SOFOSBUVIR/VELPATASVIR/VOXILAPREVIR

Products Affected

- VOSEVI

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE.
Exclusion Criteria	SEVERE RENAL IMPAIRMENT, ESRD OR ON HEMODIALYSIS. MODERATE OR SEVERE HEPATIC IMPAIRMENT (CHILD-PUGH B OR C).
Required Medical Information	HCV RNA LEVEL WITHIN PAST 6 MONTHS
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH: GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.
Coverage Duration	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.

PA Criteria	Criteria Details
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS NOT RECOMMENDED BY THE MANUFACTURER: AMIODARONE, CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, CYCLOSPORINE, PITAVASTATIN, PRAVASTATIN (DOSES ABOVE 40MG), ROSUVASTATIN, METHOTREXATE, MITOXANTRONE, IMATINIB, IRINOTECAN, LAPATINIB, SULFASALAZINE, TOPOTECAN, OR HIV REGIMEN THAT CONTAINS EFAVIRENZ, ATAZANAVIR, LOPINAVIR OR TIPRANAVIR/RITONAVIR.

SOFOSBUVIR/VELPATASVIR-GENERIC

Products Affected

- *sofosbuvir-velpatasvir*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE.
Exclusion Criteria	
Required Medical Information	HCV RNA LEVEL.
Age Restrictions	18 YEARS OF AGE AND OLDER.
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH: GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.
Coverage Duration	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.

PA Criteria	Criteria Details
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. HCV RNA LEVEL WITHIN PAST 6 MONTHS. PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS NOT RECOMMENDED BY THE MANUFACTURER: AMIODARONE, CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, HIV REGIMEN THAT CONTAINS EFAVIRENZ, ROSUVASTATIN AT DOSES ABOVE 10MG, TIPRANAVIR/RITONAVIR OR TOPOTECAN. PATIENT MUST NOT HAVE SEVERE RENAL IMPAIRMENT, ESRD OR ON HEMODIALYSIS. PATIENTS WITH DECOMPENSATED CIRRHOSIS REQUIRE CONCURRENT RIBAVIRIN UNLESS RIBAVIRIN INELIGIBLE. REQUESTS FOR GENERIC SOFOSBUVIR/VELPATASVIR REQUIRE TRIAL OF OR CONTRAINDICATION TO BRAND EPCLUSA.

SOMATROPIN - GROWTH HORMONE

Products Affected

- HUMATROPE
- OMNITROPE
- SAIZEN
- SAIZEN SAIZENPREP
- ZOMACTON

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES. GROWTH FAILURE WITH CLOSED EPIPHYSES FOR PEDIATRIC GROWTH HORMONE DEFICIENCY (GHD), IDIOPATHIC SHORT STATURE (ISS), SMALL FOR GESTATIONAL AGE (SGA), TURNER SYNDROME (TS), AND SHOX DEFICIENCY
Required Medical Information	INITIAL: PEDIATRIC GHD, ISS, SGA, TS, AND SHOX DEFICIENCY: HEIGHT AT LEAST 2 STANDARD DEVIATIONS (SD) BELOW THE MEAN HEIGHT FOR NORMAL CHILDREN OF THE SAME AGE AND GENDER. PRADER WILLI SYNDROME (PWS): PHYSICIAN ATTESTATION OF CONFIRMED GENETIC DIAGNOSIS
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH: ENDOCRINOLOGIST.
Coverage Duration	12 MONTHS

PA Criteria	Criteria Details
Other Criteria	INITIAL: ADULT GHD: GROWTH HORMONE DEFICIENCY ALONE OR ASSOCIATED WITH MULTIPLE HORMONE DEFICIENCIES (HYPOPITUITARISM), AS A RESULT OF PITUITARY DISEASES, HYPOTHALAMIC DISEASE, SURGERY, RADIATION THERAPY, TRAUMA, OR CONTINUATION OF THERAPY FROM CHILDHOOD ONSET GROWTH HORMONE DEFICIENCY. FOR ALL DIAGNOSES EXCEPT SHOX DEFICIENCY: PREVIOUS TRIAL OF PREFERRED FORMULARY ALTERNATIVES NORDITROPIN AND GENOTROPIN. RENEWAL FOR PEDIATRIC GHD, ISS, SGA, TS, AND SHOX DEFICIENCY: PHYSICIAN ATTESTATION OF IMPROVEMENT (I.E, INCREASED HEIGHT OR INCREASED GROWTH VELOCITY). PWS: PHYSICIAN ATTESTATION OF IMPROVEMENT IN BODY COMPOSITION. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.

SOMATROPIN - SEROSTIM

Products Affected

- SEROSTIM SUBCUTANEOUS
  RECON SOLN 4 MG, 5 MG, 6 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES
Required Medical Information	INITIAL: HIV/WASTING: MEETS ONE OF THE FOLLOWING CRITERIA FOR WEIGHT LOSS: 10% UNINTENTIONAL WEIGHT LOSS OVER 12 MONTHS, OR 7.5% OVER 6 MONTHS, OR 5% BODY CELL MASS (BCM) LOSS WITHIN 6 MONTHS, OR A BCM LESS THAN 35% (MEN) OF TOTAL BODY WEIGHT AND A BODY MASS INDEX (BMI) LESS THAN 27 KG PER METER SQUARED, OR BCM LESS THAN 23% (WOMEN) OF TOTAL BODY WEIGHT AND A BODY MASS INDEX (BMI) LESS THAN 27 KG PER METER SQUARED, OR BMI LESS THAN 18.5 KG PER METER SQUARED.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST, NUTRITIONAL SUPPORT SPECIALIST, OR INFECTIOUS DISEASE SPECIALIST
Coverage Duration	3 MONTHS
Other Criteria	INITIAL: HIV/WASTING: PATIENT HAS HAD INADEQUATE RESPONSE TO PREVIOUS THERAPY. RENEWAL: HIV/WASTING: PATIENT HAS SHOWN CLINICAL BENEFIT IN MUSCLE MASS AND WEIGHT. INITIAL AND RENEWAL: HIV/WASTING: CURRENTLY ON HIV ANTIRETROVIRAL THERAPY. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.

SOMATROPIN - ZORBTIVE

Products Affected

- ZORBTIVE

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST
Coverage Duration	SHORT BOWEL: 4 WEEKS ONCE.
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.

SOMATROPIN-NORDITROPIN AND GENOTROPIN

Products Affected

- GENOTROPIN
- GENOTROPIN MINIQUICK
- NORDITROPIN FLEXPRO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES. GROWTH FAILURE WITH CLOSED EPIPHYSES FOR PEDIATRIC GROWTH HORMONE DEFICIENCY (GHD), IDIOPATHIC SHORT STATURE (ISS), SMALL FOR GESTATIONAL AGE (SGA), TURNER SYNDROME (TS), AND NOONAN SYNDROME.
Required Medical Information	INITIAL: PEDIATRIC GHD, ISS, SGA, TS, AND NOONAN SYNDROME: HEIGHT AT LEAST 2 STANDARD DEVIATIONS (SD) BELOW THE MEAN HEIGHT FOR NORMAL CHILDREN OF THE SAME AGE AND GENDER. PRADER WILLI SYNDROME (PWS): PHYSICIAN ATTESTATION OF CONFIRMED GENETIC DIAGNOSIS
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH: ENDOCRINOLOGIST.
Coverage Duration	12 MONTHS

PA Criteria	Criteria Details
Other Criteria	INITIAL: ADULT GHD: GROWTH HORMONE DEFICIENCY ALONE OR ASSOCIATED WITH MULTIPLE HORMONE DEFICIENCIES (HYPOPITUITARISM), AS A RESULT OF PITUITARY DISEASES, HYPOTHALAMIC DISEASE, SURGERY, RADIATION THERAPY, TRAUMA, OR CONTINUATION OF THERAPY FROM CHILDHOOD ONSET GROWTH HORMONE DEFICIENCY. RENEWAL: PEDIATRIC GHD, ISS, SGA, TS, AND NOONAN SYNDROME: PHYSICIAN ATTESTATION OF IMPROVEMENT (I.E., INCREASED HEIGHT OR INCREASED GROWTH VELOCITY). PWS: PHYSICIAN ATTESTATION OF IMPROVEMENT IN BODY COMPOSITION. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.

SOMATROPIN-NUTROPIN AND NUTROPIN AQ

Products Affected

- NUTROPIN AQ NUSPIN

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES. GROWTH FAILURE DUE TO CKD IF PATIENT HAS HAD A RENAL TRANSPLANT, OR GROWTH FAILURE WITH CLOSED EPIPHYSES FOR PEDIATRIC GROWTH HORMONE DEFICIENCY (GHD), IDIOPATHIC SHORT STATURE (ISS), AND TURNER SYNDROME (TS)
Required Medical Information	INITIAL FOR PEDIATRIC GHD, ISS, AND TS: HEIGHT AT LEAST 2 STANDARD DEVIATIONS (SD) BELOW THE MEAN HEIGHT FOR NORMAL CHILDREN OF THE SAME AGE AND GENDER. INITIAL FOR CKD: HEIGHT OR GROWTH VELOCITY AT LEAST 2 STANDARD DEVIATIONS (SD) BELOW THE MEAN HEIGHT FOR NORMAL CHILDREN OF THE SAME AGE AND GENDER.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH: ENDOCRINOLOGIST. FOR GROWTH HORMONE FAILURE DUE TO CKD: NEPHROLOGIST.
Coverage Duration	12 MONTHS

PA Criteria	Criteria Details
Other Criteria	INITIAL: ADULT GHD: GROWTH HORMONE DEFICIENCY ALONE OR ASSOCIATED WITH MULTIPLE HORMONE DEFICIENCIES (HYPOPITUITARISM), AS A RESULT OF PITUITARY DISEASES, HYPOTHALAMIC DISEASE, SURGERY, RADIATION THERAPY, TRAUMA, OR CONTINUATION OF THERAPY FROM CHILDHOOD ONSET GROWTH HORMONE DEFICIENCY. FOR ALL DIAGNOSES EXCEPT CKD: PREVIOUS TRIAL OF PREFERRED FORMULARY ALTERNATIVES NORDITROPIN AND GENOTROPIN. RENEWAL FOR ALL INDICATIONS EXCEPT ADULT GHD: PHYSICIAN ATTESTATION OF IMPROVEMENT (I.E, INCREASED HEIGHT OR INCREASED GROWTH VELOCITY). THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.

SONIDEGIB

Products Affected

- ODOMZO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	BASELINE SERUM CREATINE KINASE (CK) AND SERUM CREATININE LEVELS
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

SORAFENIB TOSYLATE

Products Affected

- NEXAVAR

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

SUNITINIB MALATE

Products Affected

- SUTENT

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	GASTROINTESTINAL STROMAL TUMORS (GIST): TRIAL OF OR CONTRAINDICATION TO GLEEVEC.

TAFAMIDIS

Products Affected

- VYNDAQEL

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT HAS NOT PROGRESSED TO NYHA CLASS IV HEART FAILURE.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A CARDIOLOGIST, ATTR SPECIALIST, OR MEDICAL GENETICIST.
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS
Other Criteria	INITIAL: PATIENT HAS NEW YORK HEART ASSOCIATION (NYHA) CLASS I, II, OR III HEART FAILURE. DIAGNOSIS CONFIRMED BY ONE OF THE FOLLOWING: 1) BONE SCAN (SCINTIGRAPHY) STRONGLY POSITIVE FOR MYOCARDIAL UPTAKE OF 99MTCPYP/DPD, OR 2) BIOPSY OF TISSUE OF AFFECTED ORGAN(S) (CARDIAC AND POSSIBLY NON-CARDIAC SITES) TO CONFIRM AMYLOID PRESENCE AND CHEMICAL TYPING TO CONFIRM PRESENCE OF TRANSTHYRETIN (TTR) PROTEIN.

TALAZOPARIB

Products Affected

- TALZENNA ORAL CAPSULE 0.25 MG, 1 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

TALIMOGENE

Products Affected

- IMLYGIC INJECTION SUSPENSION 10EXP6 (1 MILLION) PFU/ML, 10EXP8 (100 MILLION) PFU/ML

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	HISTORY OF PRIMARY OR ACQUIRED IMMUNODEFICIENT STATES, LEUKEMIA, LYMPHOMA, OR AIDS. PATIENT IS NOT CURRENTLY RECEIVING IMMUNOSUPPRESSIVE THERAPY.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	IMLYGIC TO BE INJECTED INTO CUTANEOUS, SUBCUTANEOUS, AND OR NODAL LESIONS THAT ARE VISIBLE, PALPABLE, OR DETECTABLE BY ULTRASOUND GUIDANCE. NO CONCURRENT USE WITH PEMBROLIZUMAB, NIVOLUMAB, IPILIMUMAB, DABRAFENIB, TRAMETINIB, VEMURAFENIB, INTERLEUKIN-2, INTERFERON, DACARBAZINE, TEMOZOLOMIDE, PACLITAXEL, CARBOPLATIN, IMATINIB, MELPHALAN, IMIQUIMOD, OR RADIATION THERAPY.

TASIMELTEON

Products Affected

- HETLIOZ

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

TEDUGLUTIDE

Products Affected

- GATTEX 30-VIAL

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PATIENT IS DEPENDENT ON INTRAVENOUS PARENTERAL NUTRITION DEFINED AS REQUIRING PARENTERAL NUTRITION AT LEAST THREE TIMES PER WEEK.

TELOTRISTAT

Products Affected

- XERMELO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

TEMOZOLOMIDE

Products Affected

- TEMODAR INTRAVENOUS

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

TERIFLUNOMIDE

Products Affected

- AUBAGIO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

TERIPARATIDE

Products Affected

- FORTEO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	ONE OF THE FOLLOWING: (1) HIGH RISK FOR FRACTURES DEFINED AS ONE OF THE FOLLOWING: A) HISTORY OF OSTEOPOROTIC (I.E., FRAGILITY, LOW TRAUMA) FRACTURE(S). B) 2 OR MORE RISK FACTORS FOR FRACTURE (E.G., HISTORY OF MULTIPLE RECENT LOW TRAUMA FRACTURES, BMD T-SCORE LESS THAN OR EQUAL TO -2.5, CORTICOSTEROID USE, OR USE OF GNRH ANALOGS SUCH AS NAFARELIN, ETC.). C) NO PRIOR TREATMENT FOR OSTEOPOROSIS AND FRAX SCORE OF AT LEAST 20% FOR ANY MAJOR FRACTURE OR OF AT LEAST 3% FOR HIP FRACTURE. (2) UNABLE TO USE ORAL THERAPY (I.E., UPPER GASTROINTESTINAL PROBLEMS UNABLE TO TOLERATE ORAL MEDICATION, LOWER GASTROINTESTINAL PROBLEMS UNABLE TO ABSORB ORAL MEDICATIONS, TROUBLE REMEMBERING TO TAKE ORAL MEDICATIONS OR COORDINATING AN ORAL BISPHOSPHONATE WITH OTHER ORAL MEDICATIONS OR THEIR DAILY ROUTINE). (3) ADEQUATE TRIAL OF, INTOLERANCE TO, OR A CONTRAINDICATION TO BISPHOSPHONATES (E.G., ALENDRONATE, RISEDRONATE, IBANDRONATE).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS

PA Criteria	Criteria Details
Other Criteria	

TESTOSTERONE

Products Affected

- *testosterone cypionate*
- *testosterone enanthate*
- *testosterone transdermal gel in metered-dose pump 20.25 mg/1.25 gram (1.62 %)*
- *testosterone transdermal gel in packet 1 % (25 mg/2.5gram), 1 % (50 mg/5 gram), 1.62 % (20.25 mg/1.25 gram), 1.62 % (40.5 mg/2.5 gram)*
- XYOSTED

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D. ADDITIONAL CONSIDERATION FOR GENDER DYSPHORIA.
Exclusion Criteria	
Required Medical Information	MALE HYPOGONADISM CONFIRMED BY EITHER: 1) LAB CONFIRMED TOTAL SERUM TESTOSTERONE LEVEL OF LESS THAN 300 NG/DL OR 2) A LOW TOTAL SERUM TESTOSTERONE LEVEL AS INDICATED BY A LAB RESULT WITH A REFERENCE RANGE OBTAINED WITHIN 90 DAYS, OR 3) A FREE SERUM TESTOSTERONE LEVEL OF LESS THAN 5 PG/ML.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	LIFETIME OF MEMBERSHIP IN PLAN
Other Criteria	

TETRABENAZINE

Products Affected

- *tetrabenazine*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	NEUROLOGIST OR MOVEMENT DISORDER SPECIALIST
Coverage Duration	12 MONTHS
Other Criteria	

TEZACAFTOR/IVACAFTOR

Products Affected

- SYMDEKO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CYSTIC FIBROSIS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PULMONOLOGIST OR CYSTIC FIBROSIS EXPERT
Coverage Duration	INITIAL: 6 MONTHS RENEWAL: 12 MONTHS
Other Criteria	RENEWAL: MAINTAINED OR IMPROVEMENT IN FEV1 OR BODY MASS INDEX (BMI), OR REDUCTION IN NUMBER OF PULMONARY EXACERBATIONS.

THALIDOMIDE

Products Affected

- THALOMID

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

TILDRAKIZUMAB

Products Affected

- ILUMYA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING AT LEAST 5% OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, OR FACE. RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, COSENTYX, STELARA, ENBREL, SKYRIZI.

TOCILIZUMAB IV

Products Affected

- ACTEMRA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	RENEWAL FOR RA, PJIA, OR SJIA: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	MODERATE TO SEVERE RHEUMATOID ARTHRITIS (RA)/POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA)/SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST
Coverage Duration	INITIAL: RA, PJIA, OR SJIA: 6 MONTHS. CRS: 1 MONTH. RENEWAL: 12 MONTHS FOR RA, PJIA, OR SJIA
Other Criteria	INITIAL: RA: PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, KEVZARA, ENBREL. PJIA: PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA

TOCILIZUMAB SQ

Products Affected

- ACTEMRA
- ACTEMRA ACTPEN

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	RA, PJIA AND SJIA RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA) AND SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	RA INITIAL: PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, KEVZARA, ENBREL. PJIA INITIAL: PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA.

TOFACITINIB

Products Affected

- XELJANZ
- XELJANZ XR

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	RENEWAL FOR RHEUMATOID ARTHRITIS (RA) AND PSORIATIC ARTHRITIS (PSA): PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST. ULCERATIVE COLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, KEVZARA, ENBREL. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, STELARA, COSENTYX, ENBREL. ULCERATIVE COLITIS (UC): PREVIOUS TRIAL OF OR CONTRAINDICATION TO HUMIRA.

TOLVAPTAN

Products Affected

- JYNARQUE ORAL TABLET
- JYNARQUE ORAL TABLETS, SEQUENTIAL

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION THAT PATIENT HAS NOT PROGRESSED TO ESRD/DIALYSIS OR TRANSPLANT.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A NEPHROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: THE PATIENT MEETS ALL OF THE FOLLOWING: (1) CONFIRMED POLYCYSTIC KIDNEY DISEASE VIA CT, MRI IMAGING, OR ULTRASOUND (2) GENETIC TESTING FOR CAUSATIVE MUTATIONS OR FAMILY HISTORY OF CONFIRMED POLYCYSTIC KIDNEY DISEASE IN ONE OR BOTH PARENTS, AND (3) PATIENT DOES NOT HAVE ESRD (I.E., RECEIVING DIALYSIS OR HAS UNDERGONE RENAL TRANSPLANT).

TOPICAL TRETINOIN

Products Affected

- *tretinoin*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	WRINKLES, PHOTOAGING, MELASMA.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

TOPICAL TRETINOIN LOTION

Products Affected

- ALTRENO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	WRINKLES, PHOTOAGING, MELASMA.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANOTHER FORMULARY VERSION OF TOPICAL TRETINOIN

TRABECTEDIN

Products Affected

- YONDELIS

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

TRAMETINIB DIMETHYL SULFOXIDE

Products Affected

- MEKINIST ORAL TABLET 0.5 MG, 2 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

TRASTUZUMAB

Products Affected

- HERCEPTIN

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	BREAST CANCER, METASTATIC BREAST CANCER, GASTRIC CANCER: HER2 POSITIVE
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	B VS D COVERAGE CONSIDERATION.

TRASTUZUMAB HYALURONIDASE

Products Affected

- HERCEPTIN HYLECTA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

TRASTUZUMAB-ANNS

Products Affected

- KANJINTI

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.

TREPROSTINIL DIOLAMINE

Products Affected

- ORENITRAM

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	PATIENT DOES NOT HAVE SEVERE HEPATIC IMPAIRMENT.
Required Medical Information	DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS

PA Criteria	Criteria Details
Other Criteria	INITIAL: MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG OR GREATER, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS. PREVIOUS OR CURRENT TREATMENT WITH ONE OF THE FOLLOWING AGENTS: A FORMULARY PHOSPHODIESTERASE-5 INHIBITOR (E.G., SILDENAFIL [GENERIC FOR REVATIO] OR ADCIRCA [TADALAFIL]) OR AN ENDOTHELIN RECEPTOR ANTAGONIST (E.G., TRACLEER [BOSENTAN], LETAIRIS [AMBRISENTAN], OR OPSUMIT [MACITENTAN]). TRIAL OF A FORMULARY PHOSPHODIESTERASE-5 INHIBITOR OR ENDOTHELIN RECEPTOR ANTAGONIST IS NOT REQUIRED IF THE PATIENT WAS PREVIOUSLY STABLE ON ORENITRAM. RENEWAL: PATIENT SHOWS IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR PATIENT HAS A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/ IMPROVED WHO FUNCTIONAL CLASS.

TREPROSTINIL INHALED

Products Affected

- TYVASO

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS III-IV SYMPTOMS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS

PA Criteria	Criteria Details
Other Criteria	THIS DRUG MAYBE 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. NEBULIZER THERAPY IS COVERED UNDER PART B FOR PATIENTS WHO ARE USING THE MEDICATION VIA A NEBULIZER IN THEIR OWN HOME. THOSE WHO ARE NOT USING IT IN THEIR HOME WILL BE COVERED UNDER PART D. INITIAL: MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG OR GREATER, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS. RENEWAL: PATIENT SHOW IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR PATIENT HAS A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/ IMPROVED WHO FUNCTIONAL CLASS.

TREPROSTINIL SODIUM INJECTABLE

Products Affected

- *treprostinil sodium*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	COVERED UNDER LOCAL COVERAGE POLICY OF APPLICABLE MEDICARE DMERC.
Required Medical Information	FORMULARY DRUG ADMINISTERED IN A LONG TERM CARE FACILITY TO A PATIENT WHOSE PART A COVERAGE HAS EXPIRED OR FORMULARY DRUG NOT ADMINISTERED VIA AN IMPLANTABLE PUMP OR AN EXTERNAL PUMP OR DRUG ADMINISTERED VIA AN IMPLANTABLE PUMP/AN EXTERNAL PUMP. DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS

PA Criteria	Criteria Details
Other Criteria	INITIAL: MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG OR GREATER, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS. CONTINUATION OF CURRENT REMODULIN THERAPY: PATIENT MUST HAVE NYHA/WHO FC II-IV SYMPTOMS. NEW REQUESTS FOR REMODULIN THERAPY: PATIENT MUST HAVE NYHA/WHO FC III-IV SYMPTOMS. NEW REQUESTS FOR REMODULIN THERAPY FOR PATIENTS WITH NYHA/WHO FC II SYMPTOMS REQUIRES A TRIAL OF OR CONTRAINDICATION TO A PHOSPHODIESTERASE-5 INHIBITOR (PDE-5) (E.G., REVATIO (SILDENAFIL), ADCIRCA (TADALAFIL)) OR AN ENDOTHELIN RECEPTOR ANTAGONIST (ERA) (E.G., LETAIRIS, OPSUMIT, TRACLEER). RENEWAL: PATIENT SHOW IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR PATIENT HAS A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/ IMPROVED WHO FUNCTIONAL CLASS.

TRIENTINE

Products Affected

- *trientine*

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	KNOWN FAMILY HISTORY OF WILSON'S DISEASE OR PHYSICAL EXAMINATION CONSISTENT WITH WILSON'S DISEASE. PLASMA COPPER-PROTEIN CERULOPLASMIN LESS THAN 20 MG/DL. LIVER BIOPSY POSITIVE FOR AN ABNORMALLY HIGH CONCENTRATION OF COPPER (GREATER THAN 250 MCG/G DRY WEIGHT) OR THE PRESENCE OF KAYSER-FLEISCHER RINGS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEPATOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	PREVIOUS TRIAL OF OR CONTRAINDICATION TO PENICILLAMINE (DEPEN).

TRIFLURIDINE/TIPIRACIL

Products Affected

- LONSURF ORAL TABLET 15-6.14 MG, 20-8.19 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

URIDINE TRIACETATE

Products Affected

- XURIDEN

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	INITIAL: DIAGNOSIS CONFIRMED BY 1) GENETIC MUTATION OF URIDINE MONOPHOSPHATE SYNTHASE (UMPS) GENE AND 2) ELEVATED URINE OROTIC ACID PER AGE-SPECIFIC REFERENCE RANGE. RENEWAL: IMPROVEMENT FROM BASELINE OR STABILIZATION OF AGE DEPENDENT HEMATOLOGIC PARAMETERS (E.G., NEUTROPHIL COUNT, NEUTROPHIL PERCENT, WBC COUNT, MEAN CORPUSCULAR VOLUME)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	

USTEKINUMAB

Products Affected

- STELARA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA OR FACE. RENEWAL FOR PSORIATIC ARTHRITIS OR PLAQUE PSORIASIS: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PLAQUE PSORIASIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST. CROHN'S DISEASE: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: PSA, PSO, CD: 6 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	INITIAL: PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO AT LEAST ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION AT LEAST ONE CONVENTIONAL THERAPY SUCH AS PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE. CROHN'S DISEASE (CD): PREVIOUS TRIAL OF OR CONTRAINDICATION TO AT LEAST ONE CONVENTIONAL THERAPY SUCH AS CORTICOSTEROIDS (I.E. BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE.

USTEKINUMAB IV

Products Affected

- STELARA

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	2 MONTHS
Other Criteria	PREVIOUS TRIAL OF OR CONTRAINDICATION TO AT LEAST ONE CONVENTIONAL THERAPY SUCH AS CORTICOSTEROIDS (I.E. BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.

VALBENAZINE TOSYLATE

Products Affected

- INGREZZA
- INGREZZA INITIATION PACK

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	PATIENT HAS A PRIOR HISTORY OF USING ANTIPSYCHOTIC MEDICATIONS OR METOCLOPRAMIDE PER PHYSICIAN ATTESTATION.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST, PSYCHIATRIST, OR MOVEMENT DISORDER SPECIALIST.
Coverage Duration	12 MONTHS
Other Criteria	

VANDETANIB

Products Affected

- CAPRELSA ORAL TABLET 100 MG, 300 MG

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

VEMURAFENIB

Products Affected

- ZELBORAF

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

VENETOCLAX

Products Affected

- VENCLEXTA ORAL TABLET 10 MG, 100 MG, 50 MG
- VENCLEXTA STARTING PACK

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

VESTRONIDASE ALFA VJBK

Products Affected

- MEPSEVII

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT HAS IMPROVED, MAINTAINED, OR DEMONSTRATED A LESS THAN EXPECTED DECLINE IN AMBULATORY ABILITY FROM BASELINE.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN GENETIC OR METABOLIC DISORDERS.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS

PA Criteria	Criteria Details
Other Criteria	INITIAL: THE PATIENT MEETS ALL OF THE FOLLOWING CRITERIA: 1) THE PATIENT HAS NOT UNDERGONE SUCCESSFUL BONE MARROW OR STEM CELL TREATMENT FOR MPS VII, 2) THE PATIENT HAS LIMITATION IN MOBILITY, BUT REMAINS SUFFICIENTLY AMBUATLORY, AND 3) DIAGNOSIS OF MPS VII CONFIRMED BY ALL OF THE FOLLOWING CRITERIA: A) PHYSICIAN ATTESTATION OF URINARY GAG (GLYCOSAMINOGLYCAN) LEVEL OF GREATER THAN THREE TIMES THE UPPER LEVEL OF NORMAL BASED ON THE LABORATORY ASSAY, B) PHYSICIAN ATTESTATION OF BETA-GLUCURONIDASE ENZYME ACTIVITY DEFICIENCY OR GENETIC TESTING, AND C) PHYSICIAN ATTESTATION THAT THE PATIENT HAS AT LEAST ONE OF THE FOLLOWING CLINICAL SIGNS OF MPS VII: ENLARGED LIVER AND SPLEEN, JOINT LIMITATIONS, AIRWAY OBSTRUCTIONS OR PULMONARY DYSFUNCTION. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.

VISMODEGIB

Products Affected

- ERIVEDGE

PA Criteria	Criteria Details
Covered Uses	ALL FDA APPROVED INDICATIONS NOT OTHERWISE EXCLUDED FROM PART D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

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