ABSTRAL

Products Affected

- ABSTRAL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Individual is 18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	Individual has a diagnosis of cancer with breakthrough cancer pain AND has tried and failed fentanyl citrate lozenge (generic Actiq) AND Individual is already receiving opioid therapy and is TOLERANT to opioid therapy as defined as receiving around the clock medicine consisting of one of the following: At least 60mg morphine per day, OR At least 25mcg/hr transdermal fentanyl/hour, OR At least 30mg of oxycodone daily, OR At least 8mg of oral hydromorphone daily, OR At least 25mg of oral oxymorphone daily, OR An equianalgesic dose of another opioid for a week or longer. Individual will also continue around the clock opioids when taking Abstral (fentanyl).

ACTEMRA

Products Affected

- ACTEMRA INTRAVENOUS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Tuberculosis, or invasive fungal infections or other active serious infections, or history if recurrent infections. Individuals who have not had a tuberculin skin test or Center for Disease Control recommended equivalent to evaluate for latent tuberculosis prior to initiating Actemra (tocilizumab). Using Actemra in combination with other TNF antagonists, IL-1R antagonists, janus kinase inhibitor, anti-cd20 monoclonal antibodies or selective co-stimulation modulators. At initiation of therapy, absolute neutrophil count (ANC) below 2000/mm3, platelet count below 100,000/mm3, or ALT or AST above 1.5 times the upper limit of normal.
Required Medical Information	N/A
Age Restrictions	Member is 18 years of age or older, except for the diagnosis of JIA, PJIA. For JIA, PJIA patient is 2 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	End of plan year

PA Criteria	Criteria Details
Other Criteria	For rheumatoid arthritis (RA), agent is being used to reduce signs/symptoms or induce/maintain clinical response or inhibit progression of structural damage or to improve physical function. Member has had an inadequate response to ONE non-biological or biologic disease modifying anti-rheumatic drug (DMARD) such as methotrexate (MTX) or a tumor necrosis factor (TNF) antagonist drug AND individual has had a trial of BOTH: Humira AND Enbrel in the previous 180 days. For Systemic Juvenile Idiopathic Arthritis (SJIA), agent is being used to reduce signs/symptoms or induce/maintain clinical response. Member has failed to respond to, is tolerant of, or has a medical contraindication to ONE corticosteroid or nonsteroidal anti-inflammatory drug (NSAID). For Polyarticular Juvenile Idiopathic Arthritis (PJIA), agent is being used to reduce signs/symptoms or induce/maintain clinical response. Member has failed to respond to, is intolerant of, or has a medical contraindication to ONE non-biologic DMARD (such as methotrexate) AND individual has had a trial of BOTH: Humira AND Enbrel in the previous 180 days. For Multicentric Castleman Disease (MCD), agent is being used as a single agent for tx of relapsed/refractory or progressive MCD. Individual is HIV (human immunodeficiency virus) and HHV-8 (human herpes-8) negative. And individual has no concurrent clinically significant infection (for example, Hepatitis B or Hepatitis C) and has no concurrent lymphoma

ACTIMMUNE

Products Affected

- ACTIMMUNE

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

ADEMPAS

Products Affected

- ADEMPAS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Use in combination with nitrates (such as but not limited to, nitroglycerin) or nitric oxide donors (such as but not limited to, amyl nitrite) in any form OR Use in combination with phosphodiesterase (PDE) inhibitors [such as, PDE-5 inhibitors (sildenafil, tadalafil, vardenafil) or nonspecific PDE inhibitors (dipyridamole, theophylline)].
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	Individual has catheterization-proven diagnosis of pulmonary arterial hypertension (PAH), WHO Group 1 AND has WHO functional class II-IV symptoms. Or individual has catheterization-proven diagnosis of chronic thromboembolic pulmonary hypertension (CTEPH), WHO Group 4 AND Individual has WHO functional class II-IV symptoms AND using for one of the following: Persistent or recurrent pulmonary hypertension after at least 180 days following surgical treatment with pulmonary endarterectomey OR Inoperable (via pulmonary endarterectomey) CTEPH.

AFINITOR

Products Affected

- AFINITOR
- AFINITOR DISPERZ

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

ALDURAZYME

Products Affected

- ALDURAZYME

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

ALPHA1-PROTEINASE INHIBITOR

Products Affected

- ARALAST NP INTRAVENOUS RECON SOLN 500 MG
- ZEMAIRA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Alpha 1 proteinase inhibitors may not be approved for individuals with IgA antibodies.
Required Medical Information	Documented alpha-1 antitrypsin level is less than or equal to 11micro-mol/L. Individual has clinically evident emphysema and one of the following: Moderate airflow obstruction is evidenced by forced expiratory volume (FEV1) of 30-65 percent of predicted value, prior to initiation of therapy OR a rapid decline in lung function as measured by a change in FEV1 greater than 120 ml/year.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	N/A

ALUNBRIG

Products Affected

- ALUNBRIG

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

AMPYRA

Products Affected

- AMPYRA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Member has a history of seizures, OR moderate or severe renal impairment (defined as creatinine clearance less than or equal to 50 mL/min)
Required Medical Information	For initial approval, member has been objectively assessed for functional impairment related to ambulation AND documentation has been provided. For renewal, member achieved and sustained clinically significant improvement in ambulation related functional status AND documentation has been provided. Documentation may include chart notes, consultation notes.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial approval 12 weeks, renewal End of plan year
Other Criteria	N/A

ANADROL 50

Products Affected

- ANADROL-50

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Anadrol 50 may not be used to not replace other supportive measures for anemia such as transfusion, correction of iron, folic acid, B12 or pyridoxine deficiency, antibacterial therapy, or the appropriate use of corticosteroids. Using to enhance athletic ability. Individual has a diagnosis of Carcinoma of the prostate or breast in male individuals or Carcinoma of the breast in females with Hypercalcemia. Individual has a diagnosis of nephrosis (nephrotic phase of nephritis). Individual has a diagnosis of severe hepatic dysfunction.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	Individual has a diagnosis of a deficient red cell production-associated anemia, such as but not limited to: acquired aplastic anemia, congenital aplastic anemia, myelofibrosis, or myelotoxic drug-associated hypoplastic anemia.

APOKYN

Products Affected

- APOKYN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Erectile Dysfunction (ED) use
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	N/A

ARANESP

Products Affected

- ARANESP (IN POLYSORBATE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 25 MCG/ML, 300 MCG/ML, 40 MCG/ML, 60 MCG/ML
- ARANESP (IN POLYSORBATE) INJECTION SYRINGE 10 MCG/0.4 ML, 100 MCG/0.5 ML, 150 MCG/0.3 ML, 200 MCG/0.4 ML, 25 MCG/0.42 ML, 300 MCG/0.6 ML, 40 MCG/0.4 ML, 500 MCG/ML, 60 MCG/0.3 ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Anemia in patients due to other factors such as iron deficiency, folate deficiency or B12 deficiency, hemolysis, gastrointestinal bleeding, other active or occult bleeding, or underlying hematologic diseases (such as sickle cell anemia, thalassemia, and porphyria). Sudden loss of response with severe anemia and low reticulocyte count. Treatment of in any indication not listed in criteria including anemia of prematurity. Anemia in cancer patients receiving myelosuppressive chemotherapy when the anticipated outcome is cure. Anemia in cancer patients receiving hormonal agents, therapeutic biologic products, or radiotherapy unless receiving concomitant myelosuppressive chemotherapy. Continued use when the hemoglobin level exceeds 11.0 g/dL unless otherwise specified in the criteria. Use beyond 12 weeks in the absence of response in individuals with chronic renal failure. Use beyond 8 weeks in the absence of response in individuals with myelodysplastic syndrome (MDS). Use beyond 8-9 weeks in the absence of response or if transfusions are still required in individuals with metastatic, non-myeloid cancer being treated with myelosuppressive chemotherapy agents known to produce anemia. Continued use beyond 6 weeks after therapy with myelosuppressive chemotherapy known to produce anemia is completed. Pre-operative use for individuals who are willing to donate autologous blood. Pre-operative use for patients who are willing to donate autologous blood.

PA Criteria	Criteria Details
Required Medical Information	Hemoglobin (Hgb) levels are less than 10 g/dL, prior to initiation of therapy (unless otherwise specified) AND the individual iron status reveals, transferrin saturation at least 20% or ferritin at least 80 ng/mL or bone marrow demonstrates adequate iron stores AND For individuals with hypertension, blood pressure is adequately controlled before initiation of therapy and closely monitored and controlled during therapy. For MDS, endogenous erythropoietin level is less than 500 mU/ml. For tx of anemia due to chemotherapy known to produce anemia, chemo is planned for a minimum of 2 months and the dx is non-myeloid cancer and the anticipated outcome is not cure. For anemia associated with CKD ON dialysis use is to achieve and maintain hgb levels within the range of 10.0 to 11.0 g/dL. For anemia associated with CKD NOT ON dialysis use is to achieve and maintain hgb levels of 10.0g/dL.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	8wk.
Other Criteria	N/A

ARCALYST

Products Affected

- ARCALYST

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Use in combination with other IL-1 inhibitors or tumor necrosis factor (TNF) inhibitors. Individual is receiving live vaccines. Exhibiting evidence of active or chronic infection(s), including tuberculosis, or a history of recurrent infections. Individual has not had a tuberculin skin test (TST) or Centers for Disease Control (CDC)-recommended equivalent to evaluate for latent tuberculosis prior to initiating treatment with rilonacept.
Required Medical Information	N/A
Age Restrictions	Individual is 12 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	N/A

ARISTADA ER

Products Affected

- ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 441 MG/1.6 ML, 662 MG/2.4 ML, 882 MG/3.2 ML, 1064MG/3.9 ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	18 years old
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	Individual has established tolerability with oral aripiprazole.

AVASTIN

Products Affected

- AVASTIN

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

PA Criteria	Criteria Details
Other Criteria	Avastin may be approved for Diabetic macular edema, Established neovascular wet AMD, Macular edema from branch retinal vein occlusion, Macular edema from central retinal vein occlusion, Neovascular glaucoma, Pseudoxanthoma elasticum, Retinopathy of prematurity, or Other rare causes of choroidal neovascularization for one or more of the following conditions: angioid streaks or choroiditis (including, but not limited to histoplasmosis induced choroiditis) or degenerative myopia, idiopathic or retinal dystrophies or trauma. For metastatic Colon, Rectal, or small bowel adenocarcinoma, Avastin is used in combination with 5FU based chemotherapy for first -line treatment. Or as second-line tx in combination with 5FU based chemo, irinotecan or oxaliplatin. For NSCLC, Avastin is being used in combination with both platinum based therapies with a taxane for the first-line treatment of patients with unresectable, locally advanced, recurrent or metastatic nonsquamous NSCLC. Maintenance therapy for NSCLC is approved when Avastin was prev used as a first-line combination regimen AND used as a single agent AND can be used until disease progression. For Metastatic Breast Carcinoma, HER2-negative disease, Avastin is being used as first-line therapy in combination with paclitaxel or paclitaxel protein bound. For Metastatic Clear Cell Renal Carcinoma, Avastin is being used as first-line therapy in combination with interferon or as a single agent for relapsed or medically unresectable stage IV disease with predominant clear cell histology in individuals who have progressed on prior cytokine therapy. For primary central nervous system tumors who have failed radiation therapy, bevacizumab will be used in a single line of therapy AND tumor to be treated is a WHO Grade III/IV glioma (includes but is not limited to): Anaplastic astrocytoma, Progressive or recurrent ependymoma that has failed radiation therapy, Anaplastic glioma, High-grade glioma, Recurrent, Glioblastoma, OR Glioblastoma multiforme. For recurrent, metastatic epithelial ovarian cancer, fallopian tube cancer, or recurrent primary peritoneal cancer, bevacizumab will be used in a single line of therapy AND used for relapsed or refractory disease and used as a single agent or in combination with other chemotherapy.

BANZEL

Products Affected

- BANZEL ORAL TABLET 200 MG, 400 MG

BANZEL ORAL SUSPENSION

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	1 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	N/A

BARACLUDE

Products Affected

- *entecavir*

- BARACLUDE ORAL SOLUTION

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Member has a diagnosis of Chronic Hepatitis B virus (HBV) infection with evidence of active viral replication AND either evidence of persistent elevations in serum aminotransferases (ALT or AST) or histologically active disease. And if member is co-infected with HIV, member is using in combination with highly active antiretroviral therapy (HAART)
Age Restrictions	2 years of age and older
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	N/A

BAVENCIO

Products Affected

- BAVENCIO

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

BELEODAQ

Products Affected

- BELEODAQ

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

BENLYSTA

- *benlysta*

Products Affected

- BENLYSTA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For initial treatment, individual has a Clinical diagnosis of SLE per the American College of Rheumatology [ACR] criteria AND Unequivocally positive ANA (anti-nuclear antibody) titer greater than or equal to 1:80 or anti-dsDNA (double stranded DNA antibody) greater than or equal to 30 IU/mL AND SLE is active as documented by a SELENA-SLEDAI score greater than or equal to 6 while on current treatment regimen AND There is no evidence of severe renal disease (proteinuria greater than 6 gm/day, serum creatinine greater than 2.5 mg/dl, or requiring renal dialysis) AND There is no evidence of active central nervous system lupus (e.g. psychosis and seizures) AND SLE remains active while on corticosteroid, antimalarials, and/or immunosuppressants for at least the last 30 days. For continuation of therapy, individual has a clinical diagnosis of SLE per the American College of Rheumatology [ACR] criteria AND documentation of previous improvement in disease activity following treatment with belimumab indicating a therapeutic response AND there is no evidence of severe renal disease AND there is no evidence of active central nervous system lupus.
Age Restrictions	Individual is 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	N/A

BOSULIF

Products Affected

- BOSULIF ORAL TABLET 100 MG, 500 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	Individual has Philadelphia chromosome positive Chronic Myeloid Leukemia (Ph+ CML) in chronic phase AND has documented resistance, intolerance, contraindication or warning to BOTH Gleevec and Sprycel. (Warnings may include, but not limited to pulmonary arterial hypertension, pleural or pericardial effusion, cardiac abnormalities).

BRIVIACT

Products Affected

- BRIVIACT INTRAVENOUS
- BRIVIACT ORAL SOLUTION
- BRIVIACT ORAL TABLET 10 MG, 100 MG, 25 MG, 50 MG, 75 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Individual is 16 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	N/A

BUPHENYL

Products Affected

- BUPHENYL ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Management of acute hyperammonemia
Required Medical Information	Using as adjunctive therapy for chronic management of hyperammonemia
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	N/A

CABOMETYX

Products Affected

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

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

CAPRELSA

Products Affected

- CAPRELSA ORAL TABLET 100 MG, 300 MG

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

CARBAGLU

Products Affected

- CARBAGLU

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

CAYSTON

Products Affected

- CAYSTON

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Individual has a forced expiratory volume in 1 second (FEV1) of less than 25% or greater than 75% of predicted
Required Medical Information	N/A
Age Restrictions	7 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	N/A

CELEBREX

Products Affected

- *celecoxib oral capsule 100 mg, 200 mg, 400 mg, 50 mg*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	Member had treatment failure with ONE prescription Non-Steroidal Anti-Inflammatory Drugs (NSAID)

CIMZIA

Products Affected

- CIMZIA
- CIMZIA POWDER FOR RECONST

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Tuberculosis, invasive fungal infection, other active serious infections, or a history of recurrent infections prior to initiating Cimzia (certolizumab pegol).. Individuals who have not had a tuberculin skin test or Center for Disease Control recommended equivalent to evaluate for latent tuberculosis. Using Cimzia in combination with other TNF antagonists, non-TNF immunomodulatory drugs: abatacept, anakinra, natalizumab, tofacitinib or rituximab.
Required Medical Information	N/A
Age Restrictions	Member is 18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	End of plan year

PA Criteria	Criteria Details
Other Criteria	For Crohn's Disease, agent is being used to reduce signs/symptoms OR induce/maintain clinical response. Also member has failed to respond to, is intolerant of, or has a medical contraindication to ONE conventional therapy (e.g. 5-ASA products, systemic corticosteroids, or immunosuppressants) AND Member has had an inadequate response or is intolerant to Humira in the previous 180 days. For Rheumatoid Arthritis, agent is being used to reduce signs/symptoms OR induce/maintain clinical response OR improve physical function. Also member has failed to respond to, is intolerant of, or has a medical contraindication to ONE nonbiologic DMARDs AND Member has had a trial of BOTH: Humira AND Enbrel in the previous 180 days. For Psoriatic Arthritis, agent is being used to reduce signs/symptoms OR induce/maintain clinical response OR improve physical function. Also mbr has failed to respond to, is intolerant of, or has a medical contraindication to ONE conventional therapy (such as nonbiologic DMARDs) AND has had an inadequate response or is intolerant to BOTH: Humira AND Enbrel in the previous 180 days. For Active Ankylosing Spondylitis (AS), agent is being used to reduce signs/symptoms. Also mbr has failed to respond to, is intolerant of, or has a medical contraindication to ONE conventional therapy (such as NSAIDs or non-biologic DMARDs) AND has had an inadequate response or is intolerant to BOTH: Humira AND Enbrel in the previous 180 days.

CINRYZE

Products Affected

- CINRYZE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	HAE Type I/II to be confirmed by a C4 level below the lower limit of normal (as defined by the laboratory performing the test) and ANY of the following: 1. C1 inhibitor antigenic level below the lower limit of normal (as defined by the lab performing test). 2. C1 inhibitor functional level below the lower limit of normal (as defined by the lab performing the test). Or 3. The presence of a known HAE-causing C1-INH mutation. HAE Type III was confirmed by: C1 inhibitor (C1-INH) antigenic level is normal as defined by the laboratory performing the test AND C4 level is normal as defined by the laboratory performing the test.
Age Restrictions	13 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	Individual has a history of moderate or severe attacks and is using Cinryze as prophylaxis for short-term use prior to surgery, dental procedures or intubation OR for long-term prophylaxis and member has failed, or is intolerant to, or has contraindication to 17-alpha-alkylated androgens or antifibrinolytic agents.

COMETRIQ

Products Affected

- COMETRIQ ORAL CAPSULE 100 MG/DAY(80 MG X1-20 MG X1), 140 MG/DAY(80 MG X1-20 MG X3), 60 MG/DAY (20 MG X 3/DAY)

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

COPAXONE

Products Affected

- COPAXONE SUBCUTANEOUS SYRINGE 20 MG/ML, 40 MG/ML
- GLATOPA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Individual with primary progressive MS (PPMS). Individual with secondary progressive MS (SPMS) without relapsing disease. Treatment of MS with glatiramer acetate (Copaxone) in combination with any IFN beta-1b (i.e., Betaseron, Extavia, Avonex, Rebif) or in combination with natalizumab
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	For MSB Copaxone 20mg requests, Individual also has had a trial and inadequate response or intolerance to Glatopa (glatiramer acetate) 20 mg/mL.

COTELLIC

Products Affected

- COTELLIC

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Copy of the test results must be provided that document the BRAF V600E or V600K mutation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	Individual is using Cotellic (cobimetinib) in combination with Zelboraf (vemurafenib).

C-TOBI

Products Affected

- TOBI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Individual is 6 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	N/A

CYRAMZA

Products Affected

- CYRAMZA

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

DALIRESP

Products Affected

- DALIRESP

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Individual is using to treat acute bronchospasm.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	Individual is currently using a long-acting bronchodilator.

DEXTROAMPHETAMINE IR

Products Affected

- *dextroamphetamine oral tablet 10 mg, 5 mg*
- *zenzedi oral tablet 10 mg, 5 mg*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Member is using for ADHD, Narcolepsy.
Age Restrictions	For ADHD 3yrs and older. For Narcolepsy age 6 years and older.
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	N/A

ELAPRASE

Products Affected

- ELAPRASE

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

ELIDEL

Products Affected

- ELIDEL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Individual is 2 years of age and older.
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	Individual had a trial of and inadequate response or intolerance to one topical prescription strength corticosteroid.

ELITEK

Products Affected

- ELITEK

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Individual has a diagnosis of glucose-6-phosphate dehydrogenase (G6PD) deficiency.
Required Medical Information	Individual is receiving treatment in a setting appropriate for providing necessary monitoring and supportive care for tumor lysis syndrome AND Individual has not received a course of Elitek therapy in the past.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	30 days
Other Criteria	Individual has been diagnosed with leukemia, lymphoma or other hematologic malignancy with risk factors for tumor lysis syndrome AND Individual is receiving chemotherapy.

ENBREL

Products Affected

- ENBREL SUBCUTANEOUS RECON SOLN
- ENBREL SUBCUTANEOUS SYRINGE 25 MG/0.5ML (0.51), 50 MG/ML (0.98 ML)
- ENBREL SURECLICK

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Enbrel used in combination with other TNF antagonist or in combination with the following non-TNF immunomodulatory drugs: abatacept (Orencia), anakinra (Kineret), or tofacitinib citrate, or cyclophosphamides. Tuberculosis, invasive fungal infection, other active serious infection, or a history of recurrent infection. Individual who have not had a tuberculin skin test or a CDC-recommended equivalent to evaluate for latent tuberculosis prior to initiating Enbrel (etanercept).
Required Medical Information	For chronic moderate to severe plaque psoriasis with either of the following: Individual has greater than 5% of body surface area with plaque psoriasis OR Less than or equal to 5% of body surface area with plaque psoriasis involving sensitive areas or areas that would significantly impact daily function (such as palms, soles of feet, head/neck, or genitalia).
Age Restrictions	Patient is 18 years of age or older, except for the diagnosis of JIA. For JIA patient is 2 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	End of plan year except for Initial high dose tx chronic plaque psoriasis 12 wk

PA Criteria	Criteria Details
Other Criteria	For Ankylosing Spondylitis, agent is used to reduce signs or symptoms of the disease. Also individual has failed to respond to, is intolerant of, or has a medical contraindication to ONE conventional therapies: (such as NSAIDs or nonbiologic DMARDs). For Moderate to severe Chronic Plaque Psoriasis agent is being used to reduce signs/symptoms OR to induce/maintain clinical response. Also individual has failed to respond to, is intolerant of, or has a medical contraindication to phototherapy OR ONE other systemic therapies (such as, methotrexate, acitretin, or cyclosporine). For moderately to severely active Rheumatoid Arthritis agent is being used to reduce signs/symptoms OR to induce/maintain clinical response OR inhibit the progression of structural damage OR improve physical function. Also individual has failed to respond to, is intolerant of, or has a medical contraindication to ONE nonbiologic DMARD. For Moderate to severe active Polyarticular-course JIA (previously known as JRA), agent is being used to reduce signs/symptoms OR to induce/maintain clinical response. Also individual has failed to respond to, is intolerant of, or has a medical contraindication to ONE nonbiologic DMARD. For Psoriatic Arthritis, agent is being used to reduce signs/symptoms OR to induce/maintain clinical response OR inhibit the progression of structural damage OR improve physical function. Also individual has failed to respond to, is intolerant of, or has a medical contraindication to ONE nonbiologic DMARD.

EPOGEN AND PROCRIT

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Anemia in patients due to other factors such as iron deficiency, folate deficiency or B12 deficiency, hemolysis, gastrointestinal bleeding, other active or occult bleeding, or underlying hematologic diseases (such as sickle cell anemia, thalassemia, and porphyria). Sudden loss of response with severe anemia and low reticulocyte count. Treatment of anemia in patients with cancer not treated by chemotherapy known to produce anemia. Treatment of in any indication not listed in criteria including anemia of prematurity. Anemia in cancer patients receiving myelosuppressive chemotherapy when the anticipated outcome is cure. Anemia in cancer patients receiving hormonal agents, therapeutic biologic products, or radiotherapy unless receiving concomitant myelosuppressive chemotherapy. Continued use when the hemoglobin level exceeds 11.0 g/dL unless otherwise specified in the criteria. Use beyond 12 weeks in the absence of response in individuals with chronic renal failure. Use beyond 8 weeks in the absence of response in individuals with myelodysplastic syndrome (MDS). Use beyond 8-9 weeks in the absence of response or if transfusions are still required in individuals with metastatic, non-myeloid cancer being treated with myelosuppressive chemotherapy agents known to produce anemia. Continued use beyond 6 weeks after therapy with myelosuppressive chemotherapy known to produce anemia is completed. Pre-operative use for patients who are willing to donate autologous blood.

PA Criteria	Criteria Details
Required Medical Information	Hemoglobin (Hgb) levels are less than 10.0 g/dL, prior to initiation of therapy (unless otherwise specified) AND the individual iron status reveals, transferrin saturation at least 20% or ferritin at least 80 ng/mL or bone marrow demonstrates adequate iron stores AND For individuals with uncontrolled hypertension, blood pressure is adequately controlled before initiation of therapy and closely monitored and controlled during therapy. For MDS, endogenous erythropoietin level is less than 500 mU/ml. For anemia related to zidovudine in HIV-infected patients when the dose of zidovudine is less than or equal to 4200 mg per week, endogenous erythropoietin level is less than or equal 500 mU/ml. Reduction of Allogeneic Blood Transfusion in Pre-Operative Surgery Patients: Patient's hgb is greater than 10.0 and less than or equal to 13.0 g/dL, individual is scheduled to undergo elective, noncardiac, nonvascular surgery, individual is at high risk for perioperative transfusions with significant, anticipated blood loss, individual is unable or unwilling to donate autologous blood, Antithrombotic prophylaxis has been considered. For tx of anemia due to chemotherapy known to produce anemia, chemo is planned for a minimum of 2 months and the dx is non-myeloid cancer and the anticipated outcome is not cure. For anemia associated with CKD ON dialysis use is to achieve and maintain hgb levels within the range of 10.0 to 11.0 g/dL. For anemia associated with CKD NOT ON dialysis use is to achieve and maintain hgb levels of 10.0g/dL.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	8wk.
Other Criteria	For Hepatitis C, patient is concomitantly treated with combination of ribavirin and interferon alfa, or ribavirin and peginterferon alfa. Myelosuppressive drugs known to produce anemia in individuals with a diagnosis of chronic inflammatory disease. Allogeneic bone marrow transplantation.

ERAXIS

Products Affected

- ERAXIS(WATER DILUENT) INTRAVENOUS RECON SOLN 100 MG

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

ERBITUX

Products Affected

- ERBITUX INTRAVENOUS SOLUTION 100 MG/50 ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Erbitux is used in combination with other anti-VEGF agents (e.g., bevacizumab). Erbitux is used in more than one line of therapy.
Required Medical Information	For stage IV, kras wild type colon, rectal, colorectal, small bowel, or anal adenocarcinoma when used as a single agent or as part of combination therapy. For squamous cell carcinoma of the Head and/or Neck cancer, Erbitux is used in combination with radiation therapy, for the treatment of locally or regionally advanced disease. Or as a single agent for the treatment of patients with recurrent or metastatic disease for whom prior platinum-based therapy has failed. Or in combination with platinum-based therapy with 5-FU (fluorouracil) as first-line treatment for individuals with recurrent locoregional disease or metastatic SCCHN. OR as a single agent or in combination therapy with or without radiation therapy for any of the following indications, unresectable locoregional recurrence or second primary in individuals who have received prior radiation therapy OR resectable locoregional recurrence in individuals who have not received prior radiation therapy OR distant metastases.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	N/A

ERIVEDGE

Products Affected

- ERIVEDGE

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

ESBRIET

Products Affected

- ESBRIET

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Individuals using in combination with Ofev (nintedanib). Individuals currently taking fluvoxamine. Individuals with end-stage renal disease (ESRD). Individuals with severe hepatic impairment (child pugh class C) or end-stage liver disease.
Required Medical Information	Diagnosis of idiopathic pulmonary fibrosis (IPF) is confirmed by: Exclusion of other known causes of interstitial lung disease (ILD) such as domestic and occupational environmental exposures, connective tissue disease, and drug toxicity AND High resolution computed tomography (HRCT) with or without surgical lung biopsy. Individual has documented pulmonary function tests within prior 60 days with a Forced Vital Capacity (% FVC) greater than or equal to 50%.
Age Restrictions	18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	N/A

EXJADE

Products Affected

- EXJADE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Individual is 2 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	N/A

FABRAZYME

Products Affected

- FABRAZYME INTRAVENOUS RECON SOLN 35 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Individual is 8 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	N/A

FARYDAK

Products Affected

- FARYDAK ORAL CAPSULE 10 MG, 15 MG, 20 MG

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

FASLODEX

Products Affected

- FASLODEX

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

FENTORA

Products Affected

- FENTORA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Individual is 18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	Individual has a diagnosis of cancer with breakthrough cancer pain AND has tried and failed fentanyl citrate lozenge (generic Actiq) AND Individual is already receiving opioid therapy and is TOLERANT to opioid therapy as defined as receiving around the clock medicine consisting of one of the following: At least 60mg morphine per day, OR At least 25mcg/hr transdermal fentanyl/hour, OR At least 30mg of oxycodone daily, OR At least 8mg of oral hydromorphone daily, OR At least 25mg of oral oxymorphone daily, OR An equianalgesic dose of another opioid for a week or longer. Individual will also continue around the clock opioids when taking Fentora (fentanyl).

FERRIPROX

Products Affected

- FERRIPROX

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

FETZIMA

Products Affected

- FETZIMA ORAL CAPSULE,EXT REL 24HR DOSE PACK
- FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR 120 MG, 20 MG, 40 MG, 80 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	May not be approved for treatment of fibromyalgia
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	For MDD, individual has had a trial of TWO of the following: Desvenlafaxine ER, desvenlafaxine Fumerate ER, fluoxetine, fluvoxamine, escitalopram, citalopram, paroxetine, sertraline, mirtazapine, immediate-release venlafaxine, extended-release venlafaxine or bupropion within the past 180 days

FORTEO

Products Affected

- FORTEO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Individual is not using Forteo (teriparatide) in combination with any of the following: Prolia (denosumab), Bisphosphonates, Evista (raloxifene),Miacalcin/Fortical (calcitonin nasal spray), or Recalst (zolendronic acid).
Required Medical Information	A Bone Mineral Density (BMD) must be provided with all requests. Osteoporosis is defined as a BMD T-Score of less than or equal to -2.5 as compared to young adult reference population OR a Clinical diagnosis based on a history of a low trauma fracture (fragility fracture) at high risk for fracture OR associated with sustained systemic glucocorticoid therapy (daily dosage equivalent to 5mg or greater of prednisone for at least 3 months) at high risk for fracture. In the absence of fragility fracture, BMD T-Scores greater than -2.5 (closer to 0 or positive) are not considered osteoporotic. High risk for fracture is defined as follows: Hx of osteoporotic fracture, OR multiple risk factors for fractures (including but not limited to prior low-trauma fracture as an adult, advanced age, gender, ethnicity, low bone mineral density, low body weight, family history of osteoporosis, use of glucocorticoids (daily dosage equivalent to 5mg or greater of prednisone for at least 3 months), cigarette smoking, excessive alcohol consumption [3 or more drinks/day], secondary osteoporosis (such as, rheumatoid arthritis), early menopause, height loss or kyphosis, fall risk and low calcium intake, OR Failure or intolerance to other osteoporosis therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	2 years. Requests to continue therapy beyond 24 months (2 years) should not be approved.

PA Criteria	Criteria Details
Other Criteria	Individual has one of the following: (A) Individual has had a trial of an oral bisphosphonate therapy OR (B) Intolerance or contraindications to oral bisphosphonate as defined by having at least one of the following: 1. Hypersensitivity to TWO oral bisphosphonates (one of which must be alendronate) 2. Inability to sit or stand upright for at least 30 minutes, 3. Pre-existing gastrointestinal disorders (Barrett's esophagus, hypersecretory disorders, delayed esophageal emptying, etc.). 4. Uncorrected hypocalcemia.

GAMASTAN

Products Affected

- GAMASTAN S/D

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Individual with isolated immunoglobulin A (IgA) deficiency. Individual with severe thrombocytopenia or any coagulation disorder that would contraindicate intramuscular injections. Prophylaxis of viral hepatitis type B. Routine post-exposure prophylaxis or treatment of rubella, poliomyelitis, mumps, or varicella. Allergy or asthma in individuals who have normal levels of immunoglobulin.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of plan year

PA Criteria	Criteria Details
Other Criteria	Pre-Exposure of HAV, mbr will get IM inj prior to exposure AND mbr has no clinical manifestations of hepatitis A AND is unvaccinated (CDC 2007/2015) along with one of the following: unable to receive HAV vaccine (such as, contraindication to or unavailability of the vaccine) OR mbr is considered high-risk (such as but not limited to, travel to an endemic area, older adults, immunocompromised, or diagnosis of chronic liver disease) and will receive a simultaneous dose of HAV vaccine unless contraindicated. Post-Exposure of HAV, mbr will get IM inj within 2 weeks of exposure AND mbr has no clinical manifestations of hepatitis A AND is unvaccinated (CDC 2007/2015) along with one of the following: unable to receive HAV vaccine (such as, contraindication to or unavailability of the vaccine) OR mbr is considered high-risk (such as but not limited to, immunocompromised, diagnosis of chronic liver disease, or vaccine contraindication). For post exposure prophylaxis of rubeola, must be given within 6 days of exposure and not concomitantly with a vaccine containing the measles virus AND eligible exposed, non-immune individuals will receive a vaccine containing the measles virus greater than or equal to 6 months after receiving intramuscular immune globulin (CDC 2013) AND used in mbr considered at risk for severe disease and complications: infants or previously unvaccinated and ineligible to receive a vaccine containing the measles virus (such as, but not limited to, vaccine contraindication or an initial exposure greater than 72 hours) or no evidence of measles immunity in particular pregnant woman or severely immunocompromised individuals. For post-exposure prophylaxis of varicella infection in susceptible individuals (such as, immunocompromised) AND varicella-zoster immune globulin (human) (VZIG) and immune globulin intravenous (IGIV) are not available. For post-exposure prophylaxis administered within 72 hours of exposue to a confirmed case of rubella to modify to suppress symptoms (label, CDC 2001) AND mbr is in the early stages (first trimester) of pregnancy, and will not consider terminating the pregnancy under any circumstance.

GAUCHERS

Products Affected

- CEREZYME INTRAVENOUS RECON SOLN 400 UNIT
- VPRIV

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Use of enzyme replacement therapy (ERT) agents in conjunction with one another or in conjunction with a substrate reduction therapy (SRT) agent. Use of ERT agents for the treatment of type 2 gaucher disease.
Required Medical Information	Type 1 Gaucher is confirmed by: Glucocerebrosidase activity in white blood cells or skin fibroblasts less than or equal to 30% of normal activity, OR genotype tests indicating mutation of two alleles of the glucocerebrosidase genome. And mbr has clinically significant manifestations of gauchers including any of the following for type 1,3: [Adults] skeletal disease (demonstrated by ANY of the following: avascular necrosis, erlenmeyer flask deformity, lytic disease, marrow infiltration, osteopenia, osteosclerosis, pathological fracture, radiological evidence of joint deterioration) OR mbr presents with at least 1 of the following: clinically significant hepatomegaly/splenomegaly, hgb less than or equal to 11.5 gm/dl for females and less than 12.5 gm/dl for males or 1 gm/dl below lower limit for normal for age and sex, platelet counts less than or equal to 120,000 mm3. [Children] abdominal or bone pain, hepatosplenomegaly, documented growth fx not associated with other conditions, cachexia, exertional limitation, fatigue, evidence of skeletal involvement including but not limited to erlenmeyer flask deformity, anemia with hgb less than 2 grams per dl below lower limit of normal for age and sex, platelet count less than 60,000 mm3 and or documented abnormal bleeding episodes. Type 3 gauchers is confirmed by genotype testing indicating presence of 2 homopathic alleles for neuropathic gaucher disease. And mbr has clinically significant manifestations of gauchers listed above in type 1 AND Neurological findings are consistent with the presence of type 3 gaucher disease: Neurological examination, eye movement examination, neuro-ophthalmological investigation with direct opthalmoloscopy, measurement of peripheral hearing (electro-acoustical emission in small children, pure tone audiometry in older patients), brain imaging preferably by MRI or CT, diagnostic brain stem evoked responses, EEG, intelligence quotient testing when appropriate and reasonable.
Age Restrictions	N/A

PA Criteria	Criteria Details
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	N/A

GILENYA

Products Affected

- GILENYA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrent use with other MS disease modifying agents (such as, Aubagio, Tecfidera, Tysabri, Copaxone/Glotopa, Extavia, Rebif, Avonex, Plegridy, Betaseron). Individual has history or presence of Mobitz Type II second- or third-degree atrioventricular (AV) block or sick sinus syndrome, unless individual has a functioning pacemaker. Individual has a baseline QTc interval greater than or equal to 500 ms. Individual is being treated with Class Ia (such as quinidine, procainamide, or disopyramide) or Class III [such as amiodarone, Multaq (dronedarone), Tikosyn (dofetilide), or sotalol] anti-arrhythmic drugs. Individual has had a recent (within the past 6 months) occurrence of one of the following: Myocardial infarction, Unstable angina, Stroke, Transient ischemic attack (TIA), Decompensated heart failure requiring hospitalization, Class III/IV heart failure.
Required Medical Information	I. Individual has had a trial and inadequate response or intolerance to one of the following: Avonex (interferon beta-1a), Plegridy (interferon beta-1-a), Betaseron (interferon beta-1b), Tecfidera (dimethyl fumarate), Copaxone (glatiramer). OR II. Individual has high disease activity despite treatment with a disease modifying drug (Aubagio, Avonex, Plegridy, Rebif, Betaseron, Extavia, Copaxone/Glatopa, Tecfidera) defined as the following: At least 1 relapse in the previous year while on therapy AND At least 9 T2-hyperintense lesions in cranial MRI OR At least 1 Gadolinium-enhancing lesion. OR III. Individual is treatment naive (no previous history of use of disease modifying drugs such as Aubagio, Avonex, Plegridy, Rebif, Betaseron, Extavia, Copaxone/Glatopa, Tecfidera) AND IV. Individual has rapidly evolving severe relapsing multiple sclerosis defined as the following: Two or more disabling relapses in 1 year AND One or more Gadolinium-enhancing lesions on brain MRI.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of plan year

PA Criteria	Criteria Details
Other Criteria	N/A

GILOTRIF

Products Affected

- GILOTRIF

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For individuals with metastatic non-small cell lung cancer (NSCLC), a Copy of the test results from a FDA-approved companion diagnostic test must be provided that document the exon 19 deletions or exon 21 (L858R) substitution mutation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	N/A

GLEEVEC

- *imatinib oral tablet 100 mg, 400 mg*

Products Affected

- GLEEVEC ORAL TABLET 100 MG, 400 MG

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

HARVONI

Products Affected

- HARVONI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation is provided for a diagnosis of chronic Hepatitis C virus (CHC) infection, which includes Genotype and a persistent positive HCV RNA test result for at least 6 months following positive baseline result (AASLD/IDSA 2015) AND A copy of the baseline quantitative HCV RNA test result is provided to document baseline level of viremia. Individual does not have a short life expectancy (less than 12 months owing to non-liver related comorbid conditions) that cannot be remediated by treating HCV, by transplantation or other directed therapy (AASLD/IDSA 2015). Individual also has one of the following: Genotype 1 and compensated liver disease (with or without cirrhosis) or decompensated liver disease with cirrhosis OR Genotype 4, 5, or 6 and compensated liver disease (with or without cirrhosis) OR Genotype 1 or 4 and decompensated liver disease with cirrhosis following allograft liver transplantation (AASLD/IDSA 2014) OR Genotype 1 or 4 and compensated liver disease with or without cirrhosis following allograft liver transplantation (ASSLD/IDSA 2015).
Age Restrictions	18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Criteria will be applied consistent with current AASLD/IDSA guidance.
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance.

HEPSERA

Products Affected

- *adefovir*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	12 years of age and older
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	N/A

HETLIOZ

Products Affected

- HETLIOZ

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

HP ACTHAR

Products Affected

- ACTHAR H.P.

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Individual has a corticosteroid-responsive condition, including but not limited to acute exacerbation of multiple sclerosis AND Individual has no contraindications to or is not limited by contraindication to or intolerance of glucocorticoid effects AND there is clear documentation of why all other well established routes for corticosteroid therapy (for example, oral prednisone and intravenous methylprednisolone) cannot be used.
Age Restrictions	For West Syndrome, infant and children less than 2 years of age.
Prescriber Restrictions	N/A
Coverage Duration	6 month
Other Criteria	N/A

HRM AGE

- *trimipramine*

Products Affected

- SURMONTIL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	The physician has indicated the requested medication is not causing adverse effects OR individual has a contraindication or has a clinical reason not to use a safer alternative (prescriber acknowledgement that medication benefits outweigh potential risks is sufficient).
Age Restrictions	Members that are 64 years of age or younger are NOT subject to the prior authorization requirements. Prior Authorization applies to members that are 65 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	N/A

HRM AGE AU

Products Affected

- AMRIX
- *hydroxyzine hcl oral tablet*
- *promethazine oral tablet*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	The physician has indicated the requested medication is not causing adverse effects OR individual has a contraindication or has a clinical reason not to use a safer alternative (prescriber acknowledgement that medication benefits outweigh potential risks is sufficient).
Age Restrictions	Members that are 64 years of age or younger are NOT subject to the prior authorization requirements. Prior Authorization applies to members that are 65 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	N/A

ICLUSIG

HUMAN GROWTH HORMONE

Products Affected

- GENOTROPIN
- GENOTROPIN MINIQUICK
- HUMATROPE INJECTION CARTRIDGE 12 MG (36 UNIT), 24 MG (72 UNIT)
- NORDITROPIN FLEXPRO SUBCUTANEOUS PEN INJECTOR 10 MG/1.5 ML (6.7 MG/ML), 15 MG/1.5 ML (10 MG/ML), 5 MG/1.5 ML (3.3 MG/ML)
- ZORBTIVE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Use of GH tx when applicable criteria have not been met may not be approved for, but not limited to, the following: Renal transplant, Anabolic tx, except for AIDS, provided to counteract acute or chronic catabolic illness (e.g. surgery, trauma, cancer,chronic hemodialysis) producing catabolic (protein wasting) changes in both adult and ped. Anabolic tx to enhance body mass or strength for professional, recreational or social reasons, Constitutional delay of growth and development. Cystic fibrosis, GH Tx in combo with GnRH agonist (Lupron-leuprolide) as a Tx of precocious puberty. Hypophosphatemic rickets, osteogenesis imperfecta, osteoporosis, Short Stature associated with GH insensitivity (Laron Syndrome). Therapy in older adults with normally occurring decrease in GH, who are not congenitally GH deficient and who have no evidence of organic pituitary dz (this is referred to as age-related GH deficiency). Tx of CHF, burn patients, fibromyalgia, glucocorticoid-induced growth failure. Tx of HIV lipodystrophy (fat redistribution syndrome), also referred to as altered body habitus (e.g. buffalo hump), associated with antiviral therapy in HIV-infected patients. Tx of intrauterine growth restriction (IUGR)or Russell-Silver Syndrome that does not result in SGA. Tx of obesity. Other etiologies of SS where GH has not been shown to be associated with an increase in final height, including but not limited to achondrodoplasia and other skeletal dysplasias. GH tx used for reconstruction is terminated when BA =16 yr (M), or = 14 yr (F) is reached OR Epiphyseal fusion has occurred OR Mid-parenteral height is achieved. For individuals being treated for GHD due to trauma or aneurysmal subarachnoid hemorrhage, GHD must be reconfirmed at 12 months after the event for therapy to continue. If retesting is not confirmatory for GHD, continued Tx is considered not medically necessary. Child over 12: an X-ray report with evidence that epiphyses have closed or SMR of 3 or more

ICLUSIG

PA Criteria	Criteria Details
Required Medical Information	For idiopathic GHD, has signs/sym of GHD, GV 2 SD below age-appropriate mean or ht 2.25 SD below age-appropriate mean and A subnormal (SubNL) response (less than10ng/ml)to 2GH stim tests OR Neonates with hypoglycemia and clinical/hormone evidence of hypopit and low GH (less than 10ng/ml)OR 2other pit hormone deficiencies and low IGF-1 OR mbr has cranial irradiation with low IGF1 and normal thyroid tests.Child born SGA(birth wt or length 2 or more SD below the mean for gest age),Child fails to manifest catch up growth by age 4 yr(ht 2 or more SD below the mean for age,gender)AND Other causes for SS have been ruled out.Transitioning adolescent:GH tx has been stopped for at least a month, and GHD has been reconfirmed:idiopathic isolated GHD(SubNL response to 2 GH stim tests, OR SubNL response (GH conc of less than10 ng/mL)to 1 provocative test and low IGF-I/IGFBP-3)OR multiple pit hormone deficiency,(SubNL response to 1 provocative GH test and/or low IGF-I/IGFBP-3)or for mbr with cranial irradiation, low IGF with normal thyroid or any of the following, known genetic mutation associated with def GH production or secretion or Hypothalamic-pit tumor or structural defect or 3 other pit hormone deficiencies.Adult GHD must be confirmed/reconfirmed:SubNL response in adults to 2 GH stim tests (GH conc of less than or equal to 5ng/ml when using insulin induced hypoglycemia OR GH conc of less than or equal to 4.1ng/ml when using arginine)OR SubNL response to 1 stim test for adults with hypothalamic or pit dz and 1 pit hormone deficits OR 3 other pit hormone deficiencies.Reconstructive GH tx who dont have GHD may be approved if either mean ht is at least 2.25 but less than 2.5SD below the mean for age, gender and GV is less than the 10th percentile over 1yr or mean ht is at least 2.5SD below the mean for age, gender for conditions known responsive to GH.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	Cont of GH tx in child is approved when doubling of pre-tx growth rate or an inc in pre-tx growth rate of 3cm/yr or more seen in the first yr of tx, for tx continuing past the 1st yr, growth remains above 2.5cm/yr (doesnt apply to child with prior hypopit). GH may be approved for Adolescents with childhood onset GHD who have completed linear growth. GH for Short bowel syndrome in individuals receiving specialized nutritional support.

ICLUSIG

HUMIRA

Products Affected

- HUMIRA PEDIATRIC CROHN'S START SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML, 40 MG/0.8 ML (6 PACK)
- HUMIRA PEN
- HUMIRA PEN CROHN'S-UC-HS START
- HUMIRA SUBCUTANEOUS SYRINGE KIT 10 MG/0.2 ML, 20 MG/0.4 ML, 40 MG/0.8 ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Using Humira in combination with other TNF agents, Abatacept, tofacitinib,or Kineret (anakinra). Tuberculosis, invasive fungal infection, other active serious infections, or a history of recurrent. Patients Individuals who have not had a tuberculin skin test or CDC-recommended equivalent to evaluate for latent tuberculosis prior to initiating Humira (adalimumab).
Required Medical Information	For Chronic moderate to severe plaque psoriasis with either of the following: Patient has greater than 5% of body surface area with plaque psoriasis OR Less than or equal to 5% of body surface area with plaque psoriasis involving sensitive areas or areas that would significantly impact daily function (such as palms, soles of feet, head/neck, or genitalia) AND agent is used to reduce signs/symptoms OR to induce/maintain clinical response.
Age Restrictions	Patient is 18 years of age or older for all indications except JIA and Crohns disease. Patient must be at least 2 years old for JIA. Patient must be at least 6 years of age for Crohns disease.
Prescriber Restrictions	N/A
Coverage Duration	End of plan year

ICLUSIG

PA Criteria	Criteria Details
Other Criteria	For moderate to severe active RA: agent is being used for any of the following reasons: To reduce signs/symptoms OR induce/maintain clinical response OR inhibit the progression of structural damage OR improve physical function and individual has failed to respond to, is intolerant of, or has a medical contraindication to ONE nonbologic DMARD. For Psoriatic Arthritis, agent is being used to reduce signs/symptoms OR induce/maintain clinical response OR inhibit the progression of structural damage OR improve physical function and individual has failed to respond to, is intolerant of, has medical contraindication to ONE conventional therapy (such as non-biologic DMARDs). For moderate to severe JIA, agent is being used to reduce signs/symptoms OR induce/maintain clinical response AND individual has failed to respond to, is intolerant of, or has a medical contraindication to ONE nonbologic DMARD. For Ankylosing Spondylitis, agent is being used to reduce signs/symptoms AND individual has failed to respond to, is intolerant of, or has a medical contraindication to ONE conventional therapy (such as NSAIDs or nonbiologic DMARDs). For Crohn's disease agent is being used to reduce signs/symptoms OR induce/maintain clinical remission AND individual has failed to respond to, is intolerant of, or has a medical contraindication to ONE conventional therapy (e.g. 5-ASA products, sulfasalazine, systemic corticosteroids, or immunosuppressants) or has lost response to or is intolerant to infliximab. For chronic moderate to severe plaque psoriasis, patient has failed to respond to, is intolerant of, or has a medical contraindication to phototherapy or ONE other systemic therapy (e.g. methotrexate, acitretin, or cyclosporine). For moderately to severely active Ulcerative Colitis (UC), agent is used to reduce signs/symptoms OR induce/maintain clinical remission AND individual has failed to respond to, is intolerant of, or has a medical contraindication to ONE conventional therapy (such as 5-ASA products, Sulfasalazine, systemic corticosteroids, or immunosuppressive drugs).

ICLUSIG

IBRANCE

Products Affected

- IBRANCE

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

ICLUSIG

Products Affected

- ICLUSIG ORAL TABLET 15 MG, 45 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	Individual has T315I-positive Chronic Myeloid Leukemia in chronic phase AND has documented resistance, intolerance, contraindication or warning to BOTH Gleevec and Sprycel. (Warnings may include, but not limited to pulmonary arterial hypertension, pleural or pericardial effusion, cardiac abnormalities).

IDHIFA

Products Affected

- IDHIFA

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

ILARIS

Products Affected

- ILARIS (PF)
- ILARIS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Tuberculosis, invasive fungal infection, other active serious infection, or a history of recurrent infection. Individual who have not had a tuberculin skin test or a CDC-recommended equivalent to evaluate for latent tuberculosis prior to initiating Ilaris (canakinumab). Using Ilaris in combination with other biologic disease-modifying antirheumatic drugs (DMARDs), tumor necrosis factor (TNF) antagonists, IL-1R antagonists, Janus kinase inhibitors, or an IL-6 receptor antagonist.
Required Medical Information	N/A
Age Restrictions	For cryopyrin-associated periodic syndromes age 4 years and older and for systemic juvenile idiopathic arthritis 2 years of age and older.
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	For SIJA, agent is being used to reduce signs/symptoms or induce/maintain clinical response and individual has failed to respond to, intolerant of, or has a medical contraindication to ONE corticosteroids or nonsteroidal anti-inflammatory drugs (NSAIDs).

IMBRUVICA

Products Affected

- IMBRUVICA

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

IMFINZI

Products Affected

- IMFINZI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	History of immunodeficiency or severe autoimmune disease. Requires systemic immunosuppression, active immune-medicated disease, severe or life-threatening infections or untreated central nervous system (CNS) metastases. Has received treatment with another anti-PD-1 or anit-PD-L1 agent
Required Medical Information	Inoperable or metastatic transitional-cell urothelial carcinoma histologically or cytologically confirmed.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	Individual has inoperable or metastatic urothelial carcinoma AND Either the disease has progressed during or following platinum-containing therapy OR disease has progressed within 12 months of neoadjuvant or adjuvant treatment with platinum-containing therapy

INCRELEX

Products Affected

- INCRELEX

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Individual has an active or suspected malignancy. Individual has closed epiphyses (closed bone growth plates signifying end of potential growth). Individual has a diagnosis of secondary forms of IGFD (such as but not limited to, GH deficiency, malnutrition, hypothyroidism). Individual is using as a substitute to GH for GH-approved indications. Use via the intravenous route.
Required Medical Information	For treatment of growth failure associated with one of the following (1) Growth failure with severe primary IGFD as defined by: Height standard deviation score of less than or equal to -3.0 for sex and age AND Basal IGF-1 standard deviation score of less than or equal to -3.0 for sex and age AND normal or elevated growth hormone secretion OR (2) GH gene deletion who have development of neutralizing antibodies to GH.
Age Restrictions	2 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	N/A

INLYTA

Products Affected

- INLYTA ORAL TABLET 1 MG, 5 MG

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

INTERFERONS FOR MS

Products Affected

- AVONEX (WITH ALBUMIN)
- AVONEX INTRAMUSCULAR PEN INJECTOR KIT
- AVONEX INTRAMUSCULAR SYRINGE KIT
- BETASERON SUBCUTANEOUS KIT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Members with primary progressive MS. Members with secondary progressive MS without relapsing disease. Treatment of MS with IFN beta-1a (for example, Avonex, Rebif, Plegridy) or IFN beta-1b (for example Betaseron, Extavia) in combination with glatiramer acetate (Copaxone) or in combination with natalizumab (Tysabri).
Required Medical Information	Members with a single demyelinating episode with consistent MRI findings, considered at high risk for clinically definite MS OR Member with MS with relapsing or remitting disease (RRMS) OR Members with secondary progressive MS (SPMS) with a history of superimposed relapses.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	N/A

INTUNIV

Products Affected

- *guanfacine oral tablet extended release 24 hr*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Individual is using for Attention Deficit Hyperactivity Disorder/Attention Deficit Disorder (ADHD/ADD).
Age Restrictions	Individual is 6 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	Individual has had a trial of ONE generic stimulant medication unless either of the following applies: individual or individuals family has a history of substance diversion/abuse OR Individual has a diagnosis of anxiety or a tic disorder (such as, Tourettes Syndrome)

IVIG

Products Affected

- GAMUNEX-C INJECTION SOLUTION 1 GRAM/10 ML (10 %)

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For Chronic Inflammatory Demyelinating Polyneuropathy (CIDP), medical records must indicate clinical presentation is not consistent with other polyneuropathies (Igm neuropathy, hereditary neuropathy, diabetic neuropathy) and ONE of the following clinical and electrodiagnostic criteria are met: proximal weakness or sensory dysfunction caused by neuropathy and nerve conduction studies confirm electodiagnostic evidence of a demyelinating neuropathy in at least 2 limbs. OR distal muscle weakness and results of diagnostic testing meet recognized set of diagnostic criteria as established by AAN, Saperstien, or INTAC. Continued use of IG for CDIP requires clinically significant improvement in neurological symptoms as documented on physical exam AND continued need is demonstrated by documentation that attempts on an annual basis to titrate the dose or the interval of therapy result in worsening symptoms. For Multifocal Motor Neuropathy (MMN) patient presents with asymmetric weakness that predominantly affects distal muscles AND nerve conduction studies confirm a demyelinating neuropathy is present (conduction block, slowing, or abnormal temporal dispersion in at least one nerve) OR clinical history or exam do not suggest upper motor neuron disease (no bulbar weakness, no upper motor neuron signs) and GM-1 antibody titers are elevated. OR after initial exam and electrodiagnostic testing clinical presentation suggests MMN but the diagnosis remains uncertain. Continued use for MMN requires clinical results document an improvement in strength and function within 3 weeks of start of infusion and need is demonstrated by documentation that attempts on an annual basis to titrate the dose or interval of therapy result in worsening of symptoms.
Age Restrictions	N/A
Prescriber Restrictions	N/A

PA Criteria	Criteria Details
Coverage Duration	End of plan year
Other Criteria	To reduce the risk of graft-versus-host disease associated with interstitial pneumonia (infectious or idiopathic) and infections (cytomegalovirus infections, Varicella-zoster virus infection, and recurrent bacterial infection) in allogeneic bone marrow transplant (BMT) recipients in the first 100 days after transplantation. Dermatomyositis, refractory (IVIG is used as a second line treatment of dermatomyositis. Corticosteroids are first-line treatments of dermatomyositis.). Myasthenia Gravis, severe refractory. Polymyositis, routine use of IG is not recommended. IG may be considered in patients with severe polymyositis for whom other treatments have been unsuccessful, have become intolerable, or are contraindicated. Stiff-person syndrome not controlled by other therapies. Toxic shock syndrome caused by staphylococcal or streptococcal organisms refractory to several hours of aggressive therapy. Tx of chronic parvovirus B19 infection and severe anemia associated with bone marrow suppression. Refractory auto-immune mucocutaneous blistering diseases including: pemphigus vulgaris, pemphigus foliaceus, bullous pemphigoid, mucous membrane pemphigoid, epidermolysis bullosa acquisita. Tx of primary humoral immunodeficiency (PI) when: hx of recurrent sinopulmonary infection req antibiotic tx AND lack of, or inadequate response to immunization AND no evidence of renal (nephrotic syndrome) and gastrointestinal (e.g. protein losing enteropathy) as causes of hypogammaglobulinemia (HGG) AND initial pre-tx total serum IgG is below the lower limit of age adj lab ref range or more than 2 SD below adj mean. Tx of other PI when: no evidence of renal/GI causes of HGG AND initial pre-tx total serum IgG is more than 2 SD below adj mean. Tx of IgG sub-class deficiency (IgG1, IgG2, IgG3, IgG4) when: One or more serum IgG subclasses are below lower limit of age adj lab ref range or more than 2 SD below age adj mean AND hx of recurrent sinopulmonary infections requiring antibiotic therapy AND Lack of, or inadequate response to immunization. Tx of Kawasaki Syndrome when: within 10 days of onset and tx for no more than 5 days. For ITP when: symptomatic thrombocytopenia (for example, but not limited to hematuria, petechiae, bruising, gastrointestinal bleeding, gingival bleeding) or platelet count less than 20,000 (adult) or 30,000 (child). For hypogammaglobulinemia and recurrent bacterial infection associated with B-cell chronic lymphocytic leukemia (CLL) that includes both: Documented hx of recurrent bacterial infection or an active infection not responding to antimicrobial therapy AND Documentation that total IgG is less than 500mg/dL.

JAKAFI

Products Affected

- JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG

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

JARDIANCE

Products Affected

- JARDIANCE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Individual has an eGFR less than 45 mL/min/1.73 m2.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	Individual has had a trial and inadequate response or intolerance to metformin OR Individual has a contraindication to metformin therapy [such as but not limited to, renal insufficiency (serum creatinine greater than or equal to 1.4 in females and 1.5 in males)].

JUXTAPID

Products Affected

- JUXTAPID

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Individual has a clinical diagnosis of homozygous familial hypercholesterolemia (HoFH), based on the presence of the following: (A) Genetic confirmation of two (2) mutant alleles at the LDL receptor, apoB, PCSK9 or ARH adaptor protein gene locus OR (B) One of the following: 1. an untreated LDL-C concentration greater than 500 mg/dL (13 mmol/L) OR 2. Treated LDL-C greater than or equal to 300 mg/dL (7.76 mmol/L) AND one of the following: (i) cutaneous or tendonous xanthoma before age of 10 years OR (ii) untreated LDL-C levels consistent with heterozygous familial hypercholesterolemia in both parents (greater than 190 mg/dL).
Age Restrictions	18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	Individual has had an adequate trial and titration of Repatha OR Repatha is not acceptable due to concomitant clinical situations, such as but not limited to a known disease state or medication contraindication which is not also associated with Juxtapid.

KADCYLA

Products Affected

- KADCYLA INTRAVENOUS RECON SOLN 100 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Tumor(s) have been evaluated with an assay validated to predict HER2 positive (HER2+) protein overexpression. Individuals are considered HER2 positive (HER2+) as documented by one of the following, immunohistochemistry (IHC) 3+ or In Situ hybridization (ISH) positive by any of the following: Single probe average HER2 copy number greater than or equal to 6.0 signals/cell OR Dual-probe HER2/CEP 17 ratio greater than or equal to 2.0 OR Dual-probe HER2/CEP 17 ratio less than 2.0 with an average HER2 copy number greater than or equal to 6.0 signals/cell.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	For metastatic breast cancer, individual has previously received trastuzumab and a taxane, separately or in combination. AND has either received prior therapy for metastatic disease OR developed disease recurrence during or within six (6) months of completing adjuvant therapy. Kadcyla is only used in a single line of therapy.

KALYDECO

Products Affected

- KALYDECO ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Using Kalydeco (ivacaftor) monotherapy, without concurrent use of lumacaftor, for the F508del mutation in the CFTR gene.
Required Medical Information	Member has a diagnosis of cystic fibrosis (CF) AND Member has any of the following mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene: G551D, G1244E, G1349D, G178R, G551S, S1251N, S1255P, S549N, S549R, OR R117H. A copy of CF mutation analysis test results must be provided. Results must document a mutation in the CFTR gene.
Age Restrictions	6 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	N/A

KEYTRUDA

Products Affected

- KEYTRUDA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Previous treatment with another programmed death receptor-1 (PD-1) blocking antibody agent. OR Presence of human immunodeficiency virus (HIV) infection, hepatitis B virus infection, or hepatitis C virus infection. Receiving therapy for an autoimmune disease or chronic condition requiring treatment with an immunosuppressant.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	For the treatment of unresectable or metastatic melanoma, Keytruda is being used as a single agent AND first line therapy in untreated disease or as second line or subsequent therapy for documented disease progression while receiving or since completing most recent therapy and Current Eastern Cooperative Oncology Group (ECOG) performance status of 0-2. For metastatic non-small cell lung cancer (NSCLC) Keytruda is being used as a single agent AND Tumors express PD-L1 gene with demonstrated disease progression on or after platinum-containing chemotherapy OR Individual with ALK or EGFR genomic tumor aberrations has disease progression on U.S. Food and Drug Administration (FDA) approved therapy for the aberrations prior to receiving pembrolizumab AND Current Eastern Cooperative Oncology Group (ECOG) performance status of 0-2.

KISQALI

Products Affected

- KISQALI
- KISQALI PAK FEMARA

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

KINERET

Products Affected

- KINERET

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Individual is using Kineret in combination with other tumor necrosis factor (TNF) antagonists. Tuberculosis or other active serious infections or a history of recurrent infections. Individual has not had a tuberculin skin test (TST) or Centers for Disease Control (CDC) Prevention-recommended equivalent to evaluate for latent tuberculosis prior to initiating Kineret. In combination with Xeljanz (tofacitinib) or with NONTNF immunomodulatory drugs [such as but not limited to Actemra (tocilizumab) or Orencia (abacept)]
Required Medical Information	N/A
Age Restrictions	Individual must be 18 years of age or older for RA
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	For RA, agent is being used for any of the following: to reduce signs/symptoms or to induce/maintain clinical response or to inhibit progression of structural damage or to improve physical function AND Individual has failed or had an inadequate response to is intolerant or has a contraindication to ONE DMARD AND Individual has tried and failed BOTH: Humira AND Enbrel in the previous 180 days.

KORLYM

Products Affected

- KORLYM

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	N/A

KUVAN

Products Affected

- KUVAN ORAL TABLET,SOLUBLE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	If blood phenylalanine levels do not decrease from baseline at a dose of 10mg/kg/day administered for up to one month. The dose may be increased up to 20mg/kg/day. Individuals are non-responders if phenylalanine levels do not decrease after 1 month and tx should be discontinued
Required Medical Information	For initial requests, Individual has Dx of Hyperphenylalaninemia (HPA) due to tetrahydrobiopterin-(BH4) responsive PKU. For continued use, individual is showing signs of continuing improvement as evidenced by blood phenylalanine levels.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial 8 weeks, End of plan year for continuation
Other Criteria	N/A

KYNAMRO

Products Affected

- KYNAMRO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Individual has a clinical diagnosis of homozygous familial hypercholesterolemia (HoFH), based on the presence of the following: (A) Genetic confirmation of two (2) mutant alleles at the LDL receptor, apoB, PCSK9 or ARH adaptor protein gene locus OR (B) One of the following: 1. an untreated LDL-C concentration greater than 500 mg/dL (13 mmol/L) OR 2. Treated LDL-C greater than or equal to 300 mg/dL (7.76 mmol/L) AND one of the following: (i) cutaneous or tendonous xanthoma before age of 10 years OR (ii) untreated LDL-C levels consistent with heterozygous familial hypercholesterolemia in both parents (greater than 190 mg/dL).
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	Individual has had an adequate trial and titration of Repatha OR Repatha is not acceptable due to concomitant clinical situations, such as but not limited to a known disease state or medication contraindication which is not also associated with Kynamro.

LAZANDA

Products Affected

- LAZANDA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Individual is 18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	Individual has a diagnosis of cancer with breakthrough cancer pain AND has tried and failed fentanyl citrate lozenge (generic Actiq) AND Individual is already receiving opioid therapy and is TOLERANT to opioid therapy as defined as receiving around the clock medicine consisting of one of the following: At least 60mg morphine per day, OR At least 25mcg/hr transdermal fentanyl/hour, OR At least 30mg of oxycodone daily, OR At least 8mg of oral hydromorphone daily, OR At least 25mg of oral oxymorphone daily, OR An equianalgesic dose of another opioid for a week or longer. Individual will also continue around the clock opioids when taking Lazanda (fentanyl).

LENVIMA

Products Affected

- LENVIMA ORAL CAPSULE 10 MG/DAY (10 MG X 1/DAY), 14 MG/DAY(10 MG X 1-4 MG X 1), 18 MG/DAY (10 MG X 1-4 MG X2), 20 MG/DAY (10 MG X 2), 24 MG/DAY(10 MG X 2-4 MG X 1), 8 MG/DAY (4 MG X 2)

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

LETAIRIS

Products Affected

- LETAIRIS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Individual has idiopathic pulmonary fibrosis (IPF). Individual has a diagnosis of moderate (Child-Pugh Class B) or severe (Child-Pugh Class C) hepatic impairment. Individual is initiating therapy and has a diagnosis of clinically significant anemia.
Required Medical Information	Individual has catheterization-proven diagnosis of pulmonary arterial hypertension (PAH) (WHO Group 1) AND individual has WHO Functional Class II-IV symptoms.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	N/A

LIDODERM PATCH

Products Affected

- *lidocaine topical adhesive patch,medicated*

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

LONSURF

Products Affected

- LONSURF

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

LUPRON DEPOT

Products Affected

- LUPRON DEPOT
- LUPRON DEPOT (3 MONTH) INTRAMUSCULAR SYRINGE KIT 22.5 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For Prostate cancer: Clinically localized disease with intermediate (T2b to T2c cancer, Gleason score of 7, or prostate specific antigen (PSA) value of 10-20 ng/mL) or higher risk of recurrence as neoadjuvant therapy with radiation therapy or cryosurgery OR following radical prostatectomy as adjuvant therapy when lymph node metastases are present OR Locally advanced disease OR Other advanced, recurrent, or metastatic disease. For Gynecology Uses: Initial treatment/retreatment of endometriosis (not to continue beyond 6 months) OR Dysfunctional uterine bleeding OR Preoperative treatment as adjunct to surgical treatment of uterine fibroids (leiomyoma uteri). May be used to reduce size of fibroids to allow for a vaginal procedure, prior to surgical treatment (myomectomy or hysterectomy) in patients with documented anemia. To induce amenorrhea in women in certain populations including menstruating women diagnosed with severe thrombocytopenia or aplastic anemia. For Endocrine Uses: Precocious puberty, defined as beginning of secondary sexual characteristics before age 8 in girls and before age 9 in boys. Ovarian Cancer (including fallopian tube cancer and primary peritoneal cancer):Hormonal therapy for clinical relapse in individuals with stage II-IV granulosa cell tumors or Hormonal therapy for treatment of epithelial ovarian cancer, fallopian tube cancer, primary peritoneal cancer as a single agent for: Progressive, stable or persistent disease on primary chemotherapy or Relapse after complete remission following primary chemotherapy or Stage II-IV disease showing partial response to primary treatment or Low grade or focal recurrences after a disease free interval of greater than 6 months.
Age Restrictions	N/A
Prescriber Restrictions	N/A

PA Criteria	Criteria Details
Coverage Duration	End of plan year, except for Endometriosis:6months, Uterine Fibroids:3months
Other Criteria	For Gender Dysphoria in Adolescents: Fulfills the DSM V criteria for gender dysphoria AND has experienced puberty to at least Tanner stage 2 AND has (early) pubertal changes that have resulted in an increase of their gender dysphoria AND does not suffer from a psychiatric comorbidity that interferes with the diagnostic work-up or treatment AND has psychological and social support during treatment AND demonstrates knowledge and understanding of the expected outcomes of GnRH analog treatment.

LYNPARZA

Products Affected

- LYNPARZA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Copy of the test results from a FDA-approved test must be provided that document the BRCA mutation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	N/A

MEKINIST

Products Affected

- MEKINIST ORAL TABLET 0.5 MG, 2 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Copy of the test results must be provided that document the BRAF V600E or V600K mutation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	N/A

MEPRON

Products Affected

- *atovaquone*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Intolerance to trimethoprim-sulfamethoxazole (TMP-SMX)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	N/A

METHOXSALEN

Products Affected

- 8-MOP
- *methoxsalen rapid*

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

MODAFINIL

Products Affected

- *modafinil oral tablet 100 mg, 200 mg*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For Narcolepsy type 1: confirmed by the presence of daily periods of irrepressible need to sleep or daytime lapses into sleep occurring for at least 3 months and at least one of the following: 1. Clear cataplexy (defined as more than one episode of generally brief) usually bilaterally symmetrical, sudden loss of muscle tone with retained consciousness) AND 2.Multiple Sleep Latency Test (MSLT) showing one of the following: a. Mean sleep latency of less than 8 minutes with evidence of two sleep-onset rapid eye movement periods (SOREMPs) (ICSD-3, 2014)OR b. At least one SOREMP on MSLT and a SOREMP (less than 15 minutes) on the preceding overnight polysomnography (PSG) OR 3.Cerebrospinal fluid hypocretin-1 deficiency (less than 110 pg/mL or less than one-third of the normative values with the same standardized assay). For Narcolepsy type 2: confirmed by 1.Multiple sleep latency test (MSLT) with one of the following: a.Mean sleep latency of less than 8 minutes with and evidence of two sleep-onset rapid eye movement periods (SOREMPs) ICSD-3, 2014) OR b. At least one SOREMP on MSLT and a SOREMP (less than 15 minutes) on the preceding overnight polysomnography (PSG) AND 2.The absence of cataplexy AND 3.Exclusion of alternative causes of excessive daytime sleepiness by history, physical exam and Polysomnography.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of plan year

PA Criteria	Criteria Details
Other Criteria	For obstructive sleep apnea/hypopnea syndrome objectively confirmed by polysomnography (PSG) or home testing with portable monitor showing one of the following (AASM 2009): (1).Greater than 15 obstructive events (defined as apneas, hypopneas plus respiratory event related arousal) per hour of sleep OR (2)Greater than 5 obstructive events per hour of sleep and individual reports any of the following: a.Unintentional sleep episodes during wakefulness or b. Daytime sleepiness or c. Unrefreshing sleep or d. Fatigue or e. Insomnia or f.Waking up breath holding, gasping or choking or g.Bed partner describing loud snoring, breathing interruptions or both or h. Presence of comorbid conditions including hypertension, mood disorder, cognitive dysfunction, coronary artery disease, stroke, congestive heart failure, atrial fibrillation or type 2 diabetes mellitus. And has an Epworth Sleepiness Scale score greater than or equal to 10. For Shift-Work Sleep Disorder (SWSD) confirmed by all of the following: (1)No other medical disorder or mental disorder accounts for the symptoms AND (2)Symptoms do not meet criteria for any other sleep disorder (i.e. jet lag) AND (3)Symptoms have occurred for at least 3 months, AND (4)Individual has one of the following: a.Individual has excessive sleepiness or insomnia associated with a work period that occurs during the usual sleep phase OR b.Polysomnography demonstrates loss of a normal sleep-wake pattern (such as, disturbed chronobiological rhythmicity).

MOZOBIL

Products Affected

- MOZOBIL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Using as a mobilizing agent for an allogeneic stem cell donor, mobilizer of leukemic cells or as a component of a conditioning regimen prior to an allogeneic hematopoietic stem cell transplant.
Required Medical Information	Using in combination with granulocyte colony stimulating factor (G-CSF) and after stem cell mobilization and collection, a subsequent autologous hematopoietic stem cell transplant is anticipated.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	Individual may use a maximum of up to four consecutive doses of plerixafor (Mozobil) injections per cycle for up to 2 cycles.

NAGLAZYME

Products Affected

- NAGLAZYME

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

NATPARA

Products Affected

- NATPARA

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

NERLYNX

Products Affected

- NERLYNX

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

NEULASTA

Products Affected

- NEULASTA SUBCUTANEOUS SYRINGE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Individuals who are at high risk for infection-associated complications by any of the following: Expected prolonged (greater than 10 day) and profound (less than 0.1 x 10to the power of 9/L) neutropenia, Age greater than 65 years, Uncontrolled primary disease, Pneumonia, Hypotension and multi organ dysfunction (sepsis syndrome), Invasive fungal infection, Hospitalized at the time of the development of fever. Primary prophylaxis of FN in patients who have a risk of FN of 20% or greater based on chemotherapy regimens. OR when the risk of developing FN is greater than or equal to 10% and less than 20% based on chemotherapy in patients who have other patient specific risk factors for FN including any of the following: Individual age greater than 65 years, Poor performance status, Previous episodes of FN, history of previous chemotherapy or radiation, After completion of combined chemoradiotherapy, Bone marrow involvement by tumor producing cytopenias, Poor nutritional status, poor renal function, liver dysfunction, The presence of open wounds or active infections, recent surgery, advanced cancer or Other serious comorbidities.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of plan year

PA Criteria	Criteria Details
Other Criteria	Secondary Prophylaxis for patients who experienced a neutropenic complication from a prior cycle of chemotherapy (for which primary prophylaxis was not received), in which a reduced dose may compromise disease-free or overall survival or treatment outcome. Adjunctive use in neutropenic patients who are at high risk for infection-associated complications. In an individual with acute lymphocytic leukemia (ALL) after completion of the first few days of initial induction chemotherapy or first post-remission course of chemotherapy. For myelodysplastic syndromes (MDS) with severe neutropenia (absolute neutrophil count (ANC) less than or equal to 500 mm3 or experiencing recurrent infection. For dose dense therapy (treatment given more frequently, such as every two weeks instead of every three weeks) for adjuvant treatment of breast cancer. After a hematopoietic progenitor stem cell transplant (HPCT/HSCT) to promote myeloid reconstitution OR when engraftment is delayed or has failed.

NEUPOGEN

Products Affected

- NEUPOGEN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Febrile neutropenic individuals who are at risk for infection-associated complications or have any of the following: Expected prolonged (greater than 10 day) and profound (less than 0.1 x 10to the power of 9/L) neutropenia, Age greater than 65 years, Uncontrolled primary disease, Pneumonia, Hypotension and multi organ dysfunction (sepsis syndrome), Invasive fungal infection, or Hospitalized at the time of the development of fever. Primary prophylaxis of FN in patients who have a risk of FN of 20% or greater based on chemotherapy regimens. OR when the risk of developing FN is greater than or equal to 10% and less than 20% based on chemotherapy in patients who have other patient specific risk factors for FN including any of the following: Individual age greater than 65 years, Poor performance status, Previous episodes of FN, history of previous chemotherapy or radiation, After completion of combined chemoradiotherapy, Bone marrow involvement by tumor producing cytopenias, preexisting neutropenia, Poor nutritional status, poor renal function, liver dysfunction, The presence of open wounds or active infections, recent surgery, advanced cancer or Other serious comorbidities
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of plan year

PA Criteria	Criteria Details
Other Criteria	Secondary Prophylaxis for patients who experienced a neutropenic complication from a prior cycle of chemotherapy (for which primary prophylaxis was not received), in which a reduced dose may compromise disease-free or overall survival or treatment outcome. Adjunctive use in neutropenic patients who are at high risk for infection-associated complications. Use in acute lymphocytic leukemia (ALL) after completion of the first few days of initial induction chemotherapy or first post-remission course of chemotherapy. Use in individuals with acute myeloid leukemia (AML) shortly after the completion of induction or repeat induction chemotherapy, or after the completion of consolidation chemotherapy for AML. For tx of moderate to severe aplastic anemia. Tx of severe neutropenia in individuals with hairy cell leukemia. For myelodysplastic syndromes (MDS) with severe neutropenia (absolute neutrophil count (ANC) less than or equal to 500 mm3 or experiencing recurrent infection. For dose dense therapy (treatment given more frequently, such as every two weeks instead of every three weeks) for adjuvant treatment of breast cancer. For chronic administration to reduce the incidence and duration of sequelae of neutropenia (e.g., fever, infections, oropharyngeal ulcers) in symptomatic individuals with congenital neutropenia, cyclic neutropenia, or idiopathic neutropenia. For tx of (non-chemotherapy) drug-induced neutropenia. For tx of low neutrophil counts in individuals with glycogen storage disease type 1b. For tx of neutropenia associated with human immunodeficiency virus (HIV) infection and antiretroviral therapy. In individuals receiving radiation therapy in the absence of chemotherapy if prolonged delays secondary to neutropenia are expected. After accidental or intentional total body radiation of myleosuppressive doses (greater than 2 Grays [Gy] (such as Hematopoietic Syndrome of Acute Radiation Syndrome). After hematopoietic progenitor stem cell transplant (HPCT/HSCT) to promote myeloid reconstitution or when engraftment is delayed or has failed. To mobilize progenitor cells into peripheral blood for collection by leukapheresis, as an adjunct to peripheral blood/hematopoietic stem cell transplantation (PBSCT/PHSCT). Use as an alternate or adjunct to donor leukocyte infusions (DLI) in individuals with leukemic relapse after an allogeneic hematopoietic stem cell transplant.

NEUPRO

Products Affected

- NEUPRO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	Individual has had a previous trial of or has a contraindication to either Mirapex (pramipexole) or Requip (ropinirole). OR Individual is unable to swallow or take oral medications.

NEXAVAR

Products Affected

- NEXAVAR

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

NINLARO

Products Affected

- NINLARO

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

NON-PEGYLATED INTERFERONS

Products Affected

- INTRON A INJECTION RECON SOLN
- INTRON A INJECTION SOLUTION 6 MILLION UNIT/ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For Hepatitis B when: HBeAg is either positive or negative AND Detectable levels of Hepatitis B DNA AND member has Compensated liver disease AND ALT at least 2X upper limit of normal
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	N/A

NORTHERA

Products Affected

- NORTHERA ORAL CAPSULE 100 MG, 200 MG, 300 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Individual is 18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	Individual has had a trial (resulting in inadequate response, therapeutic failure or intolerance) of at least one prior pharmacologic therapy (which may include midodrine or fludrocortisone) for treatment of symptoms of NOH.

NP IVIG

Products Affected

- CARIMUNE NF NANOFILTERED INTRAVENOUS RECON SOLN 6 GRAM
- FLEBOGAMMA DIF INTRAVENOUS SOLUTION 10 %
- GAMMAGARD LIQUID

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For Chronic Inflammatory Demyelinating Polyneuropathy (CIDP), medical records must indicate clinical presentation is not consistent with other polyneuropathies (Igm neuropathy, hereditary neuropathy, diabetic neuropathy) and ONE of the following clinical and electrodiagnostic criteria are met: proximal weakness or sensory dysfunction caused by neuropathy and nerve conduction studies confirm electrodiagnostic evidence of a demyelinating neuropathy in at least 2 limbs. OR distal muscle weakness and results of diagnostic testing meet recognized set of diagnostic criteria as established by AAN, Saperstien, or INTAC. CONT use of IG for CDIP requires clinically significant improvement in neurological symptoms as documented on physical exam AND cont need is demonstrated by documentation that attempts on an annual basis to titrate the dose or the interval of therapy result in worsening symptoms. For Multifocal Motor Neuropathy (MMN) mbr presents with asymmetric weakness that predominantly affects distal muscles AND nerve conduction studies confirm a demyelinating neuropathy is present (conduction block, slowing, or abnormal temporal dispersion in at least one nerve) OR clinical history or exam do not suggest upper motor neuron disease (no bulbar weakness, no upper motor neuron signs) and GM-1 antibody titers are elevated. OR after initial exam and electrodiagnostic testing clinical presentation suggests MMN but the dx remains uncertain. CONT use for MMN requires clinical results document an improvement in strength and function within 3 wk of start of infusion and need is demonstrated by documentation that attempts on an annual basis to titrate the dose or interval of therapy result in worsening of symptoms. To reduce the risk of GVHD, associated with interstitial pneumonia (infectious or idiopathic) and infections (CMV infections, Varicella-zoster virus infection, and recurrent bacterial infection) in allogeneic BMT recipients in the first 100 days after transplantation.
Age Restrictions	N/A

PA Criteria	Criteria Details
Prescriber Restrictions	N/A
Coverage Duration	End of plan year

PA Criteria	Criteria Details
Other Criteria	NP IG may be approved if: trial /inadequate response/ intol to ONE PF IG agent (Gammunex, Gammunex-C, Octagam) OR PF Ig is not FDA/Off-label approved or due to concomitant clinical condition(s), such as but not limited to: Renal insuff/impairmt or Non-O blood type or Severe IgA deficiency or DM/pre-DM or CVD or Hyper-prolinemia or Hypernatremia or high risk for thrombosis, such as but not limited to: a) hyperviscosity syn (such as cryoglobulinemia, monoclonal gammopathies, polyclonal hyperglobulinemia) OR b) hypercoagulable conditions or documented hypersensitivity, as manifested by severe systemic/allergic or anaphylactic rxn, to any ingred not also present in requested NP agent or other known dz state or med CI which is not also assoc with requested NP agent OR if SQ Ig only dose forms (Hizentra, Hyqvia) are designated as NP, may be approved for pts req for any of the following: difficult vein access that precludes use of any IVIG or hx of serious systemic rxn to IVIG expected to be avoided by using SCIG or hx of inconsistent serum levels of IgG with IVIG. Dermatomyositis, refractory (IVIG used as 2nd line tx of dermatomyositis. Steroids first-line tx of dermatomyositis.). MG, severe refractory. Polymyositis, routine use of IG is not recommended. IG may be considered in pts with severe polymyositis for whom other tx was unsuccessful, is intolerable or has CI. Stiff-person syn not controlled by other therapies. TSS caused by staph or strep organisms refractory to several hrs of aggressive therapy. Tx of chronic parvovirus B19 infection and severe anemia assoc with bone marrow suppression. Refractory auto-immune mucocutaneous blistering diseases including: pemphigus vulgaris, pemphigus foliaceus, bullous pemphigoid, mucous membrane pemphigoid, epidermolysis bullosa acquisita. Tx of PI when: hx of recurrent sinopulmonary infection req antibiotic tx AND lack of, or inadequate response to immunization AND no evidence of renal (nephrotic syn) and GI (eg, protein losing enteropathy) as causes of HGG AND initial pre-tx total serum IgG is BLL of age adj lab ref range or more than 2 SD below adj mean. Tx of other PI when: no evidence of renal/GI causes of HGG AND initial pre-tx total serum IgG is more than 2 SD below adj mean. Tx of IgG sub-class deficiency (IgG1-4) when: One or more serum IgG subclasses are BLL of age adj lab ref range or more than 2 SD below age adj mean AND hx of recurrent sinopulmonary infect requiring abx therapy AND Lack of/inadequate response to immunization. Tx of Kawasaki Syn when: within 10 days of onset and tx for no more than 5 days. For ITP when: symptomatic thrombocytopenia or platelet count less than 20k (adult) or 30k (child). For hypogammaglobulinemia and recurrent bacterial infect assoc with B-cell chronic lymphocytic leukemia that includes both: Documented hx of recurrent bacterial infect or active infect not responding to antimicrobial therapy AND Documentation that total IgG is less than 500mg/dL.

NUPLAZID

Products Affected

- NUPLAZID

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of Plan Year
Other Criteria	Individual has a diagnosis of Parkinsonâ€™s disease AND Symptoms of psychosis developed after the PD diagnosis AND Symptoms of psychosis include at least one of the following, with symptoms being present for at least one month: (1) Visual hallucinations, (2) Auditory hallucination OR (3) Delusions. Psychiatric symptoms cannot be attributed to disorders such as schizophrenia, schizoaffective disorder, delusional disorder, or mood disorder with psychotic features, or a general medical condition including delirium.

ODOMZO

Products Affected

- ODOMZO

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

OFEV

Products Affected

- OFEV

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Using in combination with Esbriet (pirfenidone). Individuals with severe hepatic impairment (child pugh class C) or end-stage liver disease.
Required Medical Information	Diagnosis of idiopathic pulmonary fibrosis (IPF) is confirmed by: Exclusion of other known causes of interstitial lung disease (ILD) such as domestic and occupational environmental exposures, connective tissue disease, and drug toxicity AND High resolution computed tomography (HRCT) with or without surgical lung biopsy. Individual has documented pulmonary function tests within prior 60 days with a Forced Vital Capacity (% FVC) greater than or equal to 50%.
Age Restrictions	18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	N/A

OLYSIO

Products Affected

- OLYSIO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Using in combination with another serine protease inhibitor [such as but not limited to, paritaprevir, or asunaprevir].
Required Medical Information	Documentation is provided for a dx of Hepatitis C Virus (CHC) infection, which includes genotype and a persistent positive HCV RNA test result for at least 6 months following positive baseline result (AASLD/IDSA 2015). Copy of baseline quantitative HCV RNA test results is provided to document baseline level of viremia. Individual does not have a short life expectancy (less than 12 months owing to non-liver related comorbid conditions) that cannot be remediated by treating HCV, by transplantation or other directed therapy (AASLD/IDSA 2015).
Age Restrictions	Individual is 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Criteria will be applied consistent with current AASLD/IDSA guidance.
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance. Individual has had a trial of Harvoni.

ONFI

Products Affected

- ONFI ORAL SUSPENSION
- ONFI ORAL TABLET 10 MG, 20 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis (all ages) and if over 65 years of age or older, the physician has indicated the requested high risk medication (HRM) is not causing adverse effects OR Individual has a contraindication or has a clinical reason not to use safer alternatives (prescriber acknowledgement that medication benefits outweigh potential risks is sufficient).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	N/A

OPDIVO

Products Affected

- OPDIVO INTRAVENOUS SOLUTION 40 MG/4 ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Current ECOG performance status 0-2. For advanced or metastatic renal cell carcinoma (RCC), histologic confirmation of RCC with clear-cell component.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	For unresectable or metastatic melanoma: Opdivo is used as a single agent or in combination with Yervoy, as first-line therapy for untreated melanoma OR used as a single agent or in combination with Yervoy, as second-line or subsequent therapy for documented disease progression while receiving or since completing most recent therapy if PD-1 (programed death receptor -1) agent not previously used. For metastatic non-small cell lung cancer (NSCLC): Opdivo is used as a single agent AND demonstrated disease progression on or after platinum-containing chemotherapy. For RCC: used as a single AND demonstrated progression after 1 or 2 prior anti-angiogenic regimens (for example, axitinib, bevacizumb, pazopanib, sorafenib, sunitinib, etc) for the treatment of advanced or metastatic disease.

ORENCIA

Products Affected

- ORENCIA
- ORENCIA (WITH MALTOSE)

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Using abatacept in combination with TNF antagonists or other biologic RA therapy, such as anakinra. Tuberculosis, invasive fungal infection, other active serious infections or a history of recurrent infections. Individual has not had a tuberculin skin test (TST) or Centers for Disease Control (CDC)-recommended equivalent to evaluate for latent tuberculosis
Required Medical Information	N/A
Age Restrictions	For RA, Patient is 18 years of age or older. For JIA, Patient is 6 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	For RA, Orencia is being used to reduce signs and symptoms, induce major clinical response, inhibit the progression of structural damage, and improve physical function AND Individual has had an inadequate response to ONE non-biologic or biologic DMARD AND has tried and failed Humira OR Enbrel in the previous 180 days. For JIA, agent is being used to reduce signs and symptoms AND Individual has had an inadequate response to ONE non-biologic or biologic DMARD AND has tried and failed Humira OR Enbrel in the previous 180 days.

ORKAMBI

Products Affected

- ORKAMBI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Mutation testing indicates individual has two copies of the F508del mutation AND a copy of the CF mutation analysis test result must be provided.
Age Restrictions	Individual is 12 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	N/A

PEGYLATED INTERFERONS

Products Affected

- PEGASYS
- PEGASYS PROCLICK
- PEGINTRON
- PEGINTRON REDIPEN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For Genotype 2, 3, 4, 5, or 6, Triple therapy (IFN plus RBV plus NS5B Protease Inhibitor), individual has detectable HCV RNA. For Genotype 2, 3, 5, or 6, Dual Therapy (IFN plus RBV), individual has detectable HCV RNA and has a creatinine clearance below 30mL/min and kidney transplantation is not able to be performed.
Age Restrictions	For use in combination with a protease/polymerase inhibitor and ribavirin (triple therapy) , age 18 or older.
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	N/A

PENLAC

Products Affected

- *ciclopirox topical solution*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Individual has a confirmed fungal infection by physical exam
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	Individual has had a trial of, or is contraindicated to oral itraconazole and terbinafine OR individual has used the requested product within the previous 6 months.

POMALYST

Products Affected

- POMALYST ORAL CAPSULE 1 MG, 2 MG, 3 MG, 4 MG

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

PRALUENT

Products Affected

- PRALUENT PEN
- PRALUENT SYRINGE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrent use with Juxtapid or Kynamro.
Required Medical Information	Individual is at High Risk for Acute Coronary Syndrome (ACS) as identified by one of the following: (A) Heterozygous Familial Hypercholesterolemia (HeFH) with provided documentation confirming: 1.Presence of a mutation in LDLR, apolipoprotein B (ApoB), PCSK9 or ARH adaptor protein gene (LDLRAP1) gene OR 2. World Health Organization (WHO)/Dutch Lipid Network Criteria with score of gtr than 8 points OR (B) History of Clinical Atherosclerotic Cardiovascular Disease (ASCVD), including one of the following (documentation must be provided): 1.Acute coronary syndromes 2.History of myocardial infarction (MI) 3.Stable or unstable angina 4.Coronary or other arterial revascularization 5.Stroke 6.Transient ischemic attack (TIA) 7.Peripheral arterial disease presumed to be of atherosclerotic origin.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Initial 3 month. Continuation End of plan year

PA Criteria	Criteria Details
Other Criteria	For initial request, individual meets one of the following: (A) Individual is a on high intensity statin therapy, or statin therapy at the maximum tolerated dose, where high intensity statin is defined as atorvastatin 40 mg or higher OR rosuvastatin 20 mg or higher (documentation must be provided) OR (B) Individual is statin intolerant OR (C) Individual has a condition that is a contraindication for statin therapy including active liver disease, unexplained persistent elevation of serum transaminases, or pregnancy, which does not exist for the requested PCS-K9 agent (documentation must be provided). Individual also has had an adequate trial and titration of a Repatha (evolocumab) unless individual has one of the following: (a) Individual has achieved suboptimal lipid lowering response despite at least 90 days of Repatha therapy OR (b) The preferred agent (Repatha) is not acceptable due to concomitant clinical situations, such as but not limited to a known disease state or medication contraindication which is not also associated with the requested non-preferred agent (Praluent). For continuation, criteria outlined for initial Prior Authorization has been satisfied AND Documentation of LDL reduction has been provided.

PROLIA

Products Affected

- PROLIA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Bone Mineral Density (BMD) must be provided with all requests. Osteoporosis is defined as a BMD T-Score of less than or equal to -2.5. For osteoporosis treatment, risk factors for osteoporotic fracture is defined as: Hypogonadism or premature ovarian failure, Low body mass, Smoking, Rheumatoid arthritis, Alcohol intake of 3 or more drinks/day, Vitamin D deficiency, Low calcium intake, Hyperkyphosis, Parental hip fracture, Multiple falls, Medication: Anticoagulants, anticonvulsants, cancer chemotherapeutic drugs, gonadotropin-releasing hormone agonists, (glucocorticoid daily dosage equivalent to 5 mg or greater of prednisone for at least 3 months). For the treatment of bone loss, risk factors for osteoporotic fracture is defined as: Low body mass, Smoking, Rheumatoid arthritis, Alcohol intake of 3 or more drinks/day, Vitamin D deficiency, Low calcium intake, Hyperkyphosis, Parental hip fracture, Multiple falls, Medication: Anticoagulants, anticonvulsants, (glucocorticoid daily dosage equivalent to 5 mg or greater of prednisone for at least 3 months).
Age Restrictions	For Osteoporosis 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	For osteoporosis treatment, member has had at least ONE osteoporotic (minimal trauma) fracture OR has two or more risk factors for osteoporotic fracture OR Individual has failed or is intolerant to other available osteoporosis therapies (such as, bisphosphonates). For treatment of bone loss, member has had at least ONE osteoporotic (minimal trauma) fracture OR has one or more risk factors for osteoporotic fracture.

PROMACTA

Products Affected

- PROMACTA ORAL TABLET 12.5 MG, 25 MG, 50 MG, 75 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Using Promacta to normalize platelet counts. Use in individuals with ITP whose degree of thrombocytopenia and clinical condition do not increase the risk of bleeding. Use in individuals with chronic hepatitis C whose degree of thrombocytopenia does not prevent the initiation of interferon therapy or limits the ability to maintain an optimal interferon-based therapy. Use in individuals with thrombocytopenia in myelodysplastic syndrome. Used concomitantly with romiplostim (Nplate). Used in individuals taking in combination with direct-acting antiviral agents used without interferon for treatment of chronic hepatitis C infection.
Required Medical Information	N/A
Age Restrictions	For dx chronic immune (idiopathic) thrombocytopenic purpura (ITP), 1 years of age or older. For all other indications age 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	For diagnosis of chronic hepatitis C-associated thrombocytopenia, member will be initiated and maintained on an interferon-based regimen. For dx of chronic immune (idiopathic) thrombocytopenia purpura (ITP), member has had an insufficient response to one of the following interventions: a) corticosteroids or b) immunoglobulins or c) splenectomy. For dx of severe aplastic anemia, member has had an insufficient response to immunosuppressive therapy.

PROTOPIC

Products Affected

- *tacrolimus topical*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	For Protopic (tacrolimus) 0.03 percent, individual is 2 years of age and older. For Protopic (tacrolimus) 0.1 percent, individual is 16 years of age and older
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	Individual had a trial of and inadequate response or intolerance to one topical prescription strength corticosteroid.

PURIXAN

Products Affected

- PURIXAN

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

QUININE

Products Affected

- *quinine sulfate*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Treatment or prevention for nocturnal recumbancy leg muscle cramps or related conditions such as but not limited to: Leg cramps, muscle Cramps, myoclonus, Periodic Movements of Sleep, Periodic Limb Movements of Sleep (PLMS), Restless Leg Syndrome (RLS), severe hepatic impairment (Child-Pugh C), known prolongation of the QT interval, Individuals with glucose-6-phosphate dehydrogenase (G6PD) deficiency, Individuals with myasthenia gravis, or Individuals with optic neuritis.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	Individual has been diagnosed with uncomplicated malaria caused by one of the following: Plasmodium falciparum known or suspected to be resistant to chloroquine (CDC 2013) OR chloroquine-resistant Plasmodium vivax (CDC 2013) OR an unidentified plasmodial species known or suspected to be resistant to chloroquine (CDC 2013).

RAVICTI

Products Affected

- RAVICTI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Using for the management of acute hyperammonemia. Using to treat N-acetylglutamate synthase deficiency (NAGS).
Required Medical Information	N/A
Age Restrictions	2 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	N/A

REBIF

Products Affected

- REBIF (WITH ALBUMIN)
- REBIF REBIDOSE
- REBIF TITRATION PACK

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Members with primary progressive MS. Members with secondary progressive MS without relapsing disease. Treatment of MS with IFN beta-1a (for example, Avonex, Rebif, Plegridy) or IFN beta-1b (for example Betaseron, Extavia) in combination with glatiramer acetate (Copaxone) or in combination with natalizumab (Tysabri).
Required Medical Information	Members with a single demyelinating episode with consistent MRI findings, considered at high risk for clinically definite MS OR Member with MS with relapsing or remitting disease (RRMS) OR Members with secondary progressive MS (SPMS) with a history of superimposed relapses.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	N/A

RELISTOR

Products Affected

- RELISTOR SUBCUTANEOUS SOLUTION

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Individual has a known or suspected mechanical gastrointestinal obstruction.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	Individual must have a previous trial of or insufficient response to polyethylene glycol (generic MiraLax) (AGA 2013).

REMICADE

Products Affected

- REMICADE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Tuberculosis, invasive fungal infection, other active serious infections or a history of recurrent infection. Individuals who have not had a tuberculin skin test or CDC-recommended equivalent to evaluate for latent tuberculosis prior to initiating infliximab. Using Remicade in combination with other TNF antagonists, abatacept, anakinra, tofacitinib or tocilizumab
Required Medical Information	For chronic moderate to severe plaque psoriasis: Greater than 5% of body surface area with plaque psoriasis OR Less than or equal to 5% body surface area with plaque psoriasis involving sensitive areas or areas that would significantly impact daily function (such as palms, soles of feet, head/neck, or genitalia).
Age Restrictions	For Crohn's Disease or Ulcerative colitis, 6 yr of age or older.For all other indications 18 yr of age.
Prescriber Restrictions	N/A
Coverage Duration	End of plan year

PA Criteria	Criteria Details
Other Criteria	For RA, agent is being used to reduce signs/symptoms OR induce/maintain clinical response OR inhibit the progression of structural damage OR improve physical function AND Infliximab is given in combination with methotrexate or with another immunosuppressive agent if the individual is intolerant to methotrexate AND individual has failed to respond to, is intolerant of, or has a medical contraindication to ONE nonbiologic DMARD. For Crohn's Disease, individual has failed to respond to, is intolerant of, or has a medical contraindication to ONE conventional therapy (such as 5-ASA products, sulfasalazine, systemic corticosteroids, or immunosuppressive drugs) and infliximab is being used to reduce signs/symptoms OR induce/maintain clinical remission OR individual has fistulizing Crohn's disease with draining enterocutaneous or rectovaginal fistulas, of at least 3 months duration OR individual has fistulizing or moderately to severely active Crohn's disease and has responded to previous therapy with infliximab. For moderately to severely active Ulcerative Colitis, agent is being used to reduce signs/symptoms OR induce/maintain clinical remission and mucosal healing AND individual has failed to respond to, is intolerant of, or has a medical contraindication to ONE conventional therapy (such as 5-ASA products, sulfasalazine, systemic corticosteroids, or immunosuppressive drugs). For Ankylosing Spondylitis individual has failed to respond to, is intolerant of, or has a medical contraindication to ONE conventional therapy (such as NSAIDs, or nonbiologic DMARDs). For Psoriatic Arthritis, agent is being used to reduce signs/symptoms OR induce/maintain clinical response OR inhibit the progression of structural damage OR improve physical function AND individual has failed to respond to, is intolerant of, or has a medical contraindication to ONE nonbiologic DMARD. For chronic plaque psoriasis, agent is being used to reduce signs/symptoms OR induce/maintain clinical response AND individual has failed to respond to, is intolerant of, or has a medical contraindication to phototherapy or ONE other systemic therapy (such as methotrexate, acetretin, or cyclosporine). For Refractory Wegener's Granulomatosis, individual is using in combination with ONE corticosteroid. For JIA, agent is being used to reduce signs/symptoms OR induce/maintain clinical response AND individual has failed to respond to, is intolerant of, or has a medical contraindication to ONE nonbiologic DMARD. For chronic, recurrent, treatment-refractory or vision-threatening, non-infectious uveitis, individual has failed to respond to, is intolerant of, or has a medical contraindication to ONE conventional therapy (such as corticosteroids or immunosuppressive drugs [for example, azathioprine, cyclosporine, or methotrexate]).

REPATHA

Products Affected

- REPATHA SURECLICK
- REPATHA SYRINGE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrent use with Juxtapid or Kynamro.
Required Medical Information	Individual is at High Risk for Acute Coronary Syndrome (ACS) as identified by one of the following: A. Homozygous Familial Hypercholesterolemia (HoFH) with provided documentation confirming: 1.Presence of two (2) mutant alleles at the LDLR, apoB, PCSK9 or ARH adaptor gene locus OR 2.untreated LDL-C concentration greater than 500 mg/dL (13 mmol/L) or treated LDL-C greater than or equal to 300 mg/dL (7.76 mmol/L) AND one of the following: i.Cutaneous or tendonous xanthoma before age of 10 years OR ii.Untreated LDL-C levels consistent with heterozygous familial hypercholesterolemia in both parents (greater than190 mg/dL) OR B. Heterozygous Familial Hypercholesterolemia (HeFH) with provided documentation confirming: 1.Presence of a mutation in LDLR, apolipoprotein B (ApoB), PCSK9 or ARH adaptor protein gene (LDLRAP1) gene OR 2. World Health Organization (WHO)/Dutch Lipid Network Criteria with score of gtr than 8 points OR C. History of Clinical Atherosclerotic Cardiovascular Disease (ASCVD), including one of the following (documentation must be provided): 1.Acute coronary syndromes 2.History of myocardial infarction (MI) 3.Stable or unstable angina 4.Coronary or other arterial revascularization 5.Stroke 6.Transient ischemic attack (TIA) 7.Peripheral arterial disease presumed to be of atherosclerotic origin.
Age Restrictions	For Dx HeFH, 18 years of age or older. For Dx HoFH, 13 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Initial 3 month. Continuation End of plan year

PA Criteria	Criteria Details
Other Criteria	For initial HoFH request, individual meets the following: (A) Individual is a on high intensity statin therapy, or statin therapy at the maximum tolerated dose, where high intensity statin is defined as atorvastatin 40 mg or higher OR rosuvastatin 20 mg or higher (documentation must be provided) OR (B) Individual is statin intolerant OR (C) Individual has a condition that is a contraindication for statin therapy including active liver disease, unexplained persistent elevation of serum transaminases, or pregnancy, which does not exist for the requested PCS-K9 agent (documentation must be provided) AND Individual is on ezetimibe (applies to individuals on statin therapy only) with documentation. For initial HeFH or ASCVD requests, individual meets the following: (A) Individual is a on high intensity statin therapy, or statin therapy at the maximum tolerated dose, where high intensity statin is defined as atorvastatin 40 mg or higher OR rosuvastatin 20 mg or higher (documentation must be provided) OR (B) Individual is statin intolerant OR (C) Individual has a condition that is a contraindication for statin therapy including active liver disease, unexplained persistent elevation of serum transaminases, or pregnancy, which does not exist for the requested PCS-K9 agent (documentation must be provided). For continuation, criteria outlined for initial Prior Authorization has been satisfied AND Documentation of LDL reduction has been provided.

REVATIO

Products Affected

- *sildenafil oral*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Use in combination with phosphodiesterase-5 (PDE5) inhibitors [such as but not limited to, Viagra (sildenafil)]. Use in combination with organic nitrates, such as but not limited to, isosoribide mono/dinitrate or nitroglycerin. Use in combination with guanylate cyclase stimulators [such as but not limited to, Adempas (riociguat)]. Use in individuals requesting for the treatment of erectile dysfunction. Use in individuals with severe hepatic impairment (Child-Pugh Class C). Use in individual has a diagnosis of pulmonary veno-occlusive disease (PVOD). Use in individual has a known hereditary degenerative retinal disorder (such as but not limited to, retinitis pigmentosa).
Required Medical Information	Catheterization-proven diagnosis of Pulmonary Arterial Hypertension (PAH) World Health Organization (WHO Group I) and WHO Functional Class II-IV symptoms.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	For Sildenafil INJ, individual is temporarily unable to take oral dose forms and requires continued therapy.

REXULTI

Products Affected

- REXULTI ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	N/A

RYDAPT

Products Affected

- RYDAPT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Individual has been treated previously for acute myeloid leukemia (AML).
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of plan year

SANDOSTATIN IR

Products Affected

- *octreotide acetate injection solution*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	Individual has (A) diagnosis of carcinoid tumors for any of the following: Metastatic carcinoid tumors OR Carcinoid syndrome to suppress or inhibit severe diarrhea and flushing episodes associated with the disease OR Prophylactic administration prior to biopsy in an individual with a suspected functioning carcinoid tumor OR Prophylactic administration prior to induction of anesthesia in an individual with a functional carcinoid tumor OR Prophylactic administration to a surgical procedure in an individual with a functional carcinoid tumor. OR (B) Diagnosis of Bleeding gastroesophageal varices when GE varices are associated with liver disease AND octreotide acetate is used in combination with endoscopic therapy or alone if endoscopic therapy is not available. OR (C) Chemotherapy or radiation-induced diarrhea that is unresponsive to conventional antidiarrheal medications (for example, diphenoxylate and atropine or loperamide) OR (D) Malignant bowel obstruction to manage GI symptoms (such as nausea, vomiting or pain).

SIMPONI

Products Affected

- SIMPONI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Use of golimumab in combination with other TNF antagonists, abatacept, tofacitinib or anakinra. Tuberculosis, invasive fungal infections, other active serious infections, or a history of recurrent infections. Individuals who have not had a TST or a CDC-recommended equivalent to evaluate for latent tuberculosis prior to initiating Simponi (golimumab).
Required Medical Information	N/A
Age Restrictions	Patient is 18 years or older
Prescriber Restrictions	N/A
Coverage Duration	End of plan year

PA Criteria	Criteria Details
Other Criteria	For RA, agent is being used to reduce signs/symptoms OR induce/maintain clinical response OR improve physical function AND individual is taking in combination with methotrexate OR with another immunosuppressive agent if the individual is intoleratant to methotrexate AND individual has failed to respond to, is intolerant of, or has a medical contraindication to ONE nonbiologic DMARD AND member has tried and failed BOTH: Humira AND Enbrel in the previous 180 days. For Psoriatic Arthritis, agent is being used to reduce signs/symptoms OR induce/maintain clinical response OR improve physical function AND individual has failed to respond to, is intolerant of, or has a medical contraindication to ONE conventional therapy (such as non-biologic DMARDs) AND individual has tried and failed BOTH: Humira AND Enbrel in the previous 180 days. For Ankylosing Spondylitis, agent is being used to reduce signs/symptoms AND member has failed to respond to, is intolerant of, or has a medical contraindication to ONE conventional therapy (e.g. NSAIDs or nonbiologic DMARDs) AND member has tried and failed BOTH: Humira AND Enbrel in the previous 180 days. For UC agent is being used to reduce signs/symptoms OR induce/maintain clinical remission and mucosal healing AND individual has failed to respond to, is intolerant of, or has a medical contraindication to ONE conventional therapy (such as 6-mercaptopurine, azathioprine, oral aminosalicylates, or oral corticosteroids) OR demonstrated dependence on corticosteroids AND individual has tried and failed Humira in the previous 180 days.

SIRTURO

Products Affected

- SIRTURO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Latent infection due to Mycobacterium tuberculosis OR Drug-sensitive tuberculosis OR Extra-pulmonary tuberculosis OR Infections caused by non-tuberculosis mycobacteria.
Required Medical Information	N/A
Age Restrictions	Individual is 18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	Individual has a diagnosis of pulmonary multi-drug resistant tuberculosis AND is unable to use an effective regimen for treatment AND the individual is using Sirturo (bedaquiline) with at least 3 drugs to which the multi-drug resistant tuberculosis isolate is susceptible in vitro OR with at least 4 drugs to which the multi-drug resistant tuberculosis isolate is likely to be susceptible if in vitro testing results are unavailable.

SOLARAZE

Products Affected

- *diclofenac sodium topical gel 3 %*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Dx of Actinic Keratosis
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	N/A

SOMAVERT

Products Affected

- SOMAVERT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Dx of acromegaly AND member has had an inadequate response to surgery or radiation OR mbr is unable to tolerate or is resistant to other therapies or are not appropriate therapies for the member.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	N/A

SOVALDI

Products Affected

- SOVALDI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Individual has severe renal impairment (CrCl less than 30 mL/min), end stage renal disease, or requires dialysis (AASLD/IDSA 2014). Individual is using in combination with Daklinza (daclatasvir) and a known NS5A polymorphism is present.
Required Medical Information	Documentation is provided for a diagnosis of chronic hepatitis C (CHC) infection and genotype and a persistent positive HCV RNA test result for at least 6 months following positive baseline result (AASLD/IDSA 2015). Copy of baseline quantitative HCV RNA test results is provided to document baseline level of viremia. Individual does not have a short life expectancy (less than 12 months owing to non-liver related comorbid conditions) that cannot be remediated by treating HCV, by transplantation or other directed therapy (AASLD/IDSA 2015). Dual treatment-experienced refers to individuals who have had a partial response, no response, or prior relapse with a previous dual therapy regimen of peginterferon and ribavirin or sofosbuvir and ribavirin. Triple treatment-experienced refers to individuals who have had a partial response, no response, or prior relapse with a previous triple therapy regimen of peginterferon, ribavirin and a NS3 HCV Protease Inhibitor (such as, Onsolis, Incivek or Victrelis).
Age Restrictions	Individual is 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Criteria will be applied consistent with current AASLD/IDSA guidance.
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance. Individual has had a trial of Harvoni when used in combination with: (1) Olysio (simeprevir) with or without RBV [GT 1a/1b], (2) Daklinza (daclatasvir) [GT 1], or (3) Daklinza (daclatasvir) with (AASLD/IDSA 2015) or without RBV [GT 1].

SPRITAM

Products Affected

- *spritam oral tablet for suspension 1,000 mg, 250 mg, 500 mg, 750 mg*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Individual has a diagnosis of partial onset seizures OR primary generalized tonic-clonic seizures AND weighs more than 20 kg.
Age Restrictions	Partial onset seizures: 4 years old. Juvenile myoclonic epilepsy: 12 years old. Primary generalized tonic-clonic seizures: 6 years old.
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	N/A

STIVARGA

Products Affected

- STIVARGA

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

SUBOXONE

Products Affected

- *buprenorphine-naloxone sublingual tablet 2-0.5 mg, 8-2 mg*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	16 years or older
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	N/A

SUBSYS

Products Affected

- SUBSYS SUBLINGUAL SPRAY,NON-AEROSOL 100 MCG/SPRAY, 200 MCG/SPRAY, 400 MCG/SPRAY, 600 MCG/SPRAY, 800 MCG/SPRAY

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Individual is 18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	Individual has a diagnosis of cancer with breakthrough cancer pain AND has tried and failed fentanyl citrate lozenge (generic Actiq) AND Individual is already receiving opioid therapy and is TOLERANT to opioid therapy as defined as receiving around the clock medicine consisting of one of the following: At least 60mg morphine per day, OR At least 25mcg/hr transdermal fentanyl/hour, OR At least 30mg of oxycodone daily, OR At least 8mg of oral hydromorphone daily, OR At least 25mg of oral oxymorphone daily, OR An equianalgesic dose of another opioid for a week or longer. Individual will also continue around the clock opioids when taking Subsys (fentanyl).

SUBUTEX

Products Affected

- *buprenorphine hcl sublingual tablet 2 mg, 8 mg*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	16 years or older
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	N/A

SYLATRON

Products Affected

- SYLATRON

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Member is being treated for melanoma with microscopic or gross nodal involvement AND Treatment is initiated within 84 days after definitive surgical resection.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	N/A

SYNAGIS

Products Affected

- SYNAGIS INTRAMUSCULAR SOLUTION 50 MG/0.5 ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Administration of more than 5 doses of palivizumab in one RSV season including Florida. Immunoprophylaxis for RSV for children who reach ages 24 months prior to the commencement of the RSV season. Treatment in children or infants with known RSV disease.
Required Medical Information	Immunoprophylaxis for respiratory syncytial virus (RSV) for the prevention of serious lower respiratory tract disease in infants and young children who are at high risk, when the following are met: A. Maximum of Five (5) doses of palivizumab within the RSV season which begins during the first year of life with any of the following clinical presentations: Born before 29 weeks 0 days gestation (up to and including 28 weeks, 6 days) and younger than 12 months of age at the start of the RSV season OR Chronic lung disease (CLD) of prematurity (defined as birth at less than 32 weeks, 0 days gestation and a requirement for greater than 21% oxygen for at least 28 days after birth) OR Hemodynamically significant congenital heart disease (CHD) (for example, but not limited to, infants with acyanotic heart disease who are receiving medication to control congestive heart failure and will require cardiac surgical procedures and infants with moderate to severe pulmonary hypertension OR infants with anatomic pulmonary abnormalities (i.e., tracheal ring) or a neuromuscular condition that impairs the ability to clear secretions from the upper airway because of ineffective cough. B. Maximum of five (5) doses of palivizumab for children younger than 24 months of age with any of the following clinical presentations during the RSV season: Profoundly immunocompromised, such as severe combined immunodeficiency, advanced acquired immunodeficiency syndrome undergoing organ or hematopoietic stem cell transplant, or an absolute lymphocyte count of less than 100 cell/mm3 OR undergoing cardiac transplantation.
Age Restrictions	N/A
Prescriber Restrictions	N/A

PA Criteria	Criteria Details
Coverage Duration	5 months
Other Criteria	C. An additional dose of palivizumab may be allowed for children who undergo cardiopulmonary bypass for surgical procedures. If cardiac or pulmonary hemodynamic support remains unchanged after surgery or if any other medically necessary criteria are present (for example, prematurity). D. A second season of palivizumab prophylaxis may be approved for preterm infants born at less than 32 weeks, 0 days gestation who required at least 28 days of oxygen after birth and who continue to require medical intervention within 6 months of the start of the second RSV season (for example, supplemental oxygen, chronic systemic corticosteroid therapy, diuretics or bronchodilator therapy). E. An infant with cystic fibrosis in the first year of life with clinical evidence of CLD and/or nutritional compromise, defined as weight for length less than tenth percentile. A second season may be considered for children with severe lung disease (history of hospitalization, abnormal chest x-ray or CT scan) or weight for length less than tenth percentile.

SYNAREL NASAL SOLUTION

Products Affected

- SYNAREL

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Precocious puberty, defined as the beginning of secondary sexual maturation characteristics before age 8 in girls and before age 9 in boys.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Endometriosis: 6 months, all other indications: End of plan year
Other Criteria	For gender dysphoria in adolescents: a) Fulfills the DSM V criteria for gender dysphoria, AND b) Has experienced puberty to at least Tanner stage, 2 AND c) Has (early) pubertal changes that have resulted in an increase of their gender dysphoria, AND d) Does not suffer from a psychiatric comorbidity that interferes with the diagnostic work-up or treatment, AND e) Has psychological and social support during treatment, AND f) Demonstrates knowledge and understanding of the expected outcomes of GnRH analog treatment

TAFINLAR

Products Affected

- TAFINLAR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Tafinlar may not be approved for the treatment of individuals with wild type BRAF melanoma.
Required Medical Information	Documentation of BRAF V600E or V600K mutation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	N/A

TAGRISSO

Products Affected

- TAGRISSO ORAL TABLET 40 MG, 80 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	EGFR (epidermal growth factor receptor) T790M mutation is present and documentation is provided.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	N/A

TARGRETIN

Products Affected

- *bexarotene*
- TARGRETIN ORAL
- TARGRETIN TOPICAL

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

TECHNIVIE

Products Affected

- TECHNIVIE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Documentation is provided for a diagnosis of chronic hepatitis C virus (HCV) Genotype 4 and a persistent positive HCV RNA test result for at least 6 months following positive baseline result (AASLD/IDSA 2015) AND A copy of the baseline quantitative HCV RNA test result is provided to document baseline level of viremia.
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Criteria will be applied consistent with current AASLD/IDSA guidance.
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance. Individual has had a trial of Harvoni unless individual has one of the following: (i) Documented hypersensitivity, as manifested by a severe allergic reaction, to any ingredient in Harvoni which is not also in Technivie OR (ii)Severe renal impairment (CrCl less than 30 mL/min) OR (iii) The individual is concurrently taking amiodarone, Aptivus (tipranavir/ritonavir), oxcarbazepine, rifabutin, rifapentine, rosuvastatin, or Stribild (elvitegravir/cobicistat/emtricitabine/tenofovir DF).

TRACLEER

Products Affected

- TRACLEER

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Individual is concomitantly taking cyclosporine A or glyburide. Individual has a diagnosis of moderate (Child-Pugh Class B) or severe (Child-Pugh Class C) hepatic impairment or in the treatment of congestive heart failure with left ventricular dysfunction.
Required Medical Information	Catheterization-proven diagnosis of Pulmonary Arterial Hypertension (WHO Group I), and WHO Functional Class II-IV symptoms.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	N/A

TRANSMUCOSAL FENTANYL CITRATE

Products Affected

- *fentanyl citrate*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	Individual is 16 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	Individual has a diagnosis of cancer with breakthrough cancer pain AND Individual is already receiving opioid therapy and is TOLERANT to opioid therapy as defined as receiving around the clock medicine consisting of one of the following: At least 60mg morphine per day, OR At least 25mcg/hr transdermal fentanyl/hour, OR At least 30mg of oxycodone daily, OR At least 8mg of oral hydromorphone daily, OR At least 25mg of oral oxymorphone daily, OR An equianalgesic dose of another opioid for a week or longer. Individual will also continue around the clock opioids when taking transmucosal fentanyl Citrate.

TYSABRI

Products Affected

- TYSABRI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Using for Types of MS other than relapsing forms. Currently responsive to and tolerating another treatment for MS or CD. Current or prior history of progressive multifocal leukoencephalopathy (PML). Medical condition which significantly compromises the immune system including HIV infection or AIDS, leukemia, lymphoma or organ transplantation. Receiving chronic antineoplastics or immunosuppressants (for example, azathioprine). Receiving any other immune system modifying drugs such as interferon beta-1 (for example, Avonex). Positive test results for anti-John Cunningham virus (JCV) antibodies
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	Individual is using as monotherapy for relapsing forms of multiple sclerosis (MS) who have had an inadequate response to, or are unable to tolerate, alternative treatments for MS. For diagnosis of Crohns disease, individual is enrolled in and met all conditions of the CD or MS Touch Prescribing Program.

UPTRAVI

- UPTRAVI ORAL TABLETS,DOSE PACK

Products Affected

- UPTRAVI ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Individual has a diagnosis of severe hepatic impairment (Child-Pugh Class C) OR individual is on dialysis or a glomerular filtration rate less than 15 mL/min/1.73m2
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	Individual has catheterization-proven diagnosis of pulmonary arterial hypertension (PAH) [World Health Organization (WHO) Group 1) AND individual has WHO functional class II-IV symptoms.

VANCOCIN

Products Affected

- *vancomycin oral capsule 125 mg, 250 mg*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Individual is being treated for Staphylococcal enterocolitis including methicillin-resistant strains. Individual is being treated for clostridium difficile AND individual has had a trial of or intolerance to oral metronidazole for mild to moderate Clostridium difficile infection. OR individual is being treated for a severe or severe, complicated Clostridium difficile infection.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	14 days
Other Criteria	N/A

VECTIBIX

Products Affected

- VECTIBIX INTRAVENOUS SOLUTION 100 MG/5 ML (20 MG/ML)

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Individual has received prior treatment with cetuximab (Erbitux) [Note: a course of cetuximab discontinued because of an adverse reaction is not considered prior treatment] OR Vectibix is used in combination with other anti-VEGF agents (e.g., bevacizumab) OR Vectibix is being used for more than one line (course) of therapy.
Required Medical Information	KRAS gene mutation testing is documented and the tumor is determined to be KRAS wild-type.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	Used as a single agent or as part of combination therapy for stage IV colon, rectal, colorectal, small bowel or anal adenocarcinoma.

VENCLEXTA

Products Affected

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

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

VENTAVIS

Products Affected

- VENTAVIS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnostic Criteria for PAH: right heart catheterization which shows a mean pulmonary artery pressure (mPAP) greater than or equal to 25mmhg, a pulmonary capillary wedge pressure (PCWP), left atrial pressure or left ventricular end diastolic pressure (LVEDP) less than or equal to 15mmhg AND a pulmonary vascular resistance (PVR) greater than 3 wood units. Criteria for Vasodilator Response: a favorable response is defined as a fall in mPAP of at least 10mmhg to an absolute mPAP of less than 40mmhg without a decrease in cardiac output, when challenged with inhaled nitric oxide, intravenous epoprostenol or intravenous adenosine.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	For Ventavis , patient must meet all of the following: meets diagnostic criteria for PAH AND demonstrates an unfavorable acute response to vasodilators AND meets one of the following patient selection criteria with New York Heart Association (NYHA) functional class III, or IV symptoms: World health Organization (WHO) Group I idiopathic pulmonary arterial hypertension including all subtypes of WHO Group I PAH or Pulmonary hypertension associated with connective tissue disorders (scleroderma, systemic sclerosis, etc.) or pulmonary hypertension associated with congenital heart defects.

VFEND

Products Affected

- *voriconazole oral suspension for reconstitution*
- *voriconazole oral tablet 200 mg, 50 mg*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Transitioning from inpatient treatment with IV antifungal to an outpatient setting.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	For Disseminated (deep tissue) Candida infections in the skin, abdomen, kidney, bladder wall or wounds, Individual has had an inadequate response or has contraindication to one or more antifungal agents.

VIEKIRA

Products Affected

- VIEKIRA PAK

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Individual is requesting in concurrent therapy with alfuzosin, carbamazepine, phenytoin, phenobarbital, gemfibrozil, rifampin, ergot derivatives, ethinyl estradiol-containing agents, St. Johns Wort, lovastatin, simvastatin, pimozide, efavirenz, Revatio (sildenafil), triazolam, and oral midazolam. Individual is using in combination with another NS3/4A protease inhibitor [such as but not limited to Olysio (simeprevir). Individual is using in combination with another non-nucleoside NS5B polymerase inhibitor. Individual is using in combination with another NS5A inhibitor (such as but not limited to, Harvoni [ledipasvir/sofosbuvir]. Individual is requesting the regimen for re-treatment and either failed to achieve a SVR (defined as a lower limit HCV RNA of 25 IU/mL) or relapsed after achieving a SVR during a prior successfully completed treatment regimen consisting of a serine NS3/4A protease inhibitor [such as but not limited to, Olysio (simeprevir), or paritaprevir] (AASLD/IDSA 2014). Individual is requesting the regimen for re-treatment and either failed to achieve a SVR (defined as a lower limit HCV RNA of 25 IU/mL) or relapsed after achieving a SVR during a prior successfully completed treatment regimen consisting of ombitasvir. Individual is requesting the regimen for re-treatment and either failed to achieve a SVR (defined as a lower limit HCV RNA of 25 IU/mL) or relapsed after achieving a SVR during a prior successfully completed treatment regimen consisting of a non-nucleoside NS5B polymerase inhibitor, such as dasabuvir or a regimen containing a nucleotide NS5B polymerase inhibitor, such as Sovaldi or Harvoni (AASLD/IDSA 2014).
Required Medical Information	Documentation is provided for a diagnosis of chronic Hepatitis C virus (HCV) Genotype 1 and a persistent positive HCV RNA test result for at least 6 months following positive baseline result (AASLD/IDSA 2015). Copy of the baseline quantitative HCV RNA test result is provided to document baseline level of viremia. Individual does not have a short life expectancy (less than 12 months owing to non-liver related comorbid conditions) that cannot be remediated by treating HCV, by transplantation or other directed therapy (AASLD/IDSA 2015).
Age Restrictions	18 years of age or older

PA Criteria	Criteria Details
Prescriber Restrictions	N/A
Coverage Duration	Criteria will be applied consistent with current AASLD/IDSA guidance.
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance.

VIRAZOLE

Products Affected

- VIRAZOLE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	Individual is hospitalized and will receive treatment in an inpatient setting.

VOSEVI

Products Affected

- VOSEVI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Individual has severe renal impairment (eGFR less than 30 mL/min/1.73m2), end stage renal disease, or requires dialysis OR Individual has moderate or severe hepatic impairment (Child-Pugh B or C).
Required Medical Information	Copy of the baseline quantitative HCV RNA test result is provided to document baseline level of viremia AND One of the following: (1) Documentation is provided for a diagnosis of chronic hepatitis C (CHC) infection, which includes a positive HCV RNA test result at least 6 months following either a baseline positive HCV RNA result or reactive HCV antibody test (AASLD/IDSA 2016, CDC 2013) or (2) Individual is unable to delay treatment for 6 months owing to concurrent factors [such as but not limited to, advanced liver disease (Metavir fibrosis stage of F3 or F4), post-liver transplant recipients, co-infection with human immunodeficiency disease virus (HIV) or hepatitis B virus (HBV), coexistent liver diseases (such as nonalcoholic steatohepatitis), chronic HCV infection-associated extrahepatic manifestations (such as membranoproliferative glomerulonephritis, glomerular disease, cryoglobulinemia syndrome)] (AASLD/IDSA 2016). AND Documentation is provided for a diagnosis of chronic CHC infection, which includes a reactive HCV antibody (CDC 2013) and a subsequent positive HCV RNA result (CDC 2013). Individual does not have a short life expectancy (less than 12 months owing to non-liver related comorbid conditions) that cannot be remediated by treating HCV, by transplantation or other directed therapy (AASLD/IDSA 2016). Individual has compensated liver disease (with or without cirrhosis).
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Criteria will be applied consistent with current AASLD/IDSA guidance.

Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance. For Genotype 1, 1a Individual has had a trial of and inadequate response to Harvoni OR Individual is currently on and completing a course of therapy with Vosevi OR has one of the following: (1) Documented hypersensitivity, as manifested by a severe allergic reaction to any ingredient in Harvoni which is not also in Vosevi OR (2) concurrently using an agent that cannot be substituted with another agent or temporarily discontinued and is contraindicated or not recommended for concomitant use with the preferred regimen or regimens OR (3) Individual failed to achieve a sustained viral response (SVR) or relapsed after achieving a SVR during a prior successfully completed Hepatitis C regimen containing an NS5A inhibitor or a Hepatitis C regimen containing sofosbuvir without an NS5A inhibitor. For Genotype 4 Individual has had a trial of and inadequate response to Harvoni or Epclusa OR Individual is currently on and completing a course of therapy with Vosevi OR has one of the following: (1) Documented hypersensitivity, as manifested by a severe allergic reaction to any ingredient in Harvoni or Epclusa which is not also in Vosevi OR (2) concurrently using an agent that cannot be substituted with another agent or temporarily discontinued and is contraindicated or not recommended for concomitant use with the preferred regimen or regimens OR (3) Individual failed to achieve a sustained viral response (SVR) or relapsed after achieving a SVR during a prior successfully completed Hepatitis C regimen containing an NS5A inhibitor or a Hepatitis C regimen containing sofosbuvir without an NS5A inhibitor.

VRAYLAR

- *vraylar oral capsule,dose pack*

Products Affected

- VRAYLAR ORAL CAPSULE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	N/A

XALKORI

Products Affected

- XALKORI

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

XENAZINE

- XENAZINE ORAL TABLET 12.5 MG, 25 MG

Products Affected

- *tetrabenazine oral tablet 12.5 mg, 25 mg*

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

XGEVA

Products Affected

- XGEVA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	Skeletally mature adolescent is defined by at least one mature long bone [for example, closed epiphyseal growth plate of the humerus]. Hypercalcemia of malignancy is defined as an albumin corrected serum calcium level greater than 12.5 mg/dL (3.1 mmol/L).

XIFAXAN - HE

Products Affected

- XIFAXAN ORAL TABLET 550 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	End of Plan Year
Other Criteria	For Hepatic Encephalopathy (HE), individual has failed to respond had a trial of or has a contraindication to Lactulose (AASLD, 2014).

XOLAIR

Products Affected

- XOLAIR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Mbr has Moderate Persistent to Severe Persistent Asthma AND has a positive skin test or in vitro reactivity to a perennial aeroallergen, AND Mbr has an FEV1 less than 80% predicted AND Mbr IgE level is equal to or greater than 30 IU/ml. Severe asthma as defined by the National Heart, Lung, and Blood Institute: Severe Persistent Asthma: symptoms throughout the day, extremely limited normal activity. Nocturnal symptoms are frequent, FEV1 or PEF is less than or equal to 60% predicted. Moderate Persistent Asthma as defined by the National Heart, Lung, and Blood Institute: Daily symptoms, daily use of inhaled short-acting beta2-agonist, somewhat limited activity, Nocturnal symptoms occur greater than 1 time per week, FEV1 or PEF is greater than 60% and less then 80% predicted, FEV1 FVC is reduced 5 percent or exacerbations requiring oral systemic corticosteroids use for more than or equal to 2 times per year.
Age Restrictions	Patient is 12 years of age or older for urticaria and 6 years of age or older for moderate to severe persistent asthma
Prescriber Restrictions	N/A
Coverage Duration	End of plan year

PA Criteria	Criteria Details
Other Criteria	For moderate to severe persistent asthma, Mbr symptoms are inadequately controlled after a minimum of 3 months with combination controller therapy (medium to high doses of inhaled corticosteroids plus long acting beta-2 agonists or Leukotriene modifiers), or cannot tolerate these medications. Continued treatment beyond 12 months is allowed when treatment has resulted in clinical improvement as documented by one or more of the following: Decreased utilization of rescue medications OR Decreased frequency of exacerbations (defined as worsening of asthma that requires increase in inhaled corticosteroid dose or treatment with systemic corticosteroids) OR Increase in percent predicted FEV1 from pretreatment baseline OR Reduction in reported asthma-related symptoms, such as, but not limited to, wheezing, shortness of breath, coughing, fatigue, sleep disturbance, or asthmatic symptoms upon awakening. For chronic idiopathic urticaria, individual is refractory to prior treatment of ONE potent antihistamine at maximal FDA approved dosage.

XTANDI

Products Affected

- XTANDI

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

XYREM

Products Affected

- XYREM

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	For dx of Narcolepsy type 1 (narcolepsy with cataplexy) confirmed by the presence of daily periods of irrepressible need to sleep or daytime lapses into sleep occurring for at least 3 months and at least one of the following: (1) Clear cataplexy (defined as more than one episode of generally brief [less than 2 min]) usually bilaterally symmetrical, sudden loss of muscle tone with retained consciousness) AND (2) Multiple Sleep Latency Test (MSLT) showing one of the following: (a) MSLT of less than 8 minutes with evidence of two sleep-onset rapid eye movement periods (SOREMPs) (ICSD-3, 2014) or (b) At least one SOREMP on MSLT and a SOREMP (less than 15 minutes) on the preceding overnight polysomnography (PSG) OR (3) Cerebrospinal fluid hypocretin-1 deficiency (less than 110 pg/mL or less than one-third of the normative values with the same standardized assay).
Age Restrictions	18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	Initial Request 6 months, Renewal is End of plan year.

PA Criteria	Criteria Details
Other Criteria	For dx of Narcolepsy type 2 (narcolepsy without cataplexy) confirmed by the following: (1) Daily periods of irrepressible need to sleep or daytime lapses into sleep occurring for at least 3 months AND (2) MSLT showing one of the following: (a) MSLT of less than 8 minutes with evidence of two SOREMPs (ICSD-3, 2014) or (b) At least one SOREMP on MSLT and a SOREMP (less than 15 minutes) on the preceding overnight PSG AND (3) absence of cataplexy AND (4) Exclusion of alternative causes of excessive daytime sleepiness by history, physical exam and PSG. AND (5) Mbr has had a previous trial of and inadequate response or intolerance to TWO of the following medications: (A) One of the following wakefulness promoting medications: (i) Modafinil or (ii) Nuvigil (armodafinil) AND (B) One of the following stimulants: (i) Methylphenidate (ii) Dextroamphetamine or (iii) Amphetamine/dextroamphetamine salt immediate-release OR (6) Trials of wakefulness promoting agents and stimulant agents are not acceptable due to concomitant clinical situations including but not limited to the following: (1) Cardiovascular disease or (2) Drug interactions. For Renewal of Narcolepsy type I or II, Xyrem (sodium oxybate) use has resulted in a reduction in frequency of cataplexy attacks OR use has resulted in a reduction in excessive daytime sleepiness (EDS) as measured by improvement in Epworth Sleepiness Scale (ESS) measurements or Maintenance of Wakefulness Test (MWT).

ZALTRAP

Products Affected

- ZALTRAP INTRAVENOUS SOLUTION 100 MG/4 ML (25 MG/ML)

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of anal adenocarcinoma or appendiceal adenocarcinoma or small bowel adenocarcinoma or metastatic colorectal cancer AND used in combination with an irinotecan based regimen AND individual is resistant to or has disease progression following treatment with an oxaliplatin containing regimen AND Zaltrap will be used in a single line of therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	N/A

ZAVESCA

Products Affected

- ZAVESCA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	May not be approved for use in conjunction with enzyme replacement therapy (ERT) agents (Cerezyme, Elelyso or Vpriv)
Required Medical Information	Presence of type 1 Gaucher disease is confirmed by either of the following: Glucocerebrosidase activity in the white blood cells or skin fibroblasts less than or equal to 30% of normal activity, OR genotype testing indicating mutation of two alleles of the glucocerebrosidase genome. And patient has clinically significant manifestations of Type 1 gauchers disease including any of the following: skeletal disease (demonstrated by ANY of the following: avascular necrosis, erlenmeyer flask deformity, lytic disease, marrow infiltration, osteopenia, osteosclerosis, pathological fracture, radiological evidence of joint deterioration) OR patient presents with at least 2 of the following: clinically significant hepatomegaly, clinically significant splenomegaly, hgb less than or equal to 11.5 grams per dl for females or 12.5 grams per deciliter for males or 1 gram per deciliter below lower limit for normal for age and sex, platelet counts less than or equal to 120,000 mm3.
Age Restrictions	Patient is 18 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	Enzyme replacement therapy with Cerezyme, ELELYSO or VPRIV is not a therapeutic option for reasons such as allergy, hypersensitivity, poor venous access, etc.

ZEJULA

Products Affected

- ZEJULA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	In the last 8 weeks, the individual has had a complete or partial response to a platinum-based chemotherapy.

ZELBORAF

Products Affected

- ZELBORAF

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	Individuals with wild-type BRAF melanoma.
Required Medical Information	Individual has BRAF mutation and a copy of the BRAF test results must be provided.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	End of plan year
Other Criteria	N/A

ZEPATIER

Products Affected

- ZEPATIER

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	A copy of the baseline quantitative hepatitis C virus (HCV) RNA test result is provided to document baseline level of viremia AND Documentation is provided for a diagnosis of chronic hepatitis C (CHC) infection, which includes genotype and a persistent positive HCV RNA test result for at least 6 months following positive baseline result (AASLD/IDSA 2015). If Genotype 1a subtype is present, a copy of the baseline NS5A resistant-associated polymorphism test result is provided to document existence of a polymorphism at amino acid positions M28, Q30, L31, and/or Y93.
Age Restrictions	18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Criteria will be applied consistent with current AASLD/IDSA guidance.
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance. Individual has had a trial of Harvoni unless individual has one of the following: (i) Documented hypersensitivity, as manifested by a severe allergic reaction, to any ingredient in Harvoni which is not also in Zepatier OR (ii) Severe renal impairment (CrCl less than 30 mL/min) OR (iii) The individual is concurrently taking amiodarone, or rosuvastatin.

ZYDELIG

Products Affected

- ZYDELIG

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

ZYKADIA

Products Affected

- ZYKADIA

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

ZYTIGA

Products Affected

- ZYTIGA

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

ZYVOX

Products Affected

- *linezolid intravenous*
- *linezolid oral suspension for reconstitution*
- *linezolid oral tablet*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Confirmed vancomycin-resistant enterococcus faecium (VRE) infection. Confirmed methicillin-resistant S. aureus (MRSA) infection AND individual has had a trial of or has contraindications to an alternative antibiotic that the organism is susceptible to (depending on manifestation, severity of infection and culture or local sensitivity patterns, examples of alternative antibiotics may include, but are not limited to: vancomycin, TMP-SMX, clindamycin, doxycycline, tetracycline (Based on 2011 IDSA MRSA guideline recommendations)). Individual started treatment with Zyvox in the hospital and requires continued outpatient therapy. Isolates of MRSA have a vancomycin minimum inhibitory concentration (MIC) of greater than 2.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	30 days
Other Criteria	N/A

PART B VERSUS PART D

Products Affected

- ABELCET
- *acetylcysteine*
- *acyclovir sodium intravenous solution*
- *albuterol sulfate inhalation solution for nebulization 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg /3 ml (0.083 %), 5 mg/ml*
- AMBISOME
- AMINOSYN 8.5 %-ELECTROLYTES
- AMINOSYN II 10 %
- AMINOSYN II 7 %
- AMINOSYN II 8.5 %
- AMINOSYN II 8.5 %-ELECTROLYTES
- AMINOSYN-HBC 7%
- AMINOSYN-PF 10 %
- AMINOSYN-PF 7 % (SULFITE-FREE)
- *amiodarone intravenous solution*
- *amphotericin b*
- ASTAGRAF XL
- ATGAM
- *azasan*
- *azathioprine*
- *azathioprine sodium*
- *bleomycin injection recon soln 30 unit*
- BONIVA INTRAVENOUS
- *budesonide inhalation suspension for nebulization 0.25 mg/2 ml, 0.5 mg/2 ml*
- BUSULFEX
- *calcitriol intravenous solution 1 mcg/ml*
- *calcitriol oral capsule*
- CANCIDAS
- CELLCEPT INTRAVENOUS
- *cladribine*
- CLINIMIX 5%/D15W SULFITE FREE
- CLINIMIX 5%/D25W SULFITE-FREE
- CLINIMIX 2.75%/D5W SULFIT FREE
- CLINIMIX 4.25%/D10W SULF FREE
- CLINIMIX 4.25%/D5W SULFIT FREE
- CLINIMIX 4.25%-D20W SULF-FREE
- CLINIMIX 4.25%-D25W SULF-FREE
- CLINIMIX 5%-D20W(SULFITE-FREE)
- CLINIMIX E 2.75%/D10W SUL FREE
- CLINIMIX E 2.75%/D5W SULF FREE
- CLINIMIX E 4.25%/D25W SUL FREE
- CLINIMIX E 4.25%/D5W SULF FREE
- CLINIMIX E 5%/D15W SULFIT FREE
- CLINIMIX E 5%/D20W SULFIT FREE
- CLINIMIX E 5%/D25W SULFIT FREE
- CLINISOL SF 15 %
- *cromolyn inhalation*
- *cyclophosphamide oral capsule*
- *cyclosporine intravenous*
- *cyclosporine modified*
- *cyclosporine oral capsule*
- *cytarabine*
- *cytarabine (pf) injection solution 2 gram/20 ml (100 mg/ml)*
- *dronabinol*
- EMEND ORAL CAPSULE 125 MG, 40 MG, 80 MG
- EMEND ORAL CAPSULE,DOSE PACK
- EMPLICITI
- ENGERIX-B (PF) INTRAMUSCULAR SYRINGE
- ENGERIX-B PEDIATRIC (PF)
- *fluorouracil intravenous solution 2.5 gram/50 ml*
- *ganciclovir sodium*
- *gengraf oral capsule 100 mg, 25 mg*
- *gengraf oral solution*
- HEPARIN (PORCINE) IN 5 % DEX INTRAVENOUS PARENTERAL SOLUTION 25,000 UNIT/250 ML(100 UNIT/ML), 25,000 UNIT/500 ML (50 UNIT/ML)
- *heparin (porcine) injection solution*
- HEPATAMINE 8%
- *intralipid intravenous emulsion 20 %*
- *ipratropium bromide inhalation*
- *ipratropium-albuterol*
- *levalbuterol hcl inhalation solution for nebulization 0.31 mg/3 ml, 0.63 mg/3 ml, 1.25 mg/0.5 ml*
- *levocarnitine (with sugar)*

- MIACALCIN INJECTION
- *mycophenolate mofetil*
- *mycophenolate sodium*
- NEBUPENT
- *nitroglycerin intravenous*
- NULOJIX
- *ondansetron*
- *ondansetron hcl oral tablet 24 mg, 4 mg, 8 mg*
- *pamidronate intravenous solution*
- PROGRAF INTRAVENOUS
- PULMOZYME
- RAPAMUNE ORAL SOLUTION
- RECOMBIVAX HB (PF) INTRAMUSCULAR SUSPENSION 10 MCG/ML, 40 MCG/ML
- RECOMBIVAX HB (PF) INTRAMUSCULAR SYRINGE
- *ringers intravenous*
- SANDIMMUNE ORAL SOLUTION
- SIMULECT INTRAVENOUS RECON SOLN 20 MG
- *sirolimus*
- *tacrolimus oral*
- THYMOGLOBULIN
- *travasol 10 %*
- TROPHAMINE 10 %
- TROPHAMINE 6%
- *vinblastine intravenous solution*
- *vincasar pfs intravenous solution 1 mg/ml*
- *vincristine intravenous solution 1 mg/ml*
- ZORTRESS

Details

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

Index