PA Criteria

Prior Authorization Group	ACITRETIN
Drug Names	ACITRETIN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, Prevention of non-melanoma skin cancers in high risk individuals.
Exclusion Criteria	Severely impaired liver function or kidney function. Chronic abnormally elevated blood lipid values. Concomitant use of methotrexate or tetracycline.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	If the patient is female and able to bear children, female patient and/or guardian signed a Patient Agreement/Informed Consent (e.g., Do Your P.A.R.T) which includes confirmation of 2 negative pregnancy tests.

Prior Authorization Group	ACTEMRA
Drug Names	ACTEMRA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Latent TB screening with either a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB) prior to initiating Actemra (or other biologic). For moderately to severely active rheumatoid arthritis (new starts only): 1) inadequate response to at least a 3-month trial of a self-injectable tumor necrosis factor (TNF) inhibitor (eg, Cimzia, Enbrel, Humira or Simponi) or Xeljanz, OR 2) intolerance or contraindication to a self-injectable TNF inhibitor or Xeljanz, OR 3) history of demyelinating disorder, heart failure, hepatitis B, or autoantibody formation/lupus like syndrome. For active polyarticular juvenile idiopathic arthritis (new starts only): 1) inadequate response to at least a 3-month trial of TNF inhibitor, OR 2) intolerance or contraindication to a TNF inhibitor. For systemic juvenile idiopathic arthritis (new starts only): 1) inadequate response to at least a 2-week trial of corticosteroid monotherapy, OR 2) inadequate response to at least a 3-month trial of methotrexate or leflunomide.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	ACTHAR HP
Drug Names	H.P. ACTHAR
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Receipt of live or live attenuated vaccines in patients receiving immunosuppressive doses of H.P. Acthar Gel, suspected congenital infections in infants, scleroderma, osteoporosis, systemic fungal infection, history of or the presence of a peptic ulcer, ocular herpes simplex, congestive heart failure, recent surgery, uncontrolled hypertension, known hypersensitivity to porcine proteins, primary adrenocortical insufficiency or adrenocortical hyperfunction.
Required Medical Information	For the following diagnoses, patient must have an inadequate response to a trial of parenteral corticosteroids: 1) For rheumatic diseases (e.g., psoriatic arthritis, rheumatoid arthritis, ankylosing spondylitis): H.P. Acthar gel must be used as adjunctive treatment, 2) For nephrotic syndrome: H.P. Acthar gel must be requested for induction of diuresis or for remission of proteinuria, 3) For multiple sclerosis (MS): patient has an acute exacerbation of MS, 4) Collagen diseases (e.g., systemic lupus erythematosus, dermatomyositis, or polymyositis), 5) Dermatologic disorders (e.g., severe erythema multiforme, Stevens-Johnson syndrome), 6) Ophthalmic disorders, acute or chronic (e.g., iritis, keratitis, optic neuritis), 7) Symptomatic sarcoidosis, 8) Serum sickness.
Age Restrictions	For infantile spasms initial request: patient is less than 2 years of age.
Prescriber Restrictions	
Coverage Duration	MS exacerbation: 3 weeks. Serum sickness: 1 month. All other diagnoses: 6 months.
Other Criteria	For infantile spasms: for continuation of therapy, patient must show substantial clinical benefit from therapy.

Prior Authorization Group	ACTIMMUNE
Drug Names	ACTIMMUNE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, mycosis fungoides, Sezary syndrome, atopic dermatitis.
Exclusion Criteria	
Required Medical Information	For chronic granulomatous disease, Actimmune is used for reducing the frequency and severity of serious infections associated with chronic granulomatous disease. For atopic dermatitis, the condition is resistant to conservative treatments (eg, topical medications, phototherapy).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

Prior Authorization Group	ADAGEN
Drug Names	ADAGEN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Severe combined immunodeficiency disease (SCID) is due to adenosine deaminase (ADA) deficiency. Condition failed to respond to bone marrow transplantation or patient is not currently a suitable candidate for bone marrow transplantation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	ADCIRCA
Drug Names	ADCIRCA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient requires nitrate therapy on a regular or intermittent basis.
Required Medical Information	NYHA Functional Class II or III symptoms. PAH (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	ADEMPAS
Drug Names	ADEMPAS
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient is taking a nitrate or nitric oxide donor medication (eg, amyl nitrite) on a regular or intermittent basis. Patient is taking a phosphodiesterase inhibitor (eg, sildenafil, tadalafil, vardenafil, dipyridamole, theophylline).
Required Medical Information	For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg AND 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units. For chronic thromboembolic pulmonary hypertension (CTEPH) (WHO Group 4): 1) CTEPH was confirmed by right heart catheterization AND by CT, MRI or pulmonary angiography AND 2) Patient has inoperable CTEPH or persistent or recurrent CTEPH after pulmonary endarterectomy. For pulmonary arterial hypertension (PAH) (WHO Group 1): 1) PAH was confirmed by right heart catheterization AND 2) NYHA Functional Class II or III symptoms.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	AFINITOR
Drug Names	AFINITOR, AFINITOR DISPERZ
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, lung neuroendocrine tumors, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, soft tissue sarcoma with one of the following three histologic subtypes: perivascular epithelioid cell tumors (PEComa), angiomyolipoma, lymphangioleiomyomatosis, Classical Hodgkin lymphoma
Exclusion Criteria	
Required Medical Information	For RCC, the disease is relapsed or medically unresectable. The tumor expresses clear cell or non-clear cell histology. If clear cell histology, the patient has previous tried and failed Votrient (pazopanib) or Sutent (sunitinib). For classical Hodgkin lymphoma, Afinitor will be used as a single agent. For advanced breast cancer, patient has advanced hormone receptor positive, HER2 negative disease. Afinitor will be used in combination with exemestane. Patient's disease has progressed within 12 months, was previously treated with a nonsteroidal aromatase inhibitor, or was previously treated with tamoxifen. For subependymal giant cell astrocytoma associated with tuberous sclerosis complex (TSC), patient is not a candidate for curative surgical resection. For renal angiomyolipoma with TSC, patient does not require immediate surgery
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	ALDURAZYME
Drug Names	ALDURAZYME
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of MPS I was confirmed by an enzyme assay demonstrating a deficiency of alpha-L-iduronidase enzyme activity or by DNA testing. Patients with Scheie syndrome must have moderate to severe symptoms of MPS I.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	ALECENSA
Drug Names	ALECENSA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	ALPHA1-PROTEINASE INHIBITOR
Drug Names	ARALAST NP, GLASSIA, PROLASTIN-C, ZEMAIRA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Patients must have clinically evident emphysema. Patients must have a pretreatment serum alpha1-proteinase inhibitor level less than 11 micromoles/L (80 mg/dl). Patients must have a pretreatment post-bronchodilation FEV1 greater than, or equal to, 25 percent and less than, or equal to, 80 percent of predicted.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	AMPYRA
Drug Names	AMPYRA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Prior to initiating therapy, patient must demonstrate sustained walking impairment and the ability to walk 25 feet (with or without assistance). For continuation of therapy, patient must have experienced an improvement in walking speed or other objective measure of walking ability since starting Ampyra.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	ANABOLIC STEROIDS
Drug Names	OXANDROLONE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, AIDS-wasting or cachexia due to chronic disease, Turner's syndrome.
Exclusion Criteria	Pregnancy. Known or suspected carcinoma of the prostate or breast in male patients. Carcinoma of the breast in females with hypercalcemia. Nephrosis, the nephrotic phase of nephritis. Hypercalcemia.
Required Medical Information	Patient will be monitored for peliosis hepatis, liver cell tumors and blood lipid changes.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	

Prior Authorization Group	APOKYN
Drug Names	APOKYN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concomitant treatment with a serotonin 5HT3 antagonist (e.g., ondansetron, granisetron, dolasetron, palonosetron, and alosetron).
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	ARANESP
Drug Names	ARANESP ALBUMIN FREE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, anemia due to myelodysplastic syndromes (MDS).
Exclusion Criteria	Patients receiving chemotherapy with curative intent. Patients with myeloid cancer.
Required Medical Information	For all uses: 1) Pretreatment (no erythropoietin treatment in previous month) Hgb is less than 10 g/dL, AND 2) For reauthorizations (patient received erythropoietin in previous month), an increase in Hgb of at least 1 g/dL after at least 12 weeks of therapy. Additional requirements for anemia due to myelosuppressive cancer chemotherapy: 1) For initial therapy, at least 2 more months of chemotherapy is expected, AND 2) For reauthorizations, current Hgb is less than 11 g/dL. Additional requirements for CKD not on dialysis reauthorization: 1) Current Hgb is less than or equal to 10 g/dL OR Hgb is greater than 10 but less than or equal to 12 g/dL AND prescriber will reduce or interrupt dose. Additional requirements for MDS: 1) Patient has symptomatic anemia, AND 2) Pretreatment serum erythropoietin level is less than or equal to 500 mU/mL, AND 3) For reauthorizations, current Hgb is less than or equal to 11 g/dL OR Hgb is greater than 11 but less than or equal to 12 g/dL AND prescriber will reduce or interrupt dose.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 weeks
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual (eg, used for treatment of anemia for a patient with chronic renal failure who is undergoing dialysis, or furnished from physician's supply incident to a physician service). Requirements regarding Hgb values exclude values due to a recent transfusion.

Prior Authorization Group	ARCALYST
Drug Names	ARCALYST
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	12 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	AUBAGIO
Drug Names	AUBAGIO
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Severe hepatic impairment. Pregnancy.
Required Medical Information	Have a relapsing form of MS (eg, relapsing-remitting MS, progressive-relapsing MS, or secondary progressive MS with relapses).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	B VS. D
Drug Names	ABELCET, ABRAXANE, ACETYLCYSTEINE, ACYCLOVIR SODIUM, ADRUCIL, AKYNZEO, ALBUTEROL SULFATE, ALIMTA, AMBISOME, AMIFOSTINE, AMINOSYN, AMINOSYN 7%/ELECTROLYTES, AMINOSYN 8.5%/ELECTROLYTE, AMINOSYN II, AMINOSYN II 8.5%/ELECTROL, AMINOSYN M, AMINOSYN-HBC, AMINOSYN-PF, AMINOSYN-PF 7%, AMINOSYN-RF, AMPHOTERICIN B, ARRANON, ARZERRA, ASTAGRAF XL, ATGAM, AVASTIN, AZACITIDINE, AZASAN, AZATHIOPRINE, BENDEKA, BETHKIS, BICNU, BLEOMYCIN SULFATE, BROVANA, BUDESONIDE, BUSULFEX, CALCITRIOL, CAMPTOSAR, CARBOPLATIN, CELLCEPT INTRAVENOUS, CESAMET, CISPLATIN, CLADRIBINE, CLINIMIX 2.75%/DEXTROSE 5, CLINIMIX 4.25%/DEXTROSE 1, CLINIMIX 4.25%/DEXTROSE 2, CLINIMIX 4.25%/DEXTROSE 5, CLINIMIX 5%/DEXTROSE 15%, CLINIMIX 5%/DEXTROSE 20%, CLINIMIX 5%/DEXTROSE 25%, CLINIMIX E 2.75%/DEXTROSE, CLINIMIX E 4.25%/DEXTROSE, CLINIMIX E 5%/DEXTROSE 15, CLINIMIX E 5%/DEXTROSE 20, CLINIMIX E 5%/DEXTROSE 25, CLINISOL SF 15%, CLOLAR, COSMEGEN, CROMOLYN SODIUM, CYCLOPHOSPHAMIDE, CYCLOSPORINE, CYCLOSPORINE MODIFIED, CYTARABINE AQUEOUS, DACARBAZINE, DAUNORUBICIN HCL, DECITABINE, DEPO-MEDROL, DEPO-DEPO-PROVERA, DEXRAZOXANE, DILAUDID-HP, DIPHTHERIA/TETANUS TOXOID, DOCETAXEL, DOXERCALCIFEROL, DOXORUBICIN HCL, DOXORUBICIN HCL LIPOSOME, DRONABINOL, DUOPA, DURAMORPH, ELIGARD, ELITEK, ELOXATIN, EMEND, ENGERIX-B, ENVARSUS XR, EPIRUBICIN HCL, ERBITUX, ETOPOPHOS, ETOPOSIDE, FASLODEX, FIRMAGON, FLUDARABINE PHOSPHATE, FLUOROURACIL, FREAMINE HBC 6.9%, FREAMINE III, FUSILEV, GAMASTAN S/D, GANCICLOVIR, GEMCITABINE, GEMCITABINE HCL, GENGRAF, GRANISETRON HCL, HALAVEN, HECTOROL, HEPARIN SODIUM, HEPATAMINE, HERCEPTIN, HUMULIN R U-500 (CONCENTR, HYDROMORPHONE HCL, HYDROXYPROGESTERONE CAPRO, IBANDRONATE SODIUM, IDARUBICIN HCL, IFEX, IFOSFAMIDE, INFUMORPH 200, INFUMORPH 500, INTRALIPID, INTRON A, INTRON A W/DILUENT, IPRATROPIUM BROMIDE, IPRATROPIUM BROMIDE/ALBUT, IRINOTECAN, ISTODAX, IXEMPRA KIT, KADCYLA, KEPIVANCE, LEUCOVORIN CALCIUM, LEVALBUTEROL, LEVALBUTEROL HCL, LEVOCARNITINE, LEVOLEUCOVORIN, LEVOLEUCOVORIN CALCIUM, LIDOCAINE HCL, LIDOCAINE/PRILOCAINE, LIPOSYN III, MEDROL, MELPHALAN HYDROCHLORIDE, MESNA, METHOTREXATE SODIUM, METHYLPREDNISOLONE, METHYLPREDNISOLONE ACETAT, METHYLPREDNISOLONE SODIUM, MIACALCIN, MILLIPRED, MITOMYCIN, MITOXANTRONE HCL, MORPHINE SULFATE, MUSTARGEN, MYCOPHENOLATE MOFETIL, MYCOPHENOLIC ACID DR, NEBUPENT, NEORAL, NEPHRAMINE, NIPENT, NULOJIX, NUTRILIPID, ONDANSETRON HCL, ONDANSETRON ODT, OXALIPLATIN, PACLITAXEL, PAMIDRONATE DISODIUM, PARICALCITOL, PERFOROMIST, PLENAMINE, PREDNISOLONE, PREDNISOLONE SODIUM PHOSP, PREDNISONE, PREDNISONE INTENSOL, PREMASOL, PROCALAMINE,

	PROGRAF, PROLEUKIN, PROSOL, PULMICORT, PULMOZYME, RAPAMUNE, RAYOS, RECOMBIVAX HB, REMODULIN, SANDIMMUNE, SIMULECT, SIROLIMUS, SMOFLIPID, SOLU-MEDROL, TACROLIMUS, TENIVAC, TETANUS/DIPHTHERIA TOXOID, THIOTEPA, THYMOGLOBULIN, TOBRAMYCIN, TOPOSAR, TOPOTECAN HCL, TORISEL, TPN ELECTROLYTES, TRAVASOL, TREANDA, TREXALL, TRISENOX, TROPHAMINE, TYVASO, UVADEX, VARUBI, VECTIBIX, VELCADE, VENTAVIS, VERIPRED 20, VINBLASTINE SULFATE, VINCASAR PFS, VINCRISTINE SULFATE, VINORELBINE TARTRATE, ZANOSAR, ZEMPLAR, ZOLEDRONIC ACID, ZOMETA, ZORTRESS, ZUPLENZ
Covered Uses	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.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	N/A
Other Criteria	

Prior Authorization Group	BANZEL
Drug Names	BANZEL
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	The patient is diagnosed with familial short QT Syndrome.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	BELBUCA
Drug Names	BELBUCA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Significant respiratory depression. Known or suspected paralytic ileus.
Required Medical Information	1) The patient has been evaluated and will be monitored regularly for the development of addiction, abuse, or misuse of the requested drug AND 2) The patient can safely take the requested dose of the requested drug based on their current opioid use history.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	BELEODAQ
Drug Names	BELEODAQ
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Patient has relapsed or refractory disease.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	BENLYSTA
Drug Names	BENLYSTA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Severe active lupus nephritis (excludes other types of renal involvement associated with SLE). Severe active central nervous system lupus.
Required Medical Information	Patient has a diagnosis of active, autoantibody-positive SLE. Patient is currently receiving standard therapy for SLE (eg, corticosteroids, azathioprine, leflunomide, methotrexate, mycophenolate mofetil, hydroxychloroquine, non-steroidal anti-inflammatory drugs) OR patient is not currently receiving standard therapy for SLE because patient tried and had an inadequate response or intolerance to standard therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 6 months. Renewal: Plan Year.
Other Criteria	For renewals, patient is benefiting from Benlysta therapy (eg, reduction of steroid dose, decrease in pain medications).

Prior Authorization Group	BETASERON
Drug Names	BETASERON
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Have a relapsing form of MS (eg, relapsing-remitting MS, progressive-relapsing MS, or secondary progressive MS with relapses) OR first clinical episode of MS with MRI scan that demonstrated features consistent with a diagnosis of MS (ie, multifocal white matter disease).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	BOSENTAN
Drug Names	TRACLEER
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	NYHA Functional Class II to IV symptoms. PAH (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	BOSULIF
Drug Names	BOSULIF
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, Philadelphia chromosome-positive (Ph+) acute lymphoblastic leukemia (ALL).
Exclusion Criteria	
Required Medical Information	Diagnosis of CML or Ph+ ALL was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, patient meets any of the following: 1) patient has accelerated or blast phase CML, OR 2) patient experienced resistance, intolerance or toxicity to alternative tyrosine kinase inhibitor (imatinib, dasatinib, nilotinib, ponatinib), OR 3) patient received a hematopoietic stem cell transplant. For Ph+ ALL, ALL is relapsed or refractory to prior therapy.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	BOTOX
Drug Names	BOTOX
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, excessive salivation secondary to advanced Parkinson's disease, hemifacial spasm.
Exclusion Criteria	Cosmetic use
Required Medical Information	For chronic migraine prophylaxis, initial treatment: patient experiences at least 15 headache days per month, and patient had an inadequate response to at least 8 weeks of oral migraine preventative therapy. For chronic migraine prophylaxis, continuation of treatment (after 2 injection cycles): 50 percent reduction in monthly headache frequency since starting therapy. For urinary incontinence in a patient with a neurologic condition (eg, spinal cord injury, multiple sclerosis) or with overactive bladder: patient had an inadequate response to or is intolerant of an anticholinergic medication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Chronic migraine, initial: 24 wks. Plan Year for all other indications and chronic migraine renewal.
Other Criteria	

Prior Authorization Group	BRIVIACT
Drug Names	BRIVIACT
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	BUPRENORPHINE
Drug Names	BUPRENORPHINE HCL
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	1) The prescriber agrees not to prescribe other opioids while the patient is taking buprenorphine AND 2) If the patient is a pregnant female and being prescribed buprenorphine for induction therapy and subsequent maintenance therapy for transition from opioid use to opioid dependence treatment OR 3) if buprenorphine is being prescribed for induction therapy for transition from opioid use to opioid dependence treatment OR 4) if buprenorphine is being prescribed for maintenance therapy for opioid dependence treatment in a patient who is intolerant to naloxone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Induction 3 months, Maintenance Plan Year, Pregnancy 10 months
Other Criteria	

Prior Authorization Group	BUPRENORPHINE-NALOXONE
Drug Names	BUNAVAIL, BUPRENORPHINE HCL/NALOXON, SUBOXONE, ZUBSOLV
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	The prescriber agrees not to prescribe other opioids while the patient is taking the requested drug for opioid dependence treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	CABOMETYX
Drug Names	CABOMETYX
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	The disease expresses clear cell histology and is advanced or metastatic. The patient has received and progressed on or after prior treatment with a vascular endothelial growth factor receptor targeting tyrosine kinase inhibitor.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	CAPRELSA
Drug Names	CAPRELSA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, differentiated thyroid cancer subtypes: papillary, follicular, Hurthle cell.
Exclusion Criteria	
Required Medical Information	For medullary thyroid cancer: 1) disease is symptomatic or progressive AND 2) patient has unresectable locoregional or metastatic disease. For differentiated thyroid cancer: 1) histologic subtype is papillary, follicular, or Hurthle cell AND 2) disease is symptomatic or progressive AND 3) disease is iodine-refractory AND 4) patient has unresectable locoregional or metastatic disease.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	CARBAGLU
Drug Names	CARBAGLU
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, methylmalonic acidemia, propionic acidemia.
Exclusion Criteria	
Required Medical Information	Diagnosis of NAGS deficiency was confirmed by enzymatic or genetic testing.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	CAYSTON
Drug Names	CAYSTON
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	The diagnosis of cystic fibrosis is confirmed by appropriate diagnostic or genetic testing. Pseudomonas aeruginosa is present in the cultures of the airway.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	CERDELGA
Drug Names	CERDELGA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	CYP2D6 extensive metabolizers and intermediate metabolizers taking a strong or moderate CYP2D6 inhibitor (e.g., paroxetine, terbinafine) concomitantly with a strong or moderate CYP3A inhibitor (e.g., ketoconazole, fluconazole). CYP2D6 intermediate metabolizers and poor metabolizers taking a strong CYP3A inhibitor (e.g., ketoconazole). CYP2D6 indeterminate metabolizers (i.e., CYP2D6 genotype cannot be determined). CYP2D6 ultra-rapid metabolizers.
Required Medical Information	Diagnosis of Gaucher disease was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by DNA testing. The patient's CYP2D6 metabolizer status has been established using an FDA-cleared test. Patient is a CYP2D6 extensive metabolizer, an intermediate metabolizer, or a poor metabolizer.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	CEREZYME
Drug Names	CEREZYME
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, type 3 Gaucher disease.
Exclusion Criteria	Concomitant therapy with miglustat (Zavesca)
Required Medical Information	Diagnosis of Gaucher disease was confirmed by enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by DNA testing. For Type 1 Gaucher disease, patient has one or more of the following disease complications: anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly. For Type 3 Gaucher disease, patient has one or more of the following disease complications: anemia, thrombocytopenia, bone disease, hepatomegaly, splenomegaly, developmental delay, or ophthalmoplegia (gaze palsy).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	CIMZIA
Drug Names	CIMZIA, CIMZIA STARTER KIT
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, axial spondyloarthritis.
Exclusion Criteria	
Required Medical Information	Latent TB screening with either a TB skin test or an interferon gamma release assay (eg, QFT-GIT, T-SPOT.TB) prior to initiating Cimzia (or other biologic). For moderately to severely active Crohn's disease (new starts only): Member meets ANY of the following: 1) Inadequate response to at least one conventional therapy (eg, corticosteroids, SSZ, azathioprine, mesalamine), 2) Intolerance or contraindication to conventional therapy. For moderately to severely active RA (new starts only): Member meets ANY of the following: 1) Inadequate response to at least a 3-month trial of methotrexate (MTX) despite adequate dosing (ie, titrated to 25-30 mg/week), 2) Intolerance or contraindication to MTX. For active psoriatic arthritis (PsA) (new starts only): Member meets ANY of the following: 1) Inadequate response to at least a 3-month trial of MTX, sulfasalazine, or leflunomide 2) Intolerance or contraindication to MTX, sulfasalazine, or leflunomide, 3) Inadequate response to at least a 3-month trial of a prior biologic DMARD, 4) Intolerance to a prior biologic DMARD, 5) Severely active PsA as evidenced by ANY of the following: a) multiple swollen joints, b) structural damage in the presence of inflammation, or c) clinically relevant extra-articular manifestations (eg, extensive skin, bowel, ocular, cardiovascular, urogenital, or pulmonary involvement), 6) Active enthesitis and/or dactylitis (i.e., sausage finger) 7) Predominant axial disease (ie, extensive spinal involvement).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	For active ankylosing spondylitis and axial spondyloarthritis (new starts only): 1) Inadequate response to at least a 4-week NSAID trial at maximum recommended or tolerated dose OR intolerance and/or contraindication to NSAIDs, AND 2) Member has at least ONE of the following: a) predominant axial disease (ie, extensive spinal involvement), b) inadequate response to a synthetic DMARD (eg, sulfasalazine), c) intolerance or contraindication to a synthetic DMARD, d) inadequate response to at least a 3-month trial of a prior biologic DMARD, or e) intolerance to a prior biologic DMARD.

Prior Authorization Group	CINQAIR
Drug Names	CINQAIR
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of severe asthma with an eosinophilic phenotype. Cinqair is used in combination with other medications for the maintenance treatment of asthma. Patient has a reliever agent (i.e., short-acting beta2-agonist, low-dose combination inhaled corticosteroid/formoterol) available for rescue therapy. Cinqair is administered in a healthcare setting by a healthcare professional prepared to manage anaphylaxis. For initial therapy only: 1) Patient has baseline eosinophil count of at least 400 cells per microliter, and 2) Patient has a history of severe asthma attacks (exacerbations) despite current treatment with both of the following medications at optimized doses: a) inhaled corticosteroid AND b) additional controller (long acting beta2-agonist, leukotriene modifier, or sustained-release theophylline). For continuation therapy only: Asthma control has improved on Cinqair treatment, demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	CINRYZE
Drug Names	CINRYZE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, treatment of hereditary angioedema attacks.
Exclusion Criteria	
Required Medical Information	Diagnosis of HAE confirmed by laboratory tests (eg, C4, C1 inhibitor functional, and C1 inhibitor antigenic protein levels)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	CLORAZEPATE
Drug Names	CLORAZEPATE DIPOTASSIUM
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	1) For the management of anxiety disorders or for the short-term relief of the symptoms of anxiety, the patient has experienced an inadequate treatment response to lorazepam OR for adjunctive therapy in the management of partial seizures OR symptomatic relief in acute alcohol withdrawal AND 2) If the patient is 65 years of age or older, the benefit of therapy with the prescribed medication outweighs the potential risk. (The prescribed medication is considered a high risk medication that is considered either ineffective in most patients 65 years of age or older or that poses an unnecessarily high risk when safer alternative therapy may be available.)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	CLOZAPINE ODT
Drug Names	CLOZAPINE ODT, FAZACLO
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	History of clozapine-induced agranulocytosis or severe granulocytopenia. Dementia-related psychosis.
Required Medical Information	The patient is unwilling or unable to take tablets or capsules orally or is at high risk for non-compliance.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	COMETRIQ
Drug Names	COMETRIQ
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, NSCLC with RET rearrangements.
Exclusion Criteria	
Required Medical Information	Medullary thyroid cancer is symptomatic, progressive, or metastatic. Non-small cell lung cancer is with RET gene rearrangements.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	COPAXONE
Drug Names	COPAXONE, GLATOPA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, First clinical episode of MS.
Exclusion Criteria	
Required Medical Information	Have a relapsing form of MS (eg, relapsing-remitting MS, progressive-relapsing MS, or secondary progressive MS with relapses) OR first clinical episode of MS with MRI scan that demonstrated features consistent with a diagnosis of MS (ie, multifocal white matter disease).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	COSENTYX
Drug Names	COSENTYX, COSENTYX SENSOREADY PEN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Latent TB screening with either a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB) must be performed prior to initiating Cosentyx (or other biologic). For plaque psoriasis (PsO): Member has a diagnosis of moderate to severe plaque psoriasis. At least 5% BSA is affected or crucial body areas (eg, feet, hands, face, neck and/or groin) are affected at the time of diagnosis. For new starts, ALL of the following criteria must be met: 1) Member has experienced an inadequate response to phototherapy (e.g., UVB, PUVA), methotrexate, cyclosporine, or acitretin, unless contraindicated or intolerant to such therapies, 2) Member will be assessed for continuation of therapy after 3 months of treatment. For continuation, member must have achieved positive clinical response after 3 months of treatment or has maintained positive clinical response as evidenced by low disease activity or improvement in signs and symptoms. For active psoriatic arthritis (PsA) (new starts only): Patient meets ANY of the following: 1) Inadequate response to at least a 3-month trial of methotrexate (MTX), sulfasalazine, or leflunomide, 2) Intolerance or contraindication to MTX, sulfasalazine, or leflunomide, 3) Inadequate response to at least a 3-month trial of a prior biologic disease-modifying antirheumatic drug (DMARD), 4) Intolerance to a prior biologic DMARD, 4) Severely active PsA as evidenced by ANY of the following: a) multiple swollen joints, b) structural damage in the presence of inflammation, c) clinically relevant extra-articular manifestations (e.g., extensive skin, bowel, ocular, cardiovascular, urogenital, or pulmonary involvement), 5) Active enthesitis and/or dactylitis (i.e., sausage finger), 6) Predominant axial disease (i.e., extensive spinal involvement). For active ankylosing spondylitis (AS) (new starts only): Inadequate response to at least a 4-week NSAID trial at maximum recommended or tolerated dose OR intolerance and/or contraindication to NSAIDs.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	For PsO: Initial: 4 months. Continuation: Plan Year. For PsA and AS: Plan Year.
Other Criteria	

Prior Authorization Group	COTELLIC
Drug Names	COTELLIC
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	CYSTAGON
Drug Names	CYSTAGON
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of nephropathic cystinosis was confirmed by the presence of increased cysteine concentration in leukocytes or by DNA testing.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	DAKLINZA
Drug Names	DAKLINZA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, chronic hepatitis C genotype 1, 2 or 4 infection.
Exclusion Criteria	Use with a strong inducer of CYP3A, including phenytoin, carbamazepine, rifampin and St. John's wort
Required Medical Information	Chronic hepatitis C infection confirmed by presence of HCV RNA in serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated variants (eg, NS3 Q80K polymorphism) where applicable, liver transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 to 24 weeks depending on baseline host and viral factors
Other Criteria	For HCV/HIV coinfection, patient meets criteria for requested regimen.

Prior Authorization Group	DEFERASIROX
Drug Names	EXJADE, JADENU
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For chronic iron overload due to blood transfusions: pretreatment serum ferritin level is greater than 1000 mcg/L. For chronic iron overload in patients with non-transfusion dependent thalassemia (NTDT) syndromes: a) for initiation of the deferasirox therapy, pretreatment liver iron concentration (LIC), measured by liver biopsy or by an FDA-cleared or approved method, is at least 5 mg of iron per gram of liver dry weight (mg Fe/g dw) AND pretreatment serum ferritin levels are greater than 300 mcg/L on 2 consecutive measurements 1 month apart, b) for continuation of the deferasirox therapy: current LIC is greater than 3 mg Fe/g dw or the deferasirox therapy will be withheld until the LIC reaches above 5 mg Fe/g dw.
Age Restrictions	2 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	DIAZEPAM
Drug Names	DIAZEPAM, DIAZEPAM INTENSOL
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	1) For the management of anxiety disorders or for the short-term relief of the symptoms of anxiety, the patient has experienced an inadequate treatment response to lorazepam OR for symptomatic relief in acute alcohol withdrawal OR for use as an adjunct for the relief of skeletal muscle spasms OR for adjunctive therapy in the treatment of convulsive disorders AND 2) If the patient is 65 years of age or older, the benefit of therapy with the prescribed medication outweighs the potential risk. (The prescribed medication is considered a high risk medication that is considered either ineffective in most patients 65 years of age or older or that poses an unnecessarily high risk when safer alternative therapy may be available.).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	DICLOFENAC GEL
Drug Names	DICLOFENAC SODIUM
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	EGRIFTA
Drug Names	EGRIFTA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Use for weight loss.
Required Medical Information	Egrifta is requested to reduce excess abdominal fat in an HIV-infected patient with lipodystrophy. Patient has a diagnosis of HIV infection and is receiving anti-retroviral therapy (ART). For patients who have received at least 6 months of Egrifta therapy: patient has demonstrated clear clinical improvement from baseline that is supported by a waist circumference or CT scan.
Age Restrictions	
Prescriber Restrictions	Infectious disease specialist
Coverage Duration	6 months
Other Criteria	

Prior Authorization Group	ELAPRASE
Drug Names	ELAPRASE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of mucopolysaccharidosis II (Hunter syndrome) was confirmed by an enzyme assay demonstrating a deficiency of iduronate 2-sulfatase enzyme activity or by DNA testing.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	ELELYSO
Drug Names	ELELYSO
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concomitant therapy with miglustat (Zavesca)
Required Medical Information	Diagnosis of Gaucher disease was confirmed by enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by DNA testing. Patient has one or more of the following disease complications: anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	ELIDEL
Drug Names	ELIDEL
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, Psoriasis on the face or body skin folds.
Exclusion Criteria	
Required Medical Information	1) The short-term or noncontinuous chronic use to treat psoriasis on the face or body skin folds OR 2) The short-term or noncontinuous chronic use to treat mild to moderate atopic dermatitis (eczema).
Age Restrictions	2 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	The patient experienced an inadequate treatment response, intolerance, or contraindication to at least one medium or higher potency topical steroid when Elidel will not be used on the face, body skin folds, genital area, armpit, or around the eyes.

Prior Authorization Group	EMSAM
Drug Names	EMSAM
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Pheochromocytoma.
Required Medical Information	1) Patient will be monitored closely for suicidal thinking or behavior, clinical worsening, and unusual changes in behavior AND 2) Patient experienced an inadequate treatment response to any one of the following antidepressants: bupropion, trazodone, mirtazapine, SNRIs (e.g., venlafaxine), SSRIs (e.g., citalopram, fluoxetine, fluvoxamine, paroxetine, sertraline), tricyclic or tetracyclic antidepressants (e.g., amitriptyline, nortriptyline) OR 3) Patient is unable to swallow oral formulations.
Age Restrictions	12 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	ENTRESTO
Drug Names	ENTRESTO
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	History of angioedema related to previous ACE inhibitor or ARB therapy. Concomitant use of ACE inhibitors. Concomitant use of aliskiren in a patient with diabetes. Pregnancy.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	ENTYVIO
Drug Names	ENTYVIO
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For moderately to severely active Crohn's disease (CD), patient must have an inadequate response, intolerance, or contraindication to conventional therapy (eg, corticosteroids, sulfasalazine, azathioprine, 6-mercaptopurine) and a TNF-inhibitor for CD. For moderately to severely active ulcerative colitis (UC), patient must have an inadequate response, intolerance, or contraindication to conventional therapy (eg, oral aminosalicylates, corticosteroids, azathioprine, 6-mercaptopurine) and a TNF-inhibitor for UC.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	Initial = 4 months, renewal = Plan Year.
Other Criteria	For renewal, patient has experienced therapeutic benefit with Entyvio treatment.

Prior Authorization Group	EPO
Drug Names	EPOGEN, PROCRIT
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, anemia due to myelodysplastic syndromes (MDS), anemia in congestive heart failure (CHF), anemia in rheumatoid arthritis (RA), anemia due to hepatitis C treatment (ribavirin in combination with either interferon alfa or peginterferon alfa).
Exclusion Criteria	Patients receiving chemotherapy with curative intent. Patients with myeloid cancer. Use to facilitate preoperative autologous blood donation.
Required Medical Information	For all uses except surgery:1) Pretreatment (no erythropoietin treatment in previous month) Hgb is less than 10 g/dL (less than 9 g/dL for anemia in CHF only) AND 2) For reauthorizations (patient received erythropoietin in previous month), an increase in Hgb of at least 1 g/dL after at least 12 weeks of therapy. Additional requirements for anemia due to myelosuppressive cancer chemotherapy: 1) For initial therapy, at least 2 more months of chemotherapy is expected, AND 2) For reauthorizations, current Hgb is less than 11 g/dL. Additional requirements for CKD not on dialysis reauthorization: 1) Current Hgb is less than or equal to 10 g/dL OR Hgb is greater than 10 but less than or equal to 12 g/dL AND prescriber will reduce or interrupt dose. Additional requirements for MDS: 1) Patient has symptomatic anemia, AND 2) Pretreatment serum erythropoietin level is less than or equal to 500 mU/mL, AND 3) For reauthorizations, current Hgb is less than or equal to 11 g/dL OR Hgb is greater than 11 but less than or equal to 12 g/dL AND prescriber will reduce or interrupt dose. Additional requirements for HIV: 1) Concomitant use of zidovudine at a maximum dose of 4200 mg per week, AND 2) For initial therapy, pretreatment serum erythropoietin level is less than or equal to 500 mU/mL, AND 3) For reauthorizations, current Hgb is less than or equal to 11 g/dL OR Hgb is greater than 11 but less than or equal to 12 g/dL AND prescriber will reduce or interrupt dose. Additional requirements for anemia due to CHF, RA, hepatitis C treatment, or patients whose religious beliefs forbid blood transfusions: 1) For reauthorizations, current Hgb is less than or equal to 11 g/dL OR Hgb is greater than 11 but less than or equal to 12 g/dL AND prescriber will reduce or interrupt dose. For surgery: 1) Patient is scheduled for elective, noncardiac, nonvascular surgery, AND 2) Pretreatment Hgb is greater than 10 but not more than 13 g/dL.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 weeks
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual (eg, used for treatment of anemia for a patient with chronic renal failure who is undergoing dialysis, or furnished from physician's supply incident to a physician service). Coverage includes use in anemia in patients whose religious beliefs forbid blood transfusions. Requirements regarding Hgb values exclude values due to a recent transfusion.

Prior Authorization Group	ERIVEDGE
Drug Names	ERIVEDGE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Patient meets one of the following criteria: 1) patient has distant metastatic basal cell carcinoma (BCC), OR 2) patient has undergone surgery and/or radiation therapy for BCC and has residual or recurrent disease following surgery and/or radiation, OR 3) both surgery and radiation are contraindicated or not appropriate for the patient.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	ESBRIET
Drug Names	ESBRIET
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Initial Review Only, The patient does not have a known etiology for interstitial lung disease. The patient has completed a high-resolution computed tomography study of the chest which reveals the usual interstitial pneumonia pattern. If the study reveals the possible usual interstitial pneumonia pattern, the diagnosis is supported by surgical lung biopsy. If a surgical lung biopsy has not been conducted, the diagnosis is supported by a multidisciplinary discussion between at least a radiologist and pulmonologist who are experienced in idiopathic pulmonary fibrosis. The prescriber will collect LFTs on the schedule recommended in the package insert. For initial and continuation, Esbriet will not be used in combination with Ofev.
Age Restrictions	
Prescriber Restrictions	Pulmonologist
Coverage Duration	Initial: 6 months, Renewal: Plan Year
Other Criteria	For continuation only, The patient has experienced a reduction in disease progression. The patient's AST or ALT is not greater than 5x upper limit of normal (ULN) OR the AST or ALT is not greater than 3x and less than 5x ULN with symptoms or hyperbilirubinemia.

Prior Authorization Group	EXTAVIA
Drug Names	EXTAVIA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Have a relapsing form of MS (eg, relapsing-remitting MS, progressive-relapsing MS, or secondary progressive MS with relapses) OR first clinical episode of MS with MRI scan that demonstrated features consistent with a diagnosis of MS (ie, multifocal white matter disease).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	FABRAZYME
Drug Names	FABRAZYME
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of Fabry disease is confirmed by an enzyme assay showing deficiency of alpha-galactosidase enzyme activity or by DNA testing. Patient has clinical signs and symptoms of Fabry disease.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	FARYDAK
Drug Names	FARYDAK
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	The patient has received at least 2 prior regimens, including bortezomib and an immunomodulatory agent. Farydak will be given in combination with bortezomib and dexamethasone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	Patients may not have recent myocardial infarction or unstable angina, a history of clinically significant ST-segment or T-wave elevation, or a QTC interval greater than, or equal to, 450 ms. The patient may not have serum electrolytes outside of the normal range at baseline.

Prior Authorization Group	FERRIPROX
Drug Names	FERRIPROX
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of transfusional iron overload due to thalassemia syndromes
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	FILGRASTIM
Drug Names	GRANIX, NEUPOGEN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, treatment of chemotherapy-induced febrile neutropenia (FN), mobilization of and following transplantation of peripheral blood progenitor cells, following bone marrow transplantation, acute lymphocytic leukemia (ALL), acute myeloid leukemia (AML), severe chronic neutropenia (congenital, cyclic, or idiopathic), leukemic relapse following allogeneic stem cell transplantation, myelodysplastic syndromes (MDS), agranulocytosis, aplastic anemia, HIV-related neutropenia.
Exclusion Criteria	Use of a G-CSF product within 24 hours preceding or following chemotherapy or radiotherapy. For treatment of chemotherapy-induced FN, patient received prophylactic pegylated G-CSF (eg, Neulasta) during the current chemotherapy cycle.
Required Medical Information	For prophylaxis of myelosuppressive chemotherapy-induced FN: 1) Patient has a non-myeloid cancer AND 2) Patient is currently receiving or will be receiving treatment with myelosuppressive anti-cancer therapy. For treatment of myelosuppressive chemotherapy-induced FN: 1) Patient has a non-myeloid cancer AND 2) Patient is currently receiving or has received treatment with myelosuppressive anti-cancer therapy. For MDS: 1) Patient has neutropenia and recurrent or resistant infections OR 2) Patient has symptomatic anemia and the requested G-CSF product will be used in combination with epoetin or darbepoetin.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	

Prior Authorization Group	FIRAZYR
Drug Names	FIRAZYR
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of HAE confirmed by laboratory tests (eg, C4, C1 inhibitor functional, and C1 inhibitor antigenic protein levels)
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	FORTEO
Drug Names	FORTEO
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Paget's disease of bone, unexplained elevations of alkaline phosphatase, open epiphyses (ie, pediatric or young adult patient), prior radiation therapy involving the skeleton, history of a skeletal malignancy, bone metastases, pre-existing hypercalcemia, metabolic bone disease other than osteoporosis.
Required Medical Information	For all indications: patient has had an oral bisphosphonate trial of at least 1-year duration unless contraindicated or intolerant to an oral bisphosphonate. For primary or hypogonadal osteoporosis and postmenopausal osteoporosis: Patient has a) a history of an osteoporotic vertebral or hip fracture OR b) a pre-treatment T-score of less than or equal to -2.5 OR c) a pre-treatment T-score of less than or equal to -1 but greater than -2.5 AND a pre-treatment FRAX score of greater than or equal to 20 percent for any major osteoporotic fracture. For glucocorticoid-induced osteoporosis in postmenopausal women and men 50 years of age or older: 1) patient is currently receiving or will be initiating glucocorticoid therapy, AND 2) patient has a) a history of fragility fracture OR b) a pre-treatment T-score of less than or equal to -2.5 OR c) a pre-treatment FRAX score of greater than or equal to 20 percent for any major osteoporotic fracture. For glucocorticoid-induced osteoporosis in premenopausal women and men less than 50 years of age: 1) patient is currently receiving or will be initiating glucocorticoid therapy AND, 2) the anticipated glucocorticoid length of therapy is at least 3 months, AND 3) patient has a history of a fragility fracture.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 months (lifetime)
Other Criteria	

Prior Authorization Group	FYCOMPA
Drug Names	FYCOMPA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	The patient and caregivers will be advised to contact the healthcare provider immediately if any serious psychiatric or behavioral reactions are observed.
Age Restrictions	12 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	GATTEX
Drug Names	GATTEX
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Gattex will be used for the initial therapy of adult patients with short bowel syndrome who have required parenteral support for at least 12 months. Gattex will be used for the continuation therapy of adult patients with short bowel syndrome who have required parenteral support for at least 12 months AND have the decreased requirement for parenteral support from baseline while on Gattex therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	GILENYA
Drug Names	GILENYA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Have a relapsing form of MS (eg, relapsing-remitting MS, progressive-relapsing MS, or secondary progressive MS with relapses).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	GILOTRIF
Drug Names	GILOTRIF
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Patient has metastatic non-small cell lung cancer. Patient had EGFR mutation testing and is positive for EGFR exon 19 deletions or exon 21 (L858R) substitution mutations.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	GONADOTROPIN
Drug Names	CHORIONIC GONADOTROPIN, NOVAREL, PREGNYL W/DILUENT BENZYL
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient is female, uncontrolled thyroid or adrenal dysfunction, uncontrolled organic intracranial lesion (e.g., pituitary tumor), prostatic carcinoma or other androgen dependent neoplasm
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	GRASTEK
Drug Names	GRASTEK
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Severe, unstable, or uncontrolled asthma. History of any severe systemic allergic reaction or any severe local reaction to sublingual allergen immunotherapy. A history of eosinophilic esophagitis. Medical conditions that may reduce the ability of the patient to survive a serious allergic reaction or increase the risk of adverse reactions after epinephrine administration. Patient is on any medication(s) that can inhibit or potentiate the effect of epinephrine.
Required Medical Information	
Age Restrictions	5 through 65 years of age
Prescriber Restrictions	Allergist or in consultation with an allergist
Coverage Duration	6 months
Other Criteria	1) Auto-injectable epinephrine will be prescribed or available to the patient and the patient will be instructed and trained on its use AND 2)Treatment is initiated at least 12 weeks prior to expected onset of a grass pollen season AND 3) For a patient currently receiving Grastek, patient must show benefit from Grastek treatment (i.e., reduction in symptoms of allergic rhinitis and conjunctivitis, decreased use of rescue medications such as antihistamines and nasal or oral corticosteroids).

Prior Authorization Group	GROWTH HORMONE
Drug Names	GENOTROPIN, GENOTROPIN MINIQUICK, HUMATROPE, HUMATROPE COMBO PACK, NORDITROPIN FLEXPRO, NUTROPIN AQ NUSPIN 10, NUTROPIN AQ NUSPIN 20, NUTROPIN AQ NUSPIN 5, NUTROPIN AQ PEN, OMNITROPE, SAIZEN, SAIZEN CLICK.EASY, ZOMACTON
Covered Uses	All FDA-approved indications not otherwise excluded from Part D including pediatric growth hormone deficiency (GHD), Turner syndrome (TS), Noonan syndrome (NS), chronic kidney disease (CKD), small for gestational age (SGA), Prader-Willi syndrome (PWS), idiopathic short stature (ISS), short stature homeobox-containing gene deficiency (SHOXD), adult GHD, HIV-associated wasting/cachexia, short bowel syndrome (SBS).
Exclusion Criteria	Active malignancy. Closed epiphyses (except PWS, adult GHD, HIV wasting/cachexia and SBS).
Required Medical Information	Pediatric GHD, TS, CKD, SHOXD, NS: 1) younger than 2.5 yrs old, when applicable: pre-tx height (ht) more than 2 SD below mean and slow growth velocity, 2) 2.5 yrs old or older: pre-tx 1-yr ht velocity more than 2 SD below mean, OR pre-tx ht more than 2 SD below mean and 1-yr ht velocity more than 1 SD below mean. Pediatric GHD: 1) failed 2 pre-tx stimulation tests (peak below 10 ng/mL) OR 2) pituitary/CNS disorder and pre-tx IGF-1 more than 2 SD below mean OR 3) patient is a neonate. TS: confirmed by karyotyping. CKD: not post-kidney transplant. SGA: 1) birth wt below 2500g at gestational age (GA) more than 37 wks OR 2) birth wt or length below 3rd percentile or at least 2 SD below mean for GA, AND 3) did not manifest catch-up growth by age 2. PWS: confirmed by 1) deletion in the chromosomal 15q11.2-q13 region OR 2) maternal uniparental disomy in chromosome 15 OR 3) imprinting defects or translocations involving chromosome 15. SHOXD: confirmed by molecular or genetic testing. ISS: 1) pediatric GHD ruled out with appropriate provocative test more than 10 ng/mL, and 2) pre-tx ht more than 2.25 SD below mean, and 3) adult ht prediction below 63 inches for boys, 59 inches for girls. Adult GHD: 1) failed 2 pre-tx stimulation tests (peak below 5 ng/mL), OR 2) structural abnormality of hypothalamus/pituitary AND 3 or more pituitary hormone deficiencies, OR 3) childhood-onset GHD with congenital (genetic/structural) abnormality of hypothalamus/pituitary/CNS, OR 4) low pre-tx IGF-1 and failed 1 pre-tx stimulation test (peak below 5 ng/mL). HIV wasting/cachexia: 1) on antiretroviral tx AND 2) suboptimal response to at least 1 other therapy for wasting/cachexia (eg, megestrol, dronabinol, cyproheptadine, or testosterone if hypogonadal) OR contraindication/intolerance to alternative therapies, AND 3) pre-tx BMI less than 18.5 kg/m2 AND unintentional wt loss greater than 5% body weight in the past 6 mos. SBS: used with optimal management of SBS.
Age Restrictions	SGA: 2 years of age or older. NS and SHOXD: 3 years of age or older.
Prescriber Restrictions	Endocrinologist, pediatric nephrologist, infectious disease specialist, gastroenterologist, nutritional support specialist.
Coverage Duration	SBS = Up to 8 wks total lifetime. HIV wasting = 12 wks. All other indications = Plan Year.
Other Criteria	Renewal for pediatric GHD, TS, NS, CKD, SGA, PWS patients with open epiphyses,

ISS, or SHOXD: patient is growing more than 2 cm/year. Also for renewal for PWS only: body composition and psychomotor function have improved. Renewal for PWS patients with closed epiphyses and adult GHD patients: current IGF-1 level is normal for age and gender. Renewal for HIV-associated wasting: demonstrated response to GH therapy (ie, BMI has improved or stabilized) and BMI is less than 27 kg/m2.

Prior Authorization Group	HARVONI
Drug Names	HARVONI
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, chronic hepatitis C genotype 4, 5, or 6 infection.
Exclusion Criteria	
Required Medical Information	Chronic hepatitis C infection confirmed by presence of HCV RNA in the serum prior to starting tx. For G1 infection, monotherapy: 1)Total 12 wks for tx-naive pts with or without cirrhosis. Tx for 8 wks can be considered in tx-naive pts without cirrhosis who have pre-tx HCV RNA below 6 million IU/mL, 2)For pts who failed prior tx with PEG-IFN and RBV with or without HCV PI: a) total 12 wks if no cirrhosis, b) total 24 wks for cirrhosis. For G4 infection, monotherapy: Total 12 wks for pts who are tx-naive or failed prior tx with PEG-IFN and RBV. For G5 infection, monotherapy: Total 12 wks for pts who are tx-naive or failed prior tx with PEG-IFN and RBV. For G6 infection, monotherapy: Total 12 wks for pts who are tx-naive or failed prior tx with PEG-IFN and RBV. For recurrent HCV infection post liver txp, monotherapy: Total 24 wks for tx-naive pts with G1 or 4 infection and documented anemia or RBV ineligibility. For G1 infection, tx with RBV: 1)Total 12 wks for pts with cirrhosis who failed prior tx with PEG-IFN and RBV with or without an HCV PI, 2)Total 12 wks for pts without cirrhosis who failed prior tx with a SOF-containing regimen, 3)Total 24 wks for pts with cirrhosis who failed prior tx with a SOF-containing regimen. For decompensated cirrhosis (CTP class B or C), tx with RBV: 1)Total 12 wks for pts with G1 or 4 infection, 2)Total 24 wks for pts with G1 or 4 infection who failed prior tx with a SOF-containing regimen, 3)Total 12 wks for pts with recurrent G1 or 4 infection post liver txp. For recurrent HCV infection post liver txp, tx with RBV: Total 12 wks for pts with G1 or 4 infection. For HCV/HIV coinfection, pt meets all of the following: 1)Pt meets the criteria for requested regimen above, 2)Will not receive tx with cobicistat given with tenofovir, 3)Will not receive tx with tipranavir.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12-24 wks depending on baseline host/viral factors with reminder for 8 wk option when appropriate
Other Criteria	Harvoni will not be used with other drugs containing sofosbuvir, including Sovaldi. Anemia defined as baseline hemoglobin below 10g/dL, RBV ineligibility defined as intolerance to RBV, pregnant female or male whose female partner is pregnant, hemoglobinopathy, or coadministration with didanosine. tx=treatment, G=genotype, pt=patient, PEG-IFN=peginterferon alfa, RBV=ribavirin, PI=protease inhibitor, SOF=sofosbuvir, CTP=Child Turcotte Pugh, txp=transplantation, ART=antiretroviral therapy.

Prior Authorization Group	HETLIOZ
Drug Names	HETLIOZ
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For initial therapy and continuation of Hetlioz therapy: 1) diagnosis of Non-24 Hour Sleep-Wake Disorder, AND 2) diagnosis of total blindness in both eyes (eg, nonfunctioning retinas), AND 3) unable to perceive light in both eyes. For patients currently on Hetlioz therapy, must meet at least one of the following: 1) increased total nighttime sleep, OR 2) decreased daytime nap duration.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initiation: 3 Months, Renewal: Plan Year
Other Criteria	

Prior Authorization Group	HIGH RISK MEDICATION
Drug Names	ALORA, DIGITEK, DIGOX, DIGOXIN, DISOPYRAMIDE PHOSPHATE, ESTRADIOL, FYAVOLV, GUANFACINE ER, JINTELI, LANOXIN, MEGESTROL ACETATE, MENOSTAR, MINIVELLE, NORETHINDRONE ACETATE/ETH, NORPACE CR, TRANSDERM-SCOP
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization requirement only applies to patients 65 years of age or older. (In most patients 65 years of age or older, the prescribed medication is considered a high risk medication that poses an unnecessarily high risk when safer alternative therapy may be available.) Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older.

Prior Authorization Group	HRM-ANTICONVULSANTS
Drug Names	PHENOBARBITAL, PHENOBARBITAL SODIUM
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization requirement only applies to patients 65 years of age or older. (In most patients 65 years of age or older, the prescribed medication is considered a high risk medication that poses an unnecessarily high risk when safer alternative therapy may be available.) 1) A non-HRM alternative formulary drug (carbamazepine, lamotrigine, topiramate) has not been tried AND 2) The patient has a contraindication to a non-HRM alternative formulary drug (carbamazepine, lamotrigine, topiramate) AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older OR 4) A non-HRM alternative formulary drug (carbamazepine, lamotrigine, topiramate) has been tried AND 5) The patient experienced an inadequate treatment response OR intolerance to a non-HRM alternative formulary drug (carbamazepine, lamotrigine, topiramate) AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older.

Prior Authorization Group	HRM-ANTIDEPRESSANTS TCA
Drug Names	AMITRIPTYLINE HCL, DOXEPIN HCL, IMIPRAMINE HCL, IMIPRAMINE PAMOATE, SURMONTIL, TRIMIPRAMINE MALEATE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization requirement only applies to patients 65 years of age or older. (In most patients 65 years of age or older, the prescribed medication is considered a high risk medication that poses an unnecessarily high risk when safer alternative therapy may be available.) 1) A non-HRM alternative formulary drug (citalopram, duloxetine, escitalopram, fluoxetine, sertraline, venlafaxine, venlafaxine ER) has not been tried AND 2) The patient has a contraindication to a non-HRM alternative formulary drug (citalopram, duloxetine, escitalopram, fluoxetine, sertraline, venlafaxine, venlafaxine ER) AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older OR 4) A non-HRM alternative formulary drug (citalopram, duloxetine, escitalopram, fluoxetine, sertraline, venlafaxine, venlafaxine ER) has been tried AND 5) The patient experienced an inadequate treatment response OR intolerance to a non-HRM alternative formulary drug (citalopram, duloxetine, escitalopram, fluoxetine, sertraline, venlafaxine, venlafaxine ER) AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older.

Prior Authorization Group	HRM-ANTIPARKINSON
Drug Names	BENZTROPINE MESYLATE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization requirement only applies to patients 65 years of age or older. (In most patients 65 years of age or older, the prescribed medication is considered a high risk medication that poses an unnecessarily high risk when safer alternative therapy may be available.) 1) A non-HRM alternative formulary drug (amantadine, pramipexole, ropinirole) has not been tried AND 2) The patient has a contraindication to a non-HRM alternative formulary drug (amantadine, pramipexole, ropinirole) AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older OR 4) A non-HRM alternative formulary drug (amantadine, pramipexole, ropinirole) has been tried AND 5) The patient experienced an inadequate treatment response OR intolerance to a non-HRM alternative formulary drug (amantadine, pramipexole, ropinirole) AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older.

Prior Authorization Group	HRM-ANTIPSYCHOTICS
Drug Names	THIORIDAZINE HCL
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization requirement only applies to patients 65 years of age or older. (In most patients 65 years of age or older, the prescribed medication is considered a high risk medication that poses an unnecessarily high risk when safer alternative therapy may be available.) 1) A non-HRM alternative formulary drug (olanzapine, quetiapine, risperidone, ziprasidone) has not been tried AND 2) The patient has a contraindication to a non-HRM alternative formulary drug (olanzapine, quetiapine, risperidone, ziprasidone) AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older OR 4) A non-HRM alternative formulary drug (olanzapine, quetiapine, risperidone, ziprasidone) has been tried AND 5) The patient experienced an inadequate treatment response OR intolerance to a non-HRM alternative formulary drug (olanzapine, quetiapine, risperidone, ziprasidone) AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older.

Prior Authorization Group	HRM-CLOMIPRAMINE
Drug Names	CLOMIPRAMINE HCL
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization requirement only applies to patients 65 years of age or older. (In most patients 65 years of age or older, the prescribed medication is considered a high risk medication that poses an unnecessarily high risk when safer alternative therapy may be available.) 1) A non-HRM alternative formulary drug (fluoxetine, fluvoxamine) has not been tried AND 2) The patient has a contraindication to a non-HRM alternative formulary drug (fluoxetine, fluvoxamine) AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older OR 4) A non-HRM alternative formulary drug (fluoxetine, fluvoxamine) has been tried AND 5) The patient experienced an inadequate treatment response OR intolerance to a non-HRM alternative formulary drug (fluoxetine, fluvoxamine) AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older.

Prior Authorization Group	HRM-HYDROXYZINE HCL
Drug Names	HYDROXYZINE HCL
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization requirement only applies to patients 65 years of age or older. (In most patients 65 years of age or older, the prescribed medication is considered a high risk medication that poses an unnecessarily high risk when safer alternative therapy may be available.) For alcohol withdrawal syndrome 1) A non-HRM alternative formulary drug (clorazepate or diazepam) has not been tried AND 2) The patient has a contraindication to a non-HRM alternative formulary drug (clorazepate or diazepam) AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older. OR 4) A non-HRM alternative formulary drug (clorazepate or diazepam) has been tried AND 5) The patient experienced an inadequate treatment response OR intolerance to a non-HRM alternative formulary drug (clorazepate or diazepam) AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older. For nausea/vomiting 1) A non-HRM alternative formulary drug (ondansetron) has not been tried AND 2) The patient has a contraindication to a non-HRM alternative formulary drug (ondansetron) AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older OR 4) A non-HRM alternative formulary drug (ondansetron) has been tried AND 5) The patient experienced an inadequate treatment response OR intolerance to a non-HRM alternative formulary drug (ondansetron) AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older. For anxiety 1) A non-HRM alternative formulary drug (duloxetine, escitalopram, venlafaxine ER) has not been tried AND 2) The patient has a contraindication to a non-HRM alternative formulary drug (duloxetine, escitalopram, venlafaxine ER) AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older OR 4) A non-HRM alternative formulary drug (duloxetine, escitalopram, venlafaxine ER) has been tried AND 5) The patient experienced an inadequate treatment response OR intolerance to a non-HRM alternative formulary drug (duloxetine, escitalopram, venlafaxine ER) AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older.

Prior Authorization Group	HRM-HYPNOTICS
Drug Names	ZOLPIDEM TARTRATE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	This Prior Authorization requirement only applies to patients 65 years of age or older.
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	In most patients 65 years of age or older, the prescribed medication is considered a high risk medication that poses an unnecessarily high risk when safer alternative therapy may be available. 1) A non-HRM alternative formulary drug (temazepam 7.5mg, temazepam 15mg, Silenor 3mg, Silenor 6mg, Rozerem) has not been tried. AND 2) The patient has a contraindication to a non-HRM alternative formulary drug (temazepam 7.5mg, temazepam 15mg, Silenor 3mg, Silenor 6mg, Rozerem) AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older. OR 4) A non-HRM alternative formulary drug (temazepam 7.5mg, temazepam 15mg, Silenor 3mg, Silenor 6mg, Rozerem) has been tried. AND 5) The patient experienced an inadequate treatment response OR intolerance to a non-HRM alternative formulary drug (temazepam 7.5mg, temazepam 15mg, Silenor 3mg, Silenor 6mg, Rozerem) AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older. APPLIES TO GREATER THAN CUMULATIVE 90 DAYS OF THERAPY PER YEAR.

Prior Authorization Group	HRM-NITROFURANTOIN
Drug Names	MACRODANTIN, NITROFURANTOIN, NITROFURANTOIN MACROCRYST, NITROFURANTOIN MONOHYDRAT
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization requirement only applies to patients 65 years of age or older. (In most patients 65 years of age or older, the prescribed medication is considered a high risk medication that poses an unnecessarily high risk when safer alternative therapy may be available.) 1) A non-HRM alternative formulary drug (cephalexin, ciprofloxacin, levofloxacin, sulfamethoxazole/trimethoprim, trimethoprim) has not been tried AND 2) The patient has a contraindication to a non-HRM alternative formulary drug (cephalexin, ciprofloxacin, levofloxacin, sulfamethoxazole/trimethoprim, trimethoprim) AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older OR 4) A non-HRM alternative formulary drug (cephalexin, ciprofloxacin, levofloxacin, sulfamethoxazole/trimethoprim, trimethoprim) has been tried AND 5) The patient experienced an inadequate treatment response OR intolerance to a non-HRM alternative formulary drug (cephalexin, ciprofloxacin, levofloxacin, sulfamethoxazole/trimethoprim, trimethoprim) AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older. APPLIES TO GREATER THAN CUMULATIVE 90 DAYS OF THERAPY PER YEAR.

Prior Authorization Group	HRM-PROMETHAZINE
Drug Names	PHENADOZ, PHENERGAN, PROMETHAZINE HCL, PROMETHEGAN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization requirement only applies to patients 65 years of age or older. (In most patients 65 years of age or older, the prescribed medication is considered a high risk medication that poses an unnecessarily high risk when safer alternative therapy may be available.) For nausea/vomiting 1) A non-HRM alternative formulary drug (ondansetron) has not been tried AND 2) The patient has a contraindication to a non-HRM alternative formulary drug (ondansetron) AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older OR 4) A non-HRM alternative formulary drug (ondansetron) has been tried AND 5) The patient experienced an inadequate treatment response OR intolerance to a non-HRM alternative formulary drug (ondansetron) AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older. For allergic rhinitis 1) A non-HRM alternative formulary drug (levocetirizine, azelastine nasal, fluticasone nasal) has not been tried AND 2) The patient has a contraindication to a non-HRM alternative formulary drug (levocetirizine, azelastine nasal, fluticasone nasal) AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older OR 4) A non-HRM alternative formulary drug (levocetirizine, azelastine nasal, fluticasone nasal) has been tried AND 5) The patient experienced an inadequate treatment response OR intolerance to a non-HRM alternative formulary drug (levocetirizine, azelastine nasal, fluticasone nasal) AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older. For urticaria 1) A non-HRM alternative formulary drug (levocetirizine) has not been tried AND 2) The patient has a contraindication to a non-HRM alternative formulary drug (levocetirizine) AND 3) Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older OR 4) A non-HRM alternative formulary drug (levocetirizine) has been tried AND 5) The patient experienced an inadequate treatment response OR intolerance to a non-HRM alternative formulary drug (levocetirizine) AND 6) Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older.

Prior Authorization Group	HUMIRA
Drug Names	HUMIRA, HUMIRA PEDIATRIC CROHNS D, HUMIRA PEN, HUMIRA PEN-CROHNS DISEASE, HUMIRA PEN-PSORIASIS STAR
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Latent TB screening with either a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB) prior to initiating Humira (or other biologic). For moderately to severely active rheumatoid arthritis (new starts only): 1) Inadequate response to at least a 3-month trial of methotrexate despite adequate dosing (i.e., titrated to 25-30 mg/week) OR 2) intolerance or contraindication to MTX OR 3) Inadequate response to at least a 3-month trial of a prior biologic DMARD or a targeted synthetic DMARD (e.g. Xeljanz) OR 4) Intolerance to a prior biologic DMARD or a targeted synthetic DMARD OR 5) Severely active RA. For moderately to severely active polyarticular juvenile idiopathic arthritis (new starts only): 1) Inadequate response to at least a 3-month trial of MTX OR 2) Intolerance or contraindication to MTX OR 3) Inadequate response to at least a 3-month trial of a prior biologic DMARD OR 4) Intolerance to a prior biologic DMARD. For active ankylosing spondylitis and axial spondyloarthritis (new starts only): 1) Inadequate response to at least a 4-week NSAID trial at maximum recommended or tolerated dose OR intolerance and/or contraindication to NSAIDs AND 2) Member has at least ONE of the following: a) Predominant axial disease (i.e., extensive spinal involvement), b) Inadequate response to a synthetic DMARD (e.g., sulfasalazine), c) Intolerance or contraindication to a synthetic DMARD, d) Inadequate response to at least a 3-month trial of a prior biologic DMARD, e) Intolerance to a prior biologic DMARD. For moderate to severe chronic plaque psoriasis (new starts only): 1) At least 5% of BSA is affected or crucial body areas (e.g., feet, hands, face, neck and/or groin) are affected AND 2) Inadequate response to either phototherapy (eg, UVB, PUVA) or a traditional systemic agent (eg, methotrexate, cyclosporine, acitretin), unless contraindicated or intolerant to such therapies.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	For moderately to severely active Crohn's disease (new starts only): 1) Inadequate response to at least one conventional therapy (e.g., corticosteroids, sulfasalazine, azathioprine, mesalamine) OR 2) Intolerance or contraindication to conventional therapy. For moderately to severely active ulcerative colitis (new starts only): 1) Inadequate response to immunosuppressant therapy (e.g., corticosteroids, azathioprine, mercaptopurine) or intolerance or contraindication to immunosuppressant therapy AND 2) Patient is naive to TNF inhibitor therapy or patient lost response to previous TNF inhibitor therapy due to antibody formation. For active psoriatic arthritis (PsA) (new starts only): Member meets ANY of the following: 1) Inadequate response to at least a 3-month trial of MTX, sulfasalazine, or leflunomide, 2) Intolerance or contraindication to MTX, sulfasalazine, or leflunomide, 3) Inadequate response to at

	least a 3-month trial of a prior biologic DMARD, 4) Intolerance to a prior biologic DMARD, 5) Severely active PsA as evidenced by ANY of the following: a) multiple swollen joints, b) structural damage in the presence of inflammation, or c) clinically relevant extra-articular manifestations (eg, extensive skin, bowel, ocular, cardiovascular, urogenital, or pulmonary involvement), 6) Active enthesitis and/or dactylitis (i.e., sausage finger) 7) Predominant axial disease (ie, extensive spinal involvement).
Prior Authorization Group	IBRANCE
Drug Names	IBRANCE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	ICLUSIG
Drug Names	ICLUSIG
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of CML or Ph+ ALL was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	Patient will be monitored for evidence of thromboembolism and vascular occlusion. Cardiac and hepatic function will be monitored.

Prior Authorization Group	IMATINIB
Drug Names	IMATINIB MESYLATE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, desmoid tumors, pigmented villonodular synovitis/tenosynovial giant cell tumor (PVNS/TGCT), chordoma, and melanoma.
Exclusion Criteria	
Required Medical Information	Diagnosis of CML or Ph+ ALL was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, patient did not fail (excluding failure due to intolerance) prior therapy with a tyrosine kinase inhibitor (dasatinib, nilotinib, bosutinib, ponatinib). For myelodysplastic/ myeloproliferative disease, disease is associated with PDGFR gene re-arrangements. For aggressive systemic mastocytosis, D816V c-Kit mutation is negative or unknown. For melanoma, c-Kit mutation is positive. Patient has one of the following diagnoses: gastrointestinal stromal tumor, hypereosinophilic syndrome, chronic eosinophilic leukemia, desmoid tumor, dermatofibrosarcoma protuberans, PVNS/TGCT, or chordoma.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	IMBRUVICA
Drug Names	IMBRUVICA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, small lymphocytic lymphoma, lymphoplasmacytic lymphoma.
Exclusion Criteria	
Required Medical Information	For Waldenstrom's macroglobulinemia and lymphoplasmacytic lymphoma (WM/LPL): Imbruvica is used as a single agent.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	INCRELEX
Drug Names	INCRELEX
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Closed epiphyses
Required Medical Information	Must meet all of the following prior to beginning Increlex therapy (new starts only): 1) height 3 or more standard deviations below the mean for children of the same age and gender AND 2) basal IGF-1 level 3 or more standard deviations below the mean for children of the same age and gender AND 3) stimulation test showing a normal or elevated growth hormone level. For renewal, patient is growing more than 2 cm/year AND the current IGF-1 level is normal for age and gender.
Age Restrictions	
Prescriber Restrictions	Endocrinologist
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	INLYTA
Drug Names	INLYTA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, papillary, Hurthle cell, or follicular thyroid carcinoma
Exclusion Criteria	
Required Medical Information	For renal cell carcinoma, the disease is relapsed or medically unresectable. The medication will be used as a single agent. The tumor expresses predominantly clear cell or non-clear cell histology. If clear cell, the patient has previous tried and failed, or had an intolerance or contraindication to, Votrient (pazopanib) or Sutent (sunitinib). For thyroid carcinoma, the disease has papillary, Hurthle cell, or follicular histology. Nexavar is not an appropriate option for the patient. The disease is unresectable or metastatic. The disease is radioiodine refractory. The disease is progressive or symptomatic.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	IRESSA
Drug Names	IRESSA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	ITRACONAZOLE
Drug Names	ITRACONAZOLE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, Coccidioidomycosis, Cryptococcosis, Sporotrichosis, Penicilliosis, Microsporidiosis, Pityriasis versicolor/Tinea versicolor, Tinea corporis/Tinea cruris, Tinea manuum/Tinea pedis.
Exclusion Criteria	Evidence of ventricular dysfunction, such as congestive heart failure (CHF). Current use of certain drugs metabolized by CYP3A4.
Required Medical Information	1) If for the treatment of onychomycosis due to tinea, the diagnosis has been confirmed with a fungal diagnostic test OR 2) Pityriasis versicolor or Tinea versicolor OR 3) If for the treatment of tinea corporis, tinea cruris, tinea manuum, tinea pedis, the patient has experienced either an inadequate treatment response, adverse event, intolerance, or contraindication to griseofulvin OR 4) Diagnosis of blastomycosis, histoplasmosis, aspergillosis, coccidioidomycosis, cryptococcosis, sporotrichosis, penicilliosis, microsporidiosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Onychomycosis, Versicolor (pityriasis or tinea), Tinea-3mo, Systemic infection-6mo
Other Criteria	Criteria apply to capsule dosage form only.

Prior Authorization Group	IVIG
Drug Names	BIVIGAM, CARIMUNE NANOFILTERED, FLEBOGAMMA, FLEBOGAMMA DIF, GAMMAGARD LIQUID, GAMMAGARD S/D, GAMMAGARD S/D IGA LESS TH, GAMMAKED, GAMMAPLEX, GAMUNEX-C, OCTAGAM
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, chronic inflammatory demyelinating polyneuropathy, multifocal motor neuropathy, dermatomyositis, polymyositis, Guillain-Barre syndrome (GBS), relapsing-remitting multiple sclerosis (RRMS), myasthenia gravis, Lambert-Eaton myasthenic syndrome, Kawasaki syndrome, idiopathic thrombocytopenic purpura, pure red cell aplasia (PRCA), fetal/neonatal alloimmune thrombocytopenia, and prophylaxis of bacterial infections in B-cell chronic lymphocytic leukemia (CLL), bone marrow/hematopoietic stem cell transplant (BMT/HSCT) recipients, and pediatric HIV infection.
Exclusion Criteria	IgA deficiency with antibodies to IgA and a history of hypersensitivity. History of anaphylaxis or severe systemic reaction to human immune globulin or product components.
Required Medical Information	For dermatomyositis and polymyositis: standard 1st line treatments (corticosteroids or immunosuppressants) have been tried but were unsuccessful or not tolerated OR patient is unable to receive standard therapy because of a contraindication or other clinical reason. For GBS: physical mobility must be severely affected such that the patient requires an aid to walk AND IVIG therapy must be initiated within 2 weeks of symptom onset. For RRMS: standard 1st line treatments (interferon or glatiramer) have been tried but were unsuccessful or not tolerated OR patient is unable to receive standard therapy because of a contraindication or other clinical reason. For CLL: serum IgG less than 500 mg/dL OR a history of recurrent bacterial infections. For BMT/HSCT: serum IgG less than 400 mg/dL. For pediatric HIV infection: serum IgG less than 400 mg/dL OR a history of recurrent bacterial infections. PRCA is secondary to parvovirus B19 infection. For all indications: patients with any of the following risk factors for renal dysfunction must receive the minimum dose or concentration available of IVIG and the minimum infusion rate practicable: pre-existing renal insufficiency, diabetes mellitus, age over 65 years, volume depletion, sepsis, paraproteinemia, or receiving concomitant nephrotoxic drugs. For all indications: patients with any of the following risk factors for thrombosis must receive the minimum dose or concentration available of IVIG and the minimum infusion rate practicable: age 45 years or older, prolonged immobilization, hypercoagulable conditions, history of venous or arterial thrombosis, use of estrogens, indwelling central vascular catheters, hyperviscosity, or cardiovascular risk factors.
Age Restrictions	For pediatric HIV infection: age 12 years or younger
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

Prior Authorization Group	JAKAFI
Drug Names	JAKAFI
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For polycythemia vera, patient has had an inadequate response to or is intolerant of hydroxyurea.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	JUXTAPID
Drug Names	JUXTAPID
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	For initiation of treatment, moderate or severe hepatic impairment (eg, Child-Pugh B or C). For renewal, ALT or AST equal to or greater than 5 times the upper limit normal (ULN), or equal to greater than 3x ULN with signs or symptoms of liver toxicity or injury, increases in bilirubin greater than 2x ULN or active liver disease.
Required Medical Information	For initiation of therapy, 1. Patient has a diagnosis of homozygous familial hypercholesterolemia confirmed by one of the following: A. documented mutations in both alleles at LDL receptor, ApoB, PCSK9, or ARH adapter protein gene locus, B. documented skin fibroblast LDL receptor activity less than 20% of normal, OR C. the following criteria are met: a) untreated LDL-C greater than 500 mg/dL or unknown AND b) triglyceride level less than 350 mg/dL AND c) tendon or cutaneous xanthomas at age 10 or younger OR d) both parents with a history of LDL-C greater than 190 mg/dL, AND 2. Prior to initiation of treatment with Juxtapid, patient is/was receiving a current combination lipid-lowering regimen consisting of at least 3 of the following treatment options for at least 3 months: A. LDL apheresis, AND/OR B. For adults: atorvastatin 80mg, rosuvastatin 40mg, simvastatin 40-80mg, cholestyramine 24g, colesevelam 3.75g, colestipol 16g, ezetimibe 10mg, gemfibrozil 1200mg, or any fenofibrate or fenofibric acid product at doses greater than 105mg OR C. For children and adolescents: lipid lowering medications listed above at maximum tolerated doses AND 3. Prior to initiation of treatment with Juxtapid, patient is/was experiencing an inadequate response to such combination regimen, as demonstrated by one of the following: A. treated LDL-C greater than 300 mg/dL OR B. treated LDL-C greater than 200 mg/dL with a documented history of a) myocardial infarction, b) coronary bypass graft surgery, c) coronary arteriogram demonstrating significant coronary artery disease or percutaneous transluminal coronary angioplasty (PTCA) with or without atherectomy or coronary stent placement, or d) significant angina pectoris with a positive thallium or other heart scanning stress test. For renewal of therapy, 1. Patient meets all initial criteria AND 2. Current LDL-C is at least 20% lower from the levels immediately prior to initiation of treatment with Juxtapid.
Age Restrictions	
Prescriber Restrictions	Lipid specialist or cardiometabolic specialist
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	KALYDECO
Drug Names	KALYDECO
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	
Required Medical Information	The patient has a diagnosis of cystic fibrosis. The patient has one of the following documented mutations to the CFTR gene that was confirmed by genetic testing: G551D, G1244E, G1349D, G178R, G551S, S1251N, S1255P, S549N, S549R, or R117H.
Age Restrictions	Granules: 2 years of age and older, Tablets: 6 years of age and older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	KETOCONAZOLE
Drug Names	KETOCONAZOLE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, Cushing's syndrome.
Exclusion Criteria	Acute or chronic liver disease. Current use with dofetilide, quinidine, pimozide, cisapride, methadone, disopyramide, dronedarone, ranolazine.
Required Medical Information	The patient's liver status will be assessed prior to therapy and as needed during therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	1) Patient has one of the following diagnoses: blastomycosis, coccidioidomycosis, histoplasmosis, chromomycosis, and paracoccidioidomycosis AND other antifungal therapies are ineffective, unavailable, or not tolerated OR 2) Ketoconazole (Nizoral) is being prescribed for a patient with Cushing's syndrome who cannot tolerate surgery or surgery has not been curative.

Prior Authorization Group	KEVEYIS
Drug Names	KEVEYIS
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Severe pulmonary disease, hepatic insufficiency, concomitant use of high-dose aspirin
Required Medical Information	For primary HYPOkalemic periodic paralysis: 1) The diagnosis was supported by genetic test results, OR 2) patient has a family history of primary hypokalemic periodic paralysis, OR 3) patient's attacks are associated with hypokalemia AND both Andersen-Tawil syndrome and thyrotoxic periodic paralysis have been ruled out. For primary HYPERkalemic periodic paralysis: 1) The diagnosis was supported by genetic test results, OR 2) patient has a family history of primary hyperkalemic periodic paralysis, OR 3) patient's attacks are associated with hyperkalemia AND Andersen-Tawil syndrome has been ruled out.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 2 months. Continuation: 12 months.
Other Criteria	Keveyis is used as maintenance therapy to prevent attacks. For continuation of therapy, patient is demonstrating a response to Keveyis therapy as demonstrated by a decrease in the number of attacks.

Prior Authorization Group	KEYTRUDA
Drug Names	KEYTRUDA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For melanoma: Patient has unresectable or metastatic disease. For NSCLC: Patient has metastatic disease and tumor is positive for PD-L1 protein expression. Documentation of testing for PD-L1 protein expression, EGFR mutation, and ALK mutation. Patient meets one of the following criteria: 1) negative for the EGFR and ALK mutation and has experienced disease progression on platinum-containing chemotherapy OR 2) positive for the EGFR mutation and has experienced disease progression on EGFR targeted therapy (eg., erlotinib, afatinib) OR 3) positive for the ALK mutation and has experienced disease progression on ALK targeted therapy (eg., (crizotinib, ceritinib)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	KINERET
Drug Names	KINERET
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, systemic juvenile idiopathic arthritis, adult-onset Still's disease.
Exclusion Criteria	
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): 1) Inadequate response to at least a 3-month trial of a biologic DMARD or Xeljanz, OR 2) Intolerance to a biologic DMARD or Xeljanz. For adult onset Still's disease (new starts only): 1) Inadequate response to at least a 3-month trial of methotrexate, OR 2) Contraindication, or intolerance to methotrexate. For systemic juvenile idiopathic arthritis (new starts only): 1) Inadequate response to at least a 2-week trial of corticosteroids, OR 2) Inadequate response to at least a 3-month trial of methotrexate or leflunomide.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	KORLYM
Drug Names	KORLYM
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Korlym is being used to control hyperglycemia secondary to hypercortisolism in a patient with endogenous Cushing's syndrome who has type 2 diabetes mellitus or glucose intolerance. Patient had an inadequate or partial response to surgery or there is a clinical reason for why the patient is not a candidate for surgery.
Age Restrictions	
Prescriber Restrictions	Endocrinologist
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	KUVAN
Drug Names	KUVAN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Kuvan will be used in conjunction with a phenylalanine-restricted diet. For patients who have not yet received a therapeutic trial of Kuvan: a) patients less than or equal to 12 years of age have a baseline blood Phe level greater than 6 mg/dL OR b) patients greater than 12 years of age have a baseline blood Phe level greater than 10 mg/dL. For patients for whom this is the first treatment after a therapeutic trial of Kuvan: a) patient must have experienced a reduction in blood Phe level of greater than or equal to 30 percent from baseline OR b) patient has demonstrated an improvement in neuropsychiatric symptoms.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 1 month. Continuation of treatment: Plan Year.
Other Criteria	

Prior Authorization Group	KYNAMRO
Drug Names	KYNAMRO
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	For initiation of treatment, moderate or severe hepatic impairment (eg, Child-Pugh B or C). For renewal, ALT or AST equal to or greater than 5 times the upper limit normal (ULN), or equal to greater than 3x ULN with signs or symptoms of liver toxicity or injury, increases in bilirubin greater than 2x ULN or active liver disease.
Required Medical Information	For initiation of therapy, all of the following requirements are met : 1)Patient has a diagnosis of homozygous familial hypercholesterolemia confirmed by one of the following: a) documented mutations in both alleles at LDL receptor, ApoB, PCSK9, or ARH adapter protein gene locus, b) documented skin fibroblast LDL receptor activity less than 20% of normal, OR c) the following criteria are met: i) untreated LDL-C greater than 500 mg/dL or unknown AND ii) triglyceride level less than 350 mg/dL AND iii) tendon or cutaneous xanthomas at age 10 or younger or both parents with a history of LDL-C greater than 190 mg/dL, AND 2)Prior to initiation of treatment with Kynamro, patient is/was receiving a current combination lipid-lowering regimen consisting of at least three of the following treatment options for at least 3 months: a) For adults: atorvastatin 80mg, rosuvastatin 40mg, simvastatin 40-80mg, cholestyramine 24g, colesevelam 3.75g, colestipol 16g, ezetimibe 10mg, gemfibrozil 1200mg, or any fenofibrate or fenofibric acid product at doses greater than 105mg, b) For children and adolescents: lipid lowering medications listed above in a) at maximum tolerated doses, AND 3)Prior to initiation of treatment with Kynamro, patient is/was experiencing an inadequate response to such combination regimen, as demonstrated by one of the following: a) treated LDL-C greater than 300 mg/dL OR b) treated LDL-C greater than 200 mg/dL with a documented history of myocardial infarction, coronary bypass graft surgery, coronary arteriogram demonstrating significant coronary artery disease, percutaneous transluminal coronary angioplasty (PTCA) with or without atherectomy, coronary stent placement, or significant angina pectoris with a positive thallium or other heart scanning stress test. For renewal of therapy, Patient meets all criteria for initiation of therapy AND current LDL-C is at least 20% lower from levels immediately prior to initiation of treatment with Kynamro.
Age Restrictions	
Prescriber Restrictions	Lipid specialist or cardiometabolic specialist
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	LEMTRADA
Drug Names	LEMTRADA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Human immunodeficiency virus (HIV) infection
Required Medical Information	Member has a diagnosis of a relapsing form of multiple sclerosis (MS) (eg, relapsing-remitting MS, progressive-relapsing MS, or secondary progressive MS with relapses). For First Course, member has had an inadequate response to two or more drugs indicated for MS despite adequate duration of treatment. For Second Course, member received the first course of treatment (ie, five 12-mg infusions) at least 12 months prior to the planned date of the first dose of the second course.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	For first course, 5 days. For second course, 3 days.
Other Criteria	

Prior Authorization Group	LENVIMA
Drug Names	LENVIMA 10 MG DAILY DOSE, LENVIMA 14 MG DAILY DOSE, LENVIMA 18 MG DAILY DOSE, LENVIMA 20 MG DAILY DOSE, LENVIMA 24 MG DAILY DOSE, LENVIMA 8 MG DAILY DOSE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	LETAIRIS
Drug Names	LETAIRIS
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	NYHA Functional Class II or III symptoms. PAH (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	LEUKINE
Drug Names	LEUKINE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, chemotherapy-induced febrile neutropenia (FN), following chemotherapy for acute lymphocytic leukemia (ALL) or acute myeloid leukemia (AML), myelodysplastic syndromes (MDS), agranulocytosis, aplastic anemia, HIV-related neutropenia.
Exclusion Criteria	Use of Leukine within 24 hours preceding or following chemotherapy or radiotherapy. For treatment of chemotherapy-induced FN, patient received prophylactic pegylated G-CSF (eg, Neulasta) during the current chemotherapy cycle.
Required Medical Information	For prophylaxis of myelosuppressive chemotherapy-induced FN: 1) Patient has a non-myeloid cancer AND 2) Patient is currently receiving or will be receiving treatment with myelosuppressive anti-cancer therapy. For treatment of myelosuppressive chemotherapy-induced FN: 1) Patient has a non-myeloid cancer AND 2) Patient is currently receiving or has received treatment with myelosuppressive anti-cancer therapy. For MDS: Patient has neutropenia and recurrent or resistant infections.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	

Prior Authorization Group	LIDOCAINE PATCHES
Drug Names	LIDOCAINE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, pain associated with diabetic neuropathy, pain associated with cancer-related neuropathy
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	LONSURF
Drug Names	LONSURF
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For metastatic colorectal cancer, KRAS (with or without NRAS) mutation testing is performed on either the primary tumor or metastases to confirm RAS mutation status. The patient must have been previously treated with fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy, an anti-VEGF therapy, and, if KRAS or NRAS wild type, an anti-EGFR therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	LOTRONEX
Drug Names	ALOSETRON HYDROCHLORIDE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient has a history of any of the following conditions: Chronic or severe constipation or sequelae from constipation. Intestinal obstruction, stricture, toxic megacolon, gastrointestinal perforation, and/or adhesions. Ischemic colitis. Impaired intestinal circulation, thrombophlebitis or hypercoagulable state. Crohn's disease or ulcerative colitis. Diverticulitis. Severe hepatic impairment.
Required Medical Information	1) Lotronex is being prescribed for a woman with a diagnosis of severe diarrhea-predominant irritable bowel syndrome (IBS) AND 2) chronic IBS symptoms lasting at least 6 months AND 3) gastrointestinal tract abnormalities have been ruled out AND 4) inadequate response to conventional therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	LUMIZYME
Drug Names	LUMIZYME
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of Pompe disease was confirmed by an enzyme assay demonstrating a deficiency of GAA enzyme activity or by DNA testing that identifies mutations in the GAA gene.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	LUPANETA
Drug Names	LUPANETA PACK
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Undiagnosed abnormal vaginal bleeding. Pregnancy. Breastfeeding.
Required Medical Information	For retreatment patient must meet all of the following (one-time retreatment course allowed): 1) Patient has had a recurrence of symptoms, AND 2) Bone mineral density is within normal limits.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	

Prior Authorization Group	LUPRON
Drug Names	LEUPROLIDE ACETATE, LUPRON DEPOT, LUPRON DEPOT-PED
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, breast cancer (Lupron Depot 3.75mg only), ovarian stromal tumors (Lupron Depot 3.75mg and Lupron Depot 3-Month 11.25mg only), epithelial ovarian cancer/fallopian tube cancer/primary peritoneal cancer (Lupron Depot 3.75mg only), in combination with growth hormone for children with growth failure and advancing puberty (leuprolide acetate only).
Exclusion Criteria	Pregnancy for female patients except for children with CPP. Breastfeeding (Lupron Depot 3.75mg and Lupron Depot 3-Month 11.25mg). Undiagnosed abnormal vaginal bleeding (Lupron Depot 3.75mg and Lupron Depot 3-Month 11.25mg).
Required Medical Information	For prostate cancer: If the patient (pt) has metastatic disease (ds), node positive ds, or recurrent ds as defined as a biochemical failure after previous therapy, then no further information is required. If the pt has none of the abovementioned criteria and has intermediate or high risk stratification (RS), then the medication must be used with external beam radiation therapy. If the pt has none of the abovementioned criteria and has very high RS, the medication may be used with radiation therapy unless the pt is not a candidate for definitive therapy. For endometriosis retreatment, pt must meet all of the following: 1) Pt has had a recurrence of symptoms AND 2) Pt will be receiving add-back therapy (eg, norethindrone) AND 3) Bone mineral density (BMD) is within normal limits (WNL). For uterine fibroids (UF), pt must meet one of the following: 1) Diagnosis of anemia (ie, hematocrit less than or equal to 30 percent and/or hemoglobin less than or equal to 10g/dL) AND Lupron Depot will be used in conjunction with iron therapy OR 2) Lupron Depot will be used in the preoperative setting to facilitate surgery. For UF retreatment, BMD is WNL. For epithelial ovarian cancer/fallopian tube cancer/primary peritoneal cancer: Lupron Depot (3.75mg only) will be used as a single agent AND disease is persistent or recurrent. For breast cancer, Lupron Depot (3.75mg only), pt must meet both of the following: 1) Premenopausal woman AND 2) Hormone receptor positive disease. For CPP (Lupron Depot-PED), patients not currently receiving therapy must meet all of the following: 1) Diagnosis of CPP confirmed by a) A pubertal response to a GnRH agonist OR a basal 3rd generation LH level AND b) Assessment of bone age versus chronological age AND c) Appropriate diagnostic imaging of the brain has been done to exclude an intracranial tumor, AND 2) The onset of sexual characteristics occurred prior to 8 years of age for female patients OR prior to 9 years of age for male patients.
Age Restrictions	For endometriosis, fibroids, breast cancer, ovarian stromal tumors, epithelial ovarian cancer/fallopian tube cancer/primary peritoneal cancer: 18 years of age or older. CPP: Patient must be less than 12 years old if female and less than 13 years old if male.
Prescriber Restrictions	
Coverage Duration	Fibroids: 3 mo, max 6 mo (lifetime). Endometriosis: 6 mo, max 12 mo (lifetime). Others: Plan Year.
Other Criteria	For prostate cancer, the medication will not be used as neoadjuvant androgen deprivation therapy (ADT) before radical prostatectomy.

Prior Authorization Group	LYNPARZA
Drug Names	LYNPARZA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	MEGACE ES
Drug Names	MEGESTROL ACETATE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Pregnancy
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	MEKINIST
Drug Names	MEKINIST
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	As a single agent for the treatment of patients who have received prior BRAF-inhibitor therapy (eg, Zelboraf, Tafinlar)
Required Medical Information	Patient has a diagnosis of unresectable or metastatic melanoma AND the tumor is positive for either BRAF V600E or V600K mutation AND patient will use Mekinist as either a single agent or in combination with Tafinlar.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	MIRCERA
Drug Names	MIRCERA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Pretreatment (no Mircera treatment in previous two months or other erythropoietin treatment in previous month) Hgb is less than 10 g/dL. For reauthorizations (patient received Mircera in previous two months or other erythropoietin in previous month): 1) an increase in Hgb of at least 1 g/dL after at least 12 weeks of therapy, AND 2) current Hgb is less than or equal to 10 g/dL OR Hgb is greater than 10 but less than or equal to 12 g/dL AND prescriber will reduce or interrupt dose.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	12 weeks
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual (eg, used for treatment of anemia for a patient with chronic renal failure who is undergoing dialysis, or furnished from physician's supply incident to a physician service). Requirements regarding Hgb values exclude values due to a recent transfusion.

Prior Authorization Group	MODAFINIL
Drug Names	MODAFINIL
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	1) Diagnosis is narcolepsy confirmed by sleep lab evaluation OR 2) Diagnosis is obstructive sleep apnea (OSA) confirmed by polysomnography OR 3) Diagnosis is shift work disorder (SWD).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	MOZOBIL
Drug Names	MOZOBIL
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	

Prior Authorization Group	MYOZYME
Drug Names	MYOZYME
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of Pompe disease was confirmed by an enzyme assay demonstrating a deficiency of GAA enzyme activity or by DNA testing that identifies mutations in the GAA gene.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	NAGLAZYME
Drug Names	NAGLAZYME
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of mucopolysaccharidosis VI (MPS VI) was confirmed by an enzyme assay demonstrating a deficiency in N-acetylgalactosamine 4-sulfatase (arylsulfatase B) enzyme activity or by DNA testing.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	NAMENDA
Drug Names	MEMANTINE HCL, MEMANTINE HYDROCHLORIDE, NAMENDA XR, NAMENDA XR TITRATION PACK
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	The drug is being prescribed for the treatment of moderate to severe dementia of the Alzheimer's type.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	This edit only applies to patients less than 30 years of age.

Prior Authorization Group	NATPARA
Drug Names	NATPARA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D
Exclusion Criteria	Acute postsurgical hypoparathyroidism (within 6 months of surgery). Hypoparathyroidism due to calcium-sensing receptor mutations. Any of the following risk factors for osteosarcoma: Paget's disease of bone, unexplained elevations of alkaline phosphatase, open epiphyses (ie, children or young adults), hereditary disorder that predisposes to osteosarcoma, or history of external beam or implant radiation therapy involving the skeleton.
Required Medical Information	Natpara is prescribed to control hypocalcemia associated with hypoparathyroidism. Natpara will be used in conjunction with calcium supplements with or without calcitriol (activated vitamin D). For initial therapy only: 1) total serum calcium levels are inadequately controlled despite treatment with optimized doses of calcium supplements and calcitriol, 2) total serum calcium level (albumin-corrected) is above 7.5 mg/dL, 3) serum 25-hydroxyvitamin D level is within the normal range, and 4) serum magnesium level is within the normal range. For continuation of therapy only: 1) total serum calcium level (albumin-corrected) is within the low-normal range (generally between 8 mg/dL and 9 mg/dL) OR the dose of Natpara, calcitriol, or calcium supplement is being adjusted to achieve total serum calcium levels within the low-normal range, AND 2) serum 25-hydroxyvitamin D level is within the normal range.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	NEULASTA
Drug Names	NEULASTA, NEULASTA ONPRO KIT
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, mobilization of peripheral blood progenitor cells prior to autologous transplantation.
Exclusion Criteria	Use of Neulasta within 14 days before or 24 hours after chemotherapy, unless Neulasta is requested for administration once per cycle at least 24 hours after completion of chemotherapy for a patient receiving a chemotherapy regimen administered every 14 days.
Required Medical Information	For prophylaxis of myelosuppressive chemotherapy-induced febrile neutropenia: 1) Patient has a non-myeloid cancer AND 2) Patient is currently receiving or will be receiving treatment with myelosuppressive anti-cancer therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	

Prior Authorization Group	NEXAVAR
Drug Names	NEXAVAR
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, osteosarcoma, angiosarcoma, desmoid tumors (aggressive fibromatosis), progressive gastrointestinal stromal tumor (GIST), medullary thyroid carcinoma
Exclusion Criteria	
Required Medical Information	For renal cell carcinoma, patient has relapsed or medically unresectable disease and Nexavar will be used as a single agent. If clear cell histology, the patient has previous tried and failed, or had an intolerance or contraindication to, Votrient (pazopanib) or Sutent (sunitinib). For hepatocellular carcinoma, patient has unresectable disease and Nexavar will be used as a single agent. For osteosarcoma, Nexavar will be used as a single agent. For GIST, disease progressed after failure of imatinib, sunitinib, or regorafenib. For follicular, Hurthle cell, and papillary thyroid carcinoma, the disease is unresectable or metastatic. The disease is radio-iodine refractory. The disease is progressive or symptomatic. For medullary thyroid carcinoma, after progression on vandetanib or cabozantinib OR vandetanib or cabozantinib are not appropriate options
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	NINLARO
Drug Names	NINLARO
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	NUCALA
Drug Names	NUCALA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of severe asthma with an eosinophilic phenotype. Nucala is used in combination with other medications for the maintenance treatment of asthma. Patient has a rapid acting beta2-agonist available for rescue therapy. For initial therapy only: 1) Patient has baseline eosinophil count of at least 150 cells per microliter, and 2) Patient has a history of severe asthma attacks (exacerbations) despite current treatment with both of the following medications at optimized doses: a) inhaled corticosteroid AND b) additional controller (long acting beta2-agonist, leukotriene modifier, or sustained-release theophylline). For continuation therapy only: Asthma control has improved on Nucala treatment, demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations.
Age Restrictions	12 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	NUEDEXTA
Drug Names	NUEDEXTA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient is currently using quinidine, quinine, mefloquine, monoamine oxidase inhibitors (MAOIs), or drugs that both prolong the QT interval and are metabolized by CYP2D6 (examples: thioridazine and pimozide). Patient has a prolonged QT interval or congenital long QT syndrome (LQTS), or heart failure or a history suggestive of torsades de pointes (TdP). Patient has complete atrioventricular (AV) block without an implanted pacemaker or is at high risk of complete AV block.
Required Medical Information	Nuedexta is being prescribed for the treatment of pseudobulbar affect (PBA).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	NUPLAZID
Drug Names	NUPLAZID
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Dementia-related psychosis that is unrelated to the hallucinations and delusions associated with Parkinson's disease psychosis.
Required Medical Information	The diagnosis of Parkinson's disease was made prior to the onset of psychotic symptoms. Member has a baseline mini-mental status examination (MMSE) score of at least 21 points.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	NUVIGIL
Drug Names	ARMODAFINIL, NUVIGIL
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	1) Diagnosis is narcolepsy confirmed by sleep lab evaluation OR 2) Diagnosis is obstructive sleep apnea (OSA) confirmed by polysomnography OR 3) Diagnosis is Shift Work Disorder (SWD).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	OCTREOTIDE
Drug Names	OCTREOTIDE ACETATE
Covered Uses	All FDA-approved indication not otherwise covered under Part D, poorly differentiated (high-grade) neuroendocrine tumor (NET)/large or small cell, pancreatic endocrine tumors (Islet cell tumors), carcinoid tumors, lung NET, unresectable and recurrent meningiomas, thymic carcinomas.
Exclusion Criteria	
Required Medical Information	For Acromegaly, must meet all of the following: 1) Clinical evidence of acromegaly, AND 2) Pre-treatment high IGF-1 level for age/gender, AND 3) Patient had an inadequate or partial response to surgery and/or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	For acromegaly continuation of therapy: the IGF-1 level decreased or normalized.

Prior Authorization Group	ODOMZO
Drug Names	ODOMZO
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Pregnancy
Required Medical Information	Member has a diagnosis of locally advanced basal cell carcinoma (BCC). Member experienced disease recurrence following surgery or radiation therapy OR member is not a candidate for surgery or radiation therapy. For females of reproductive potential, pregnancy has been ruled out with a negative pregnancy test result.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	OFEV
Drug Names	OFEV
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Initial Review Only: The patient does not have a known etiology for interstitial lung disease. The patient has completed a high-resolution computed tomography study of the chest which reveals the usual interstitial pneumonia pattern. If the study reveals the possible usual interstitial pneumonia pattern, the diagnosis is supported by surgical lung biopsy. If a surgical lung biopsy has not been previously conducted, the diagnosis is supported by a multidisciplinary discussion between a radiologist and pulmonologist who are experienced in idiopathic pulmonary fibrosis. The prescriber will collect LFTs on the schedule recommended in the package insert. For initial and continuation: Ofev will not be used in combination with Esbriet.
Age Restrictions	
Prescriber Restrictions	Pulmonologist
Coverage Duration	Initial: 6 months, Renewal: Plan Year
Other Criteria	For continuation only: The patient has experienced a reduction in disease progression. The patient's AST or ALT is not greater than 5x upper limit of normal (ULN) OR the AST or ALT is not greater than 3x ULN with signs or symptoms of severe liver damage.

Prior Authorization Group	ONFI
Drug Names	ONFI
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	ONMEL
Drug Names	ONMEL
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Evidence of ventricular dysfunction, such as congestive heart failure (CHF). Current use of certain drugs metabolized by CYP3A4.
Required Medical Information	Treatment of onychomycosis of the toenail due to Trichophyton that has been confirmed by a fungal diagnostic test.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	Criteria apply to tablet dosage form only.

Prior Authorization Group	OPSUMIT
Drug Names	OPSUMIT
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	NYHA Functional Class II or III symptoms. PAH (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	ORAL-INTRANASAL FENTANYL
Drug Names	ABSTRAL, FENTANYL CITRATE ORAL TRA, FENTORA, LAZANDA, SUBSYS
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Significant respiratory depression. Known or suspected paralytic ileus.
Required Medical Information	1) The drug is being prescribed for the management of breakthrough pain in a cancer patient who is already receiving around-the-clock opioid therapy for underlying cancer pain AND 2) The patient can safely take the requested dose based on their current opioid use history. [Note: The TIRF (Transmucosal Immediate-Release Fentanyl) products (Abstral, Actiq, Fentora, Lazanda, and Subsys) are indicated for opioid-tolerant patients. Patients considered opioid tolerant are those who are taking at least: 60 mg of oral morphine/day, 25 mcg of transdermal fentanyl/hour, 30 mg oral oxycodone/day, 8 mg oral hydromorphone/day, 25 mg oral oxymorphone/day, or an equianalgesic dose of another opioid for a week or longer.]
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	ORENCIA
Drug Names	ORENCIA, ORENCIA CLICKJECT
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Latent TB screening with either a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB) prior to initiating Orencia (or other biologic). For moderately to severely active rheumatoid arthritis (new starts only): 1) Inadequate response to at least a 3-month trial of methotrexate (MTX) OR 2) Intolerance or contraindication to MTX OR 3) Inadequate response to at least a 3-month trial of biologic DMARD or Xeljanz OR 4) Intolerance to a prior biologic DMARD or Xeljanz. For active polyarticular juvenile idiopathic arthritis (new starts only): 1) Inadequate response to at least a 3-month trial of a TNF inhibitor (eg, Humira), OR 2) Intolerance or contraindication to a TNF inhibitor (eg, Humira).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	Orencia will not be used in combination with a TNF inhibitor.

Prior Authorization Group	ORENITRAM
Drug Names	ORENITRAM
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Severe hepatic impairment (Child Pugh Class C).
Required Medical Information	NYHA Functional Class II or III symptoms. PAH (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	ORFADIN
Drug Names	ORFADIN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of hereditary tyrosinemia type 1 is confirmed by one of the following: 1) biochemical testing (eg, detection of succinylacetone in urine) and appropriate clinical picture of the patient, OR 2) DNA testing (mutation analysis).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	ORKAMBI
Drug Names	ORKAMBI
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Use in combination with Kalydeco
Required Medical Information	The patient is positive for the F508del mutation on both alleles of the CFTR gene.
Age Restrictions	12 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	OTEZLA
Drug Names	OTEZLA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For active psoriatic arthritis, patient has had an inadequate response, contraindication, or intolerance to at least two disease-modifying antirheumatic drugs (DMARDs). For moderate to severe plaque psoriasis: 1) At least 5% of body surface area (BSA) is affected or crucial body areas (eg, feet, hands, face, neck and/or groin) are affected, AND 2) Inadequate response to either phototherapy (eg, UVB, PUVA) or a traditional systemic agent (eg, methotrexate, cyclosporine, acitretin), unless contraindicated or intolerant to such therapies.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	PEGASYS
Drug Names	PEGASYS, PEGASYS PROCLICK
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, chronic myelogenous leukemia (CML), giant cell tumor of the bone (GCTB).
Exclusion Criteria	Decompensated cirrhosis (Child Turcotte Pugh class B or C)
Required Medical Information	For chronic hepatitis C (CHC): CHC infection confirmed by presence of HCV RNA in serum prior to starting treatment (tx). For monotherapy OR dual therapy with ribavirin (RBV): total 48 weeks (wks). For tx with Olysio and RBV: total 48 wks. For tx with Sovaldi and RBV: total 12 wks. For chronic hepatitis B: 1) For pt with cirrhosis, must have been HBsAg positive for at least 6 months AND must have serum HBV-DNA greater than or equal to 10,000 copies/mL or greater than or equal to 2,000 IU/mL regardless of HBeAg status. 2) For pts without cirrhosis, must have been HBsAg positive for at least 6 months. If HBeAg positive, pt must have serum HBV-DNA greater than 100,000 copies/mL or greater than 20,000 IU/mL. If HBeAg negative, pt must have serum HBV-DNA greater than 10,000 copies/mL or greater than 2,000 IU/mL. Must have persistent or intermittently elevated ALT greater than 2 times the upper limit of normal OR liver biopsy showing chronic hepatitis with moderate to severe inflammation or significant fibrosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	HCV=12 to 48 wks depending on treatment regimen. HBV=48 wks. CML and GCTB = Plan Year.
Other Criteria	

Prior Authorization Group	PEGINTRON
Drug Names	PEG-INTRON REDIPEN, PEGINTRON
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, chronic myelogenous leukemia (CML).
Exclusion Criteria	Decompensated liver disease (eg, Child Turcotte Pugh class B or C)
Required Medical Information	For chronic hepatitis C (CHC): CHC infection confirmed by presence of HCV RNA in serum prior to starting treatment (tx). For monotherapy OR dual therapy with ribavirin (RBV): total 48 weeks (wks). For tx with Olysio and RBV (G1 only): 1) total 24 wks for patients (pts) without history of nonresponse to prior therapy with PEG-IFN and RBV, 2) total 48 wks for pts with nonresponse to prior HCV therapy with PEG-IFN and RBV and HCV-RNA less than 25 IU/mL at wk 24. For tx with Sovaldi and RBV: 1)Total 12 wks for G2 infection in pts who failed prior tx with PEG-IFN and RBV or prior tx with sofosbuvir and ribavirin, 2)Total 12 wks for G3,4,5,6 infection and tx-naive or failed prior tx with PEG-IFN and RBV, 3)Total 12 wks for G3 infection in pts who failed prior tx with sofosbuvir and RBV, 4)HCV/HIV coinfection: a) Pt meets criteria for requested regimen above, and b) Will not receive tx with tipranavir.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	HCV=12 to 48 wks depending on treatment regimen and genotype. CML = Plan Year.
Other Criteria	

Prior Authorization Group	PERJETA
Drug Names	PERJETA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, adjuvant therapy for early stage breast cancer.
Exclusion Criteria	
Required Medical Information	For neoadjuvant therapy or adjuvant therapy if a Perjeta-containing regimen was not used as neoadjuvant therapy to treat HER2-positive breast cancer: disease must be greater than or equal to T2 or greater than or equal to N1 HER2-positive early stage breast cancer AND Perjeta must be used 1) in combination with trastuzumab and paclitaxel or trastuzumab and docetaxel following AC (doxorubicin and cyclophosphamide) regimen, 2) in combination with TCH (docetaxel, carboplatin, and trastuzumab) regimen, OR 3) in combination with trastuzumab and paclitaxel or trastuzumab and docetaxel prior to or following FEC/CEF (fluorouracil, epirubicin, and cyclophosphamide) regimen. For recurrent or metastatic HER2-positive breast cancer: disease is either hormone receptor (HR)-negative or HR-positive and endocrine therapy refractory or with symptomatic visceral disease AND Perjeta must be used 1) in combination with trastuzumab with a taxane OR 2) in combination with trastuzumab with or without cytotoxic therapy (e.g., vinorelbine or taxane) in patients previously treated with chemotherapy and trastuzumab in the absence of pertuzumab.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Neoadjuvant/adjuvant therapy: 6 months Recurrent or metastatic breast cancer: Plan Year
Other Criteria	

Prior Authorization Group	PHENYLBUTYRATE
Drug Names	BUPHENYL
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of urea cycle disorder (UCD) was confirmed by enzymatic, biochemical or genetic testing. Buphenyl will be used for chronic management of UCD.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	POMALYST
Drug Names	POMALYST
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, systemic light chain amyloidosis.
Exclusion Criteria	
Required Medical Information	For multiple myeloma, The patient has been previously treated with bortezomib. The patient has been previously treated with lenalidomide or thalidomide. The disease progressed during the previous treatment or within 60 days of completion of the previous therapy. Pomalyst will be used as a single agent or in combination with dexamethasone. For amyloidosis, Pomalyst will be given in combination with dexamethasone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	PRALUENT
Drug Names	PRALUENT
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Member must have one of the following conditions (new starts and continuation): 1) Prior clinical atherosclerotic cardiovascular disease (ASCVD) or cardiovascular event (see Other Criteria), or 2) Heterozygous familial hypercholesterolemia (HeFH): Definite diagnosis of FH (See Other Criteria). For new starts: For members with prior clinical ASCVD or cardiovascular event, at least one of the following requirements is met: 1) Current LDL-C level 70 mg/dL or greater after treatment with a high-intensity statin (eg, atorvastatin, rosuvastatin), 2) Current LDL-C level 70 mg/dL or greater with intolerance to a high-intensity statin AND is taking a maximally tolerated dose of any statin, 3) Current LDL-C level 70 mg/dL or greater with contraindication to statin (see Other Criteria) OR intolerance to any dose of two statins, or 4) Recent treatment (ie, within the last 120 days) with another PCSK9 inhibitor. For members with HeFH, at least one of the following requirements is met: 1) With ASCVD: See requirements for members with prior ASCVD above, 2) Current LDL-C level 100 mg/dL or greater after treatment with a high-intensity statin (eg, atorvastatin, rosuvastatin), 3) Current LDL-C level 100 mg/dL or greater with intolerance to a high-intensity statin AND is taking a maximally tolerated dose of any statin, 4) Current LDL-C level 100 mg/dL or greater with contraindication to statin (see Other Criteria) OR intolerance to any dose of two statins, or 5) Recent treatment (ie, within the last 120 days) with another PCSK9 inhibitor. For continuation: Response to therapy as demonstrated by a reduction in LDL-C.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	Clinical ASCVD or cardiovascular event defined as acute coronary syndromes, myocardial infarction, stable or unstable angina, coronary or other arterial revascularization procedure [eg, PTCA, CABG], stroke of presumed atherosclerotic origin, transient ischemic attack, peripheral arterial disease of presumed atherosclerotic origin, findings from CT angiogram or catheterization consistent with clinical ASCVD). Diagnosis of FH must be confirmed by one of the following: 1) Genetic confirmation: An LDL-receptor mutation, familial defective apo B-100, or a PCSK9 gain-of-function mutation, 2) Simon-Broome Diagnostic Criteria for definite FH: Total cholesterol greater than 290 mg/dL or LDL-C greater than 190 mg/dL, plus tendon xanthoma in patient, first-degree (parent, sibling or child) or second-degree relative (grandparent, uncle or aunt), or 3) Dutch Lipid Clinic Network Criteria for definite FH: Total score greater than 8 points. Contraindication to statin must be due to one of the following: 1) Active liver disease, including unexplained persistent elevations in hepatic transaminase levels (eg, ALT level at least 3 times ULN), 2) Women who are pregnant or may become pregnant, or 3) Nursing mothers.

Prior Authorization Group	PRIVIGEN
Drug Names	PRIVIGEN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, chronic inflammatory demyelinating polyneuropathy, multifocal motor neuropathy, dermatomyositis, polymyositis, Guillain-Barre syndrome (GBS), relapsing-remitting multiple sclerosis (RRMS), myasthenia gravis, Lambert-Eaton myasthenic syndrome, Kawasaki syndrome, pure red cell aplasia (PRCA), fetal/neonatal alloimmune thrombocytopenia, and prophylaxis of bacterial infections in B-cell chronic lymphocytic leukemia (CLL), bone marrow/hematopoietic stem cell transplant (BMT/HSCT) recipients, and pediatric HIV infection.
Exclusion Criteria	IgA deficiency with antibodies to IgA and a history of hypersensitivity. History of anaphylaxis or severe systemic reaction to human immune globulin or product components. Hyperprolinemia.
Required Medical Information	For dermatomyositis and polymyositis: standard 1st line treatments (corticosteroids or immunosuppressants) have been tried but were unsuccessful or not tolerated OR patient is unable to receive standard therapy because of a contraindication or other clinical reason. For GBS: physical mobility must be severely affected such that the patient requires an aid to walk AND IVIG therapy must be initiated within 2 weeks of symptom onset. For RRMS: standard 1st line treatments (interferon or glatiramer) have been tried but were unsuccessful or not tolerated OR patient is unable to receive standard therapy because of a contraindication or other clinical reason. For CLL: serum IgG less than 500 mg/dL OR a history of recurrent bacterial infections. For BMT/HSCT: serum IgG less than 400 mg/dL. For pediatric HIV infection: serum IgG less than 400 mg/dL OR a history of recurrent bacterial infections. PRCA is secondary to parvovirus B19 infection. For all indications: patients with any of the following risk factors for renal dysfunction must receive the minimum dose or concentration available of IVIG and the minimum infusion rate practicable: pre-existing renal insufficiency, diabetes mellitus, age over 65 years, volume depletion, sepsis, paraproteinemia, or receiving concomitant nephrotoxic drugs. For all indications: patients with any of the following risk factors for thrombosis must receive the minimum dose or concentration available of IVIG and the minimum infusion rate practicable: age 45 years or older, prolonged immobilization, hypercoagulable conditions, history of venous or arterial thrombosis, use of estrogens, indwelling central vascular catheters, hyperviscosity, or cardiovascular risk factors.
Age Restrictions	For pediatric HIV infection: age 12 years or younger
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

Prior Authorization Group	PROCYSBI
Drug Names	PROCYSBI
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of nephropathic cystinosis was confirmed by the presence of increased cysteine concentration in leukocytes or by DNA testing. Patient has tried and experienced intolerance to prior Cystagon therapy.
Age Restrictions	2 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	PROMACTA
Drug Names	PROMACTA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For chronic or persistent immune thrombocytopenia (ITP): 1) For new starts: a) Patient has had an inadequate response or is intolerant to corticosteroids, immunoglobulins or splenectomy, AND b) Untransfused platelet count at time of diagnosis is less than 30,000/mcL OR 30,000-50,000/mcL with symptomatic bleeding or risk factor(s) for bleeding. 2) For continuation of therapy, platelet (plt) count response to Promacta: a) Current plt count is 50,000-200,000/mcL OR b) Current plt count is less than 50,000/mcL and sufficient to avoid clinically important bleeding OR c) Current plt count is less than 50,000/mcL and patient has not received a maximal dose of Promacta for at least 4 weeks OR d) Current plt count is greater than 200,000/mcL and dosing will be adjusted to a plt count sufficient to avoid clinically important bleeding. For thrombocytopenia associated with chronic hepatitis C: 1) For new starts: a) Promacta is used for initiation and maintenance of interferon-based therapy, AND b) Untransfused platelet count at time of diagnosis is less than 75,000/mcL. 2) For continuation of therapy: patient is receiving interferon-based therapy. For severe aplastic anemia (AA): 1) For new starts: a) Patient has had an inadequate response to immunosuppressive therapy, AND b) Untransfused platelet count at time of diagnosis is less than or equal to 30,000/mcL. 2) For continuation of therapy, plt count response to Promacta: a) Current plt count is 50,000-200,000/mcL OR b) Current plt count is less than 50,000/mcL and patient has not received appropriately titrated therapy for at least 16 weeks OR c) Current plt count is greater than 200,000/mcL and dosing will be adjusted to achieve and maintain an appropriate target plt count. Adequate platelet response = APR. Inadequate platelet response = IPR.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	HCV:6mo, ITP/AA initial:6mo, ITP/AA APR reauth: Plan Yr, ITP IPR reauth:3mo, AA IPR reauth:16wks
Other Criteria	

Prior Authorization Group	QUININE SULFATE
Drug Names	QUININE SULFATE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, Babesiosis.
Exclusion Criteria	Prolonged QT interval. Glucose-6-phosphate dehydrogenase (G6PD) deficiency. Myasthenia gravis. Optic neuritis.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 month
Other Criteria	

Prior Authorization Group	RAGWITEK
Drug Names	RAGWITEK
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Severe, unstable, or uncontrolled asthma. History of any severe systemic allergic reaction or any severe local reaction to sublingual allergen immunotherapy. A history of eosinophilic esophagitis. Medical conditions that may reduce the ability of the patient to survive a serious allergic reaction or increase the risk of adverse reactions after epinephrine administration. Patient is on any medication(s) that can inhibit or potentiate the effect of epinephrine.
Required Medical Information	
Age Restrictions	18 through 65 years of age
Prescriber Restrictions	Allergist or in consultation with an allergist
Coverage Duration	6 months
Other Criteria	1) Auto-injectable epinephrine will be prescribed or available to the patient and the patient will be instructed and trained on its use AND 2)Treatment is initiated at least 12 weeks prior to expected onset of the ragweed pollen season AND 3) For a patient currently receiving Ragwitek, patient must show benefit from Ragwitek treatment (i.e., reduction in symptoms of allergic rhinitis and conjunctivitis, decreased use of rescue medications such as antihistamines and nasal or oral corticosteroids).

Prior Authorization Group	RAVICTI
Drug Names	RAVICTI
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of urea cycle disorder (UCD) was confirmed by enzymatic, biochemical or genetic testing. Ravicti will be used for chronic management of UCD. UCD cannot be managed by dietary protein restriction and/or amino acid supplementation alone. Ravicti will be used in combination with dietary protein restriction. Patient has experienced intolerance to prior Buphenyl therapy OR patient has not tried Buphenyl because of a comorbid condition that prohibits a trial due to its sodium content (eg, heart failure, hypertension, renal impairment, edema).
Age Restrictions	2 months of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	REBIF
Drug Names	REBIF, REBIF REBIDOSE, REBIF REBIDOSE TITRATION, REBIF TITRATION PACK
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, clinically isolated syndrome (first clinical episode).
Exclusion Criteria	
Required Medical Information	Have a relapsing form of MS (eg, relapsing-remitting MS, progressive-relapsing MS, or secondary progressive MS with relapses) OR first clinical episode of MS with MRI scan that demonstrated features consistent with a diagnosis of MS (ie, multifocal white matter disease).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	REGRANEX
Drug Names	REGRANEX
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Neoplasm(s) at site(s) of application.
Required Medical Information	1) For the treatment of lower extremity diabetic ulcers that extend into the subcutaneous tissue or beyond and have an adequate blood supply AND 2) Good ulcer care practices including initial sharp debridement, pressure relief, and infection control will be performed.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	20 weeks
Other Criteria	

Prior Authorization Group	RELISTOR
Drug Names	RELISTOR
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Known or suspected mechanical gastrointestinal obstruction. At increased risk of recurrent obstruction due to the potential for gastrointestinal perforation.
Required Medical Information	1) Relistor is being prescribed for opioid-induced constipation in an adult patient with advanced illness who is receiving palliative care when response to laxative therapy has not been sufficient OR 2) Relistor is being prescribed for opioid-induced constipation in an adult patient with chronic non-cancer pain AND 3) The patient is unable to tolerate oral medications OR 4) An oral drug indicated for opioid-induced constipation in an adult patient with chronic non-cancer pain has been tried.(Note: Examples are Amitiza or Movantik) AND 5) The patient experienced an inadequate treatment response or intolerance to an oral drug indicated for opioid-induced constipation in an adult patient with chronic non-cancer pain. (Note: Examples are Amitiza or Movantik) OR 6) An oral drug indicated for opioid-induced constipation in an adult patient with chronic non-cancer pain has not been tried. (Note: Examples are Amitiza or Movantik) AND 7) The patient has a contraindication to an oral drug indicated for opioid-induced constipation in an adult patient with chronic non-cancer pain (Note: Examples are Amitiza or Movantik).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	4 months
Other Criteria	

Prior Authorization Group	REMICADE
Drug Names	REMICADE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D. Axial spondyloarthritis (AxSpA). Behcet's syndrome. Granulomatosis with polyangiitis (Wegener's granulomatosis). Hidradenitis suppurativa. Juvenile idiopathic arthritis (JIA). Pyoderma gangrenosum. Sarcoidosis. Takayasu's arteritis. Uveitis.
Exclusion Criteria	
Required Medical Information	Latent TB screening w/ skin test or interferon gamma release assay before initiating Remicade/other biologic. The following apply to new starts only. For moderate to severe active Crohn's disease: 1) fistulizing disease OR 2) inadequate response to at least 3-mo trial of a self-inj TNF inhibitor (eg, Humira, Cimzia) or intolerance. For moderate to severe active UC: inadequate response to at least 1 conventional tx (eg, steroids, sulfasalazine [SSZ], azathioprine) or intolerance/contraindication (CI). For moderate to severe active RA: 1) Remicade used w/ MTX or leflunomide (LEF) OR intolerance/CI to MTX or LEF, AND 2) inadequate response to at least 3-mo trial of a self-inj TNF inhibitor (eg, Humira, Cimzia) or intolerance. For active AS/AxSpA: 1) inadequate response to at least 4-wk trial of NSAID at max recommended/tolerated dose OR intolerance/contraindication to NSAIDs, AND 2) at least 1 of the following: a) predominant axial disease b) inadequate response to a synthetic DMARD c) intolerance/contraindication to a synthetic DMARD or d) inadequate response to at least 3-mo trial of a self-inj TNF inhibitor (eg, Humira, Cimzia) or intolerance. For active PsA: 1) inadequate response to at least 3-mo trial of MTX, LEF, or SSZ OR intolerance/contraindication to MTX, LEF, or SSZ, 2) inadequate response to at least 3-mo trial of a self-inj TNF inhibitor (eg, Humira, Cimzia) or intolerance, 3) severe active PsA w/ ANY of the following: multiple swollen joints, structural damage w/ inflammation, clinically relevant extra-articular manifestations, 4) active enthesitis and/or dactylitis, or 5) predominant axial disease. For chronic moderate to severe plaque psoriasis: 1) at least 5% BSA affected or crucial body areas (eg, feet, hands, face) affected AND 2) inadequate response to at least 3-mo trial of a self-inj TNF inhibitor (eg, Humira) or intolerance. For JIA: inadequate response to at least 3-mo trial of a self-inj TNF inhibitor (eg, Humira) or intolerance.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	REVLIMID
Drug Names	REVLIMID
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, systemic light chain amyloidosis, chronic lymphocytic leukemia/small lymphocytic lymphoma, classical Hodgkin lymphoma, mantle cell lymphoma, non-Hodgkin's lymphoma with the following subtypes: AIDS-related diffuse large B-cell lymphoma, primary effusion lymphoma, lymphoma associated with Castleman's disease, diffuse large B-cell lymphoma, follicular lymphoma, nongastric/gastric MALT lymphoma, primary cutaneous B-cell lymphoma, splenic marginal zone lymphoma
Exclusion Criteria	
Required Medical Information	For multiple myeloma: Revlimid (REV) will be used as primary, maintenance, or salvage therapy. If primary and the patient is a stem cell transplant (SCT) candidate, REV will be used with dexamethasone (dex), dex and bortezomib, or dex and carfilzomib. If primary and the patient is not a SCT candidate, REV will be used with dex OR melphalan and prednisone. If maintenance, REV will be used as monotherapy. If salvage and the patient will be retreated with the same regimen and they were a SCT candidate, REV will be used in combination with dex, dex and bortezomib, or dex and carfilzomib. If salvage and the patient will be retreated with the same regimen and they were not a SCT candidate, REV will be used in combination with dex OR melphalan and prednisone. If salvage and the patient will not be retreated with the same regimen, REV will be used as monotherapy or in combination with dex, dex and bortezomib, dex and cyclophosphamide, or dex and bendamustine. For myelodysplastic syndrome: patients must have low- to intermediate-1 risk MDS. If the patient has the 5q deletion, no further questions. If they do not, no further questions are required if their serum erythropoietin (EPO) level is greater than 500 mU/ml. If they do not have the deletion and their serum EPO level is less than 500 mU/ml, the patient must have failed epoetin or darbepoetin AND failed, had intolerance to, or a contraindication to immunosuppressive therapy. For mantle cell lymphoma: the disease is relapsed, refractory, or progressive. For systemic light chain amyloidosis: REV will be used with either dex or dex AND cyclophosphamide. Chronic lymphocytic leukemia/small lymphocytic lymphoma: the disease is relapsed or refractory. For Hodgkin lymphoma: REV will be used as a single agent as third line or salvage therapy. For non-Hodgkin lymphoma: the disease is relapsed, refractory, or progressive. REV will be used as monotherapy or in combination with rituximab.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	RITUXAN
Drug Names	RITUXAN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, primary CNS lymphoma, leptomeningeal metastases from lymphomas, Hodgkin's lymphoma (lymphocyte-predominant), non-Hodgkin's lymphoma subtypes [marginal zone lymphomas (splenic, MALT), Mantle cell lymphoma, Burkitt lymphoma, AIDS-related B-cell lymphoma, relapsed/refractory hairy cell leukemia, small lymphocytic lymphoma (SLL), post-transplant lymphoproliferative disorder (PTLD), primary cutaneous B-cell lymphoma], acute lymphoblastic leukemia, acquired blood factor VIII deficiency, autoimmune hemolytic anemia, chronic graft-versus-host disease (GVHD), multicentric Castleman's disease with HIV, refractory immune or idiopathic thrombocytopenic purpura (ITP), Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, Sjogren syndrome, thrombotic thrombocytopenic purpura, and prevention of Epstein-Barr virus (EBV)-related PTLD.
Exclusion Criteria	
Required Medical Information	Prior to initiating therapy, patient has been screened for hepatitis B virus (HBV) infection with Hepatitis B serologic assays. For moderately to severely active rheumatoid arthritis (new starts only): Inadequate response to a self-injectable tumor necrosis factor (TNF) inhibitor OR Intolerance or contraindication to a self-injectable TNF inhibitor. Hematologic malignancies must be CD20-positive. For Burkitt lymphoma and ALL, Rituxan is used as a component of a chemotherapy regimen. For diffuse large B-cell lymphoma (DLBCL), patient meets one of the following: 1) has relapsed or refractory disease and will use Rituxan as a component of a chemotherapy regimen if patient is a candidate for high dose therapy with autologous stem cell rescue 2) has relapsed or refractory disease and is not a candidate for high dose therapy with autologous stem cell rescue OR 3) does not have relapsed or refractory disease and will use Rituxan as a component of a chemotherapy regimen. For Wegener's Granulomatosis (WG) and Microscopic Polyangiitis (MPA), Rituxan will be used in combination with glucocorticoids.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	For rheumatoid arthritis, Rituxan is used in combination with methotrexate unless methotrexate is contraindicated or was not tolerated.

Prior Authorization Group	RUCONEST
Drug Names	RUCONEST
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Known or suspected allergy to rabbits or rabbit-derived products. History of immediate hypersensitivity reactions to C1 esterase inhibitor preparations (eg, Cinryze, Berinert).
Required Medical Information	Diagnosis of HAE confirmed by laboratory tests (eg, C4, C1 inhibitor functional, and C1 inhibitor antigenic protein levels)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	SABRIL
Drug Names	SABRIL
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For infantile spasms (IS): Sabril is used as a single agent in the treatment of IS. For complex partial seizures (CPS): 1) patient had an inadequate response to at least 2 alternative therapies for CPS (e.g., carbamazepine, phenytoin, levetiracetam, topiramate, oxcarbazepine or lamotrigine), AND 2) Sabril is used as adjunctive therapy.
Age Restrictions	Initial treatment infantile spasms: 1 month to 2 years. CPS: none
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	SAMSCA
Drug Names	SAMSCA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Underlying liver disease.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	30 days
Other Criteria	Samsca therapy was initiated (or re-initiated) in the hospital.

Prior Authorization Group	SANDOSTATIN LAR
Drug Names	SANDOSTATIN LAR DEPOT
Covered Uses	All FDA-approved indication not otherwise covered under Part D, poorly differentiated (high-grade) neuroendocrine tumor (NET)/large or small cell, pancreatic endocrine tumors (Islet cell tumors), carcinoid tumors, lung NET, unresectable and recurrent meningiomas, thymic carcinomas.
Exclusion Criteria	
Required Medical Information	For Acromegaly, must meet all of the following: 1) Clinical evidence of acromegaly, AND 2) Pre-treatment high IGF-1 level for age/gender, AND 3) Patient had an inadequate or partial response to surgery and/or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	For acromegaly continuation of therapy: the IGF-1 level decreased or normalized.

Prior Authorization Group	SEROSTIM
Drug Names	SEROSTIM
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Active malignancy.
Required Medical Information	Patient has a diagnosis of cachexia or wasting syndrome associated with HIV infection. Serostim is used in combination with antiretroviral therapy. Patient has had a suboptimal response to at least 1 other therapy for wasting or cachexia (eg, megestrol, dronabinol, cyproheptadine, or testosterone therapy if hypogonadal) OR patient has contraindication or intolerance to alternative therapies. For initial approval, patient must have a body mass index (BMI) less than 18.5 kg/m2 AND have experienced unintentional weight loss greater than 5 percent of body weight in the previous 6 months. For continuation of therapy, patient must have demonstrated a response to therapy with Serostim (ie, BMI has improved or stabilized) AND have BMI less than 27 kg/m2.
Age Restrictions	
Prescriber Restrictions	Infectious disease specialist.
Coverage Duration	12 weeks
Other Criteria	

Prior Authorization Group	SIGNIFOR
Drug Names	SIGNIFOR
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Patient had pituitary surgery that was not curative unless surgery is not an option. Patient must have controlled blood glucose levels or is receiving optimized antidiabetic therapy. Fasting plasma glucose and/or hemoglobin A1c levels must be obtained at baseline. For continuation of therapy, patient must show a clinically meaningful reduction in 24-hour urinary free cortisol levels and/or improvement in signs or symptoms of the disease.
Age Restrictions	
Prescriber Restrictions	Endocrinologist
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	SIGNIFOR LAR
Drug Names	SIGNIFOR LAR
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Must meet all of the following: 1) Patient has clinical evidence of acromegaly, AND 2) High pre-treatment IGF-1 level for age and/or gender, AND 3) Patient had an inadequate response to surgery OR there is a clinical reason for why the patient has not had surgery
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	For continuation of therapy: the IGF-1 level has decreased or normalized since initiation of therapy.

Prior Authorization Group	SILDENAFIL
Drug Names	REVATIO, SILDENAFIL
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Patient requires nitrate therapy on a regular or intermittent basis.
Required Medical Information	NYHA Functional Class II or III symptoms. PAH (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	SIMPONI
Drug Names	SIMPONI, SIMPONI ARIA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, Axial spondyloarthritis (Simponi only).
Exclusion Criteria	
Required Medical Information	Latent TB screening with either a TB skin test or an interferon gamma release assay (eg, QFT-GIT, T-SPOT.TB) prior to initiating Simponi/Simponi Aria (or other biologic). For moderately to severely active rheumatoid arthritis (new starts only): 1) Simponi/Simponi Aria is prescribed in combination with methotrexate (MTX) or MTX is contraindicated or was not tolerated AND 2) Member must meet ANY of the following requirements: a) Inadequate response to at least a 3-month trial of methotrexate despite adequate dosing (ie, titrated to 25-30 mg/week), b) intolerance or contraindication to MTX, c) inadequate response to at least a 3-month trial of a prior biologic DMARD or a targeted synthetic DMARD (e.g. Xeljanz), d) intolerance to a prior biologic DMARD or a targeted synthetic DMARD, OR e) severely active RA. For active psoriatic arthritis (PsA) (new starts only): Member must meet at least one of the following requirements: 1) Inadequate response to at least a 3-month trial of MTX, leflunomide or sulfasalazine, 2) intolerance or contraindication to MTX, leflunomide or sulfasalazine, 3) inadequate response to at least a 3-month trial of a prior biologic DMARD, 4) intolerance to a prior biologic DMARD, 5) severely active PsA as evidenced by ANY of the following: a) multiple swollen joints, b) structural damage in the presence of inflammation, or c) clinically relevant extra-articular manifestations (eg, extensive skin, bowel, ocular, cardiovascular, urogenital, or pulmonary involvement), 6) active enthesitis and/or dactylitis (ie, sausage finger), or 7) predominant axial disease (ie, extensive spinal involvement).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	For active ankylosing spondylitis and axial spondyloarthritis (new starts only): 1) Member has an inadequate response to at least a 4-week NSAID trial at maximum recommended or tolerated dose OR intolerance and/or contraindication to NSAIDs AND 2) Member has at least ONE of the following: a) predominant axial disease (ie, extensive spinal involvement), b) inadequate response to synthetic DMARD (eg, sulfasalazine), c) intolerance or contraindication to synthetic DMARD, d) inadequate response to at least a 3-month trial of a prior biologic DMARD, or e) intolerance to a prior biologic DMARD. For moderately to severely active ulcerative colitis (new starts only): Member has at least one of the following: 1) Corticosteroid dependence, 2) inadequate response to a conventional therapy (eg, oral aminosalicylates, oral corticosteroids, azathioprine, or 6-mercaptopurine), or 3) intolerance or a contraindication to conventional therapy.

Prior Authorization Group	SIRTURO
Drug Names	SIRTURO
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Sirturo being prescribed for the treatment of latent infection due to Mycobacterium tuberculosis, drug-sensitive tuberculosis, extra-pulmonary tuberculosis (e.g.central nervous system), or infection caused by the non-tuberculous mycobacteria (NTM).
Required Medical Information	Another effective treatment regimen cannot be used instead of Sirturo.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	

Prior Authorization Group	SOMATULINE DEPOT
Drug Names	SOMATULINE DEPOT
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, poorly differentiated (high-grade) neuroendocrine tumors (NET)/large or small cell, pancreatic endocrine tumors (Islet cell tumors), carcinoid tumors.
Exclusion Criteria	
Required Medical Information	For Acromegaly, must meet all of the following: 1) Clinical evidence of acromegaly, AND 2) Pre-treatment high IGF-1 level for age/gender, AND 3) Patient had an inadequate or partial response to surgery and/or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	For acromegaly continuation of therapy: the IGF-1 level decreased or normalized.

Prior Authorization Group	SOMAVERT
Drug Names	SOMAVERT
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Patient must meet all of the following: 1) Clinical evidence of acromegaly, AND 2) Pre-treatment high IGF-1 level for age/gender, AND 3) Patient had an inadequate or partial response to surgery and/or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy, AND 4) Patient had an inadequate response to octreotide or lanreotide OR patient is intolerant or has a contraindication to octreotide or lanreotide
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	For renewal, the IGF-1 level decreased or normalized

Prior Authorization Group	SOVALDI
Drug Names	SOVALDI
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, chronic hepatitis C genotype 5 or 6 infection.
Exclusion Criteria	
Required Medical Information	Chronic hepatitis C infection confirmed by presence of HCV RNA in serum prior to treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated variants (eg, NS3 Q80K polymorphism) where applicable, liver transplantation status if applicable. For patients with genotype 1, 2, 3, or 4 infection and hepatocellular carcinoma awaiting liver transplantation: must meet MILAN criteria. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 to 48 weeks depending on baseline host and viral factors
Other Criteria	For HCV/HIV coinfection, patient meets criteria for requested regimen and will not receive treatment with tipranavir. For patients prescribed a treatment regimen that includes Olysio, no prior treatment failure with an HCV protease inhibitor (eg, telaprevir, simeprevir, boceprevir, paritaprevir) despite adequate dosing and duration of therapy. MILAN criteria defined as: 1) tumor size 5cm or less in diameter in pts with single hepatocellular carcinoma OR 3 tumor nodules or less, each 3cm or less in diameter in pts with multiple tumors, and 2) no extrahepatic manifestations of the cancer or evidence of vascular invasion of tumor.

Prior Authorization Group	SPRYCEL
Drug Names	SPRYCEL
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, gastrointestinal stromal tumor (GIST).
Exclusion Criteria	
Required Medical Information	Diagnosis of CML or Ph+ ALL was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, patient has experienced resistance, intolerance or toxicity to imatinib or an alternative tyrosine kinase inhibitor (e.g., nilotinib). For GIST, patient must have PDGFRA D842V mutation.
Age Restrictions	For Ph+ ALL: 15 years of age or older. Other indications: 18 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	STELARA
Drug Names	STELARA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Latent TB screening with either a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB) prior to initiating Stelara (or other biologic). For moderate to severe plaque psoriasis (new starts only): 1) At least 5% of BSA is affected or crucial body areas (eg, feet, hands, face, neck and/or groin) are affected, AND 2) Inadequate response to either phototherapy (eg, UVB, PUVA) or a traditional systemic agent (eg, methotrexate, cyclosporine, acitretin), unless contraindicated or intolerant to such therapies. For active psoriatic arthritis (new starts only):1) Inadequate response to at least a 3-month trial of methotrexate (MTX), leflunomide or sulfasalazine, OR 2) Intolerance or contraindication to MTX, leflunomide or sulfasalazine OR 3) Inadequate response to at least a 3-month trial of a prior biologic DMARD, OR 4) Intolerance to a prior biologic DMARD, OR 5) Severely active psoriatic arthritis as evidenced by any of the following [multiple swollen joints, structural damage in the presence of inflammation, or clinically relevant extra-articular manifestations (eg, extensive skin, bowel, ocular, cardiovascular, urogenital, or pulmonary involvement)], OR 6) Active enthesitis and/or dactylitis (i.e., sausage finger), OR 7) Predominant axial disease (i.e., extensive spinal involvement).
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	STIVARGA
Drug Names	STIVARGA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For unresectable advanced or metastatic colorectal cancer, KRAS (with or without NRAS) mutation testing is performed on either the primary tumor or metastases to confirm RAS mutation status. The patient must have been previously treated with fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy, and, if KRAS or NRAS wild type, an anti-EGFR therapy. Stivarga must be used as a single agent. For locally advanced, unresectable or metastatic gastrointestinal stromal tumor (GIST), the patient must have been previously treated with imatinib or sunitinib.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	SUTENT
Drug Names	SUTENT
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, thyroid carcinoma (follicular, papillary, Hurthle cell, or medullary), angiosarcoma, solitary fibrous tumor, hemangiopericytoma, alveolar soft part sarcoma, chordoma (bone cancer), lung neuroendocrine tumor.
Exclusion Criteria	
Required Medical Information	For renal cell carcinoma, disease is relapsed or medically unresectable and Sutent will be used as a single agent. For PNET, disease is unresectable, locally advanced, or metastatic. For GIST, patient experienced disease progression on imatinib or was intolerant to imatinib. For chordoma: disease is recurrent. For follicular, papillary, or Hurthle cell thyroid carcinoma: Nexavar is not an appropriate option for the patient. The disease is unresectable or metastatic. The disease is radioiodine-refractory. The disease is progressive or symptomatic. For medullary thyroid carcinoma: patient experienced progression on vandetanib or cabozantinib OR vandetanib or cabozantinib are not appropriate options.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	SYLATRON
Drug Names	SYLATRON
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, giant cell tumor of the bone.
Exclusion Criteria	
Required Medical Information	For giant cell tumor of the bone, patient has unresectable disease OR surgical resection is likely to result in severe morbidity.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	For melanoma, Sylatron must be requested within 84 days (12 weeks) of the surgical resection.

Prior Authorization Group	SYMLIN
Drug Names	SYMLINPEN 120, SYMLINPEN 60
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Recurrent severe hypoglycemia that required assistance during the past 6 months. Gastroparesis. Patient requires drug therapy to stimulate gastrointestinal motility. Hypoglycemia unawareness (i.e., inability to detect and act upon the signs or symptoms of hypoglycemia). HbA1c level greater than 9 percent.
Required Medical Information	1) Diagnosis of type 1 or type 2 diabetes mellitus AND 2) The patient has demonstrated an inadequate treatment response, contraindication or been intolerant to metformin OR a sulfonylurea OR a thiazolidinedione OR insulin AND 3) The patient is currently receiving optimal mealtime insulin therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	If the patient has been receiving the Symlin for at least 3 months, patient demonstrated a reduction in HbA1c since starting Symlin therapy

Prior Authorization Group	SYNRIBO
Drug Names	SYNRIBO
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For CML, the patient has experienced resistance, toxicity or intolerance to prior therapy with at least two tyrosine kinase inhibitors (TKIs) (eg, imatinib, dasatinib, nilotinib, bosutinib, ponatinib).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	TAFINLAR
Drug Names	TAFINLAR
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, CNS metastases, NSCLC.
Exclusion Criteria	
Required Medical Information	For monotherapy in melanoma, patient must have a diagnosis of unresectable or metastatic melanoma AND the tumor must be positive for BRAF V600E mutation. For combination with Mekinist in melanoma, patient must have a diagnosis of unresectable or metastatic melanoma AND the tumor must be positive for either BRAF V600E or V600K mutation. For CNS metastases, the patient has a diagnosis of melanoma AND Tafinlar was active against primary tumor (melanoma) AND Tafinlar will be used as a single agent.For non-small cell lung cancer (NSCLC), the patient has BRAF V600E mutation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	TAGRISSO
Drug Names	TAGRISSO
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	TARCEVA
Drug Names	TARCEVA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, chordoma, renal cell carcinoma.
Exclusion Criteria	
Required Medical Information	For non-small cell lung cancer, Tarceva is used for locally advanced, recurrent, or metastatic disease. EGFR mutation testing was performed and is positive for EGFR exon 19 deletion or exon 21 (L858R) substitution mutation, Tarceva is used as either a first-line or second-line therapy. For first-line therapy, Tarceva is used as a single agent for the disease with locoregional recurrence with evidence of disseminated disease or with distant metastases. For second-line therapy, Tarceva is used following disease progression on erlotinib or afatinib, Tarceva is continued to be used as a single agent or used in combination with platinum-doublet therapy with or without bevacizumab. For EGFR mutation negative or unknown, Tarceva is used for the disease which progressed after chemotherapy as a second-line or third-line therapy. For pancreatic cancer, Tarceva is used in combination with gemcitabine for patients with locally advanced unresectable or metastatic disease. For chordoma, Tarceva is used as a single agent for the treatment of recurrent disease. For RCC, Tarceva is used as a single agent for patients with relapsed or medically unresectable stage IV disease with non-clear cell histology.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	TARGRETIN
Drug Names	BEXAROTENE, TARGRETIN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, mycosis fungoides, Sezary syndrome (capsules only), primary cutaneous CD30-positive T-cell lymphoproliferative disorder types: primary cutaneous anaplastic large cell lymphoma (capsules only) and lymphomatoid papulosis (capsules only), adult T-cell leukemia/lymphoma (gel only), primary cutaneous B-cell lymphoma types: primary cutaneous marginal zone lymphoma (gel only) and primary cutaneous follicle center lymphoma (gel only).
Exclusion Criteria	
Required Medical Information	For bexarotene capsules: Patient has any of the following types of cutaneous T-cell lymphomas: mycosis fungoides, Sezary syndrome, primary cutaneous anaplastic large cell lymphoma, and lymphomatoid papulosis. For primary cutaneous anaplastic large cell lymphoma: 1) The disease is CD30-positive, AND 2) Patient has multifocal lesions, AND 3) bexarotene will be used as a single agent. For lymphomatoid papulosis: 1) The disease is CD30-positive, AND 2) Patient has extensive lesions or symptomatic disease, AND 3) bexarotene will be used as a single agent. For Targretin gel: For cutaneous T-cell lymphoma, patient has a diagnosis of stage I to III mycosis fungoides. For primary cutaneous B-cell lymphoma: 1) Patient has any of the following types: a) primary cutaneous marginal zone lymphoma or b) primary cutaneous follicle center lymphoma AND 2) disease is confined to the skin.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	TASIGNA
Drug Names	TASIGNA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), gastrointestinal stromal tumor (GIST).
Exclusion Criteria	
Required Medical Information	Diagnosis of CML or Ph+ ALL was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, patient has experienced resistance, intolerance or toxicity to imatinib or an alternative tyrosine kinase inhibitor (e.g., dasatinib). For Ph+ ALL, 1) patient has relapsed or refractory Ph+ ALL, OR 2) patient has received hematopoietic stem cell transplant after achieving complete response to induction chemotherapy. For GIST, patient must have progressed on imatinib, sunitinib or regorafenib.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	TAZORAC
Drug Names	TAZORAC
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	1) For patients being treated for plaque psoriasis Tazorac must be applied to less than 20 percent of the patient's body surface area AND 2) For patients being treated for plaque psoriasis a trial of at least one topical corticosteroid (e.g., clobetasol, fluocinonide, mometasone, triamcinolone) (patient may still be using a corticosteroid product in addition to Tazorac) OR 3) The patient experienced an adverse event, intolerance, or contraindication to topical corticosteroids.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	For female patients who are able to bear children, the pregnancy status of the patient has been evaluated and the patient made aware of the potential risks of fetal harm and importance of birth control while using Tazorac.

Prior Authorization Group	TECENTRIQ
Drug Names	TECENTRIQ
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	TECFIDERA
Drug Names	TECFIDERA, TECFIDERA STARTER PACK
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Have a relapsing form of MS (eg, relapsing-remitting MS, progressive-relapsing MS, or secondary progressive MS with relapses).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	TEMAZEPAM
Drug Names	TEMAZEPAM
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Prescriber must acknowledge that medication benefits outweigh potential risks in the patient 65 years of age or older.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization requirement only applies to patients 65 years of age or older. APPLIES TO GREATER THAN CUMULATIVE 90 DAYS OF THERAPY PER YEAR.

Prior Authorization Group	TESTOSTERONE CYPIONATE INJ
Drug Names	DEPO-TESTOSTERONE, TESTOSTERONE CYPIONATE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, Gender Identity Disorder in Female-to-Male transgender
Exclusion Criteria	
Required Medical Information	1) Drug is being prescribed for hypogonadism in a male patient who had or currently has at least two confirmed low testosterone levels according to current practice guidelines or your standard lab reference values OR 2) Drug is being prescribed for female-to-male gender reassignment in a patient who is 14 years of age or older and able to make an informed, mature decision to engage in therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	TESTOSTERONE ENANTHATE INJ
Drug Names	TESTOSTERONE ENANTHATE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	1) Drug being prescribed for inoperable metastatic breast cancer in a patient who is 1 to 5 years postmenopausal and who has had an incomplete response to other therapy for metastatic breast cancer OR 2) Drug is being prescribed for hypogonadism in a male patient or a patient that self-identifies as male who had or currently has at least two confirmed low testosterone levels according to current practice guidelines or your standard male lab reference values OR 3) Drug is being prescribed for delayed puberty in a male patient.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	THALOMID
Drug Names	THALOMID
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, systemic light chain amyloidosis, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, recurrent apthous stomatitis, cachexia, HIV-associated diarrhea, Kaposi's sarcoma, Behcet's syndrome, graft-versus-host disease, Crohn's disease, myelofibrosis with myeloid metaplasia
Exclusion Criteria	
Required Medical Information	For systemic light chain amyloidosis: Thalomid will be used in combination with dexamethasone or dexamethasone and cyclophosphamide. For Waldenstrom's macroglobulinemia/lymphoplasmacytic leukemia, Thalomid will be used as monotherapy or in combination with rituximab. For multiple myeloma, Thalomid will be used as primary, maintenance, or salvage therapy. If primary and the patient is a stem cell transplant candidate, Thalomid will be used in combination with dexamethasone and bortezomib. If primary and the patient is not a stem cell transplant candidate, Thalomid will be used in combination with melphalan and prednisone. If maintenance, Thalomid will be used as a single agent. If salvage and the patient will be retreated with the same regimen and they are a transplant candidate, Thalomid will be used in combination with dexamethasone and bortezomib. If salvage and the patient will be retreated with the same regimen and they are not a transplant candidate, Thalomid will be used in combination with melphalan and prednisone. If salvage and the patient will not be treated with the same regimen as primary therapy, Thalomid will be used as monotherapy for steroid intolerant patients, or in combination with dexamethasone, dexamethasone and bortezomib, DT-PACE (dexamethasone, cisplatin, doxorubicin, cyclophosphamide, and etoposide), or VTD-PACE (dexamethasone, bortezomib, cisplatin, doxorubicin, cyclophosphamide, and etoposide). For cachexia, cachexia must be due to cancer or HIV-infection. For Kaposi's sarcoma, the patient must be HIV-positive. For graft-versus-host disease, use must be for the treatment of chronic or recurrent disease that is refractory to other therapies. Patient must be a bone marrow transplant recipient. For Crohn's disease, the patient must have failed or been intolerant to prior therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	TOBI INHALER
Drug Names	TOBI PODHALER
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, non-cystic fibrosis bronchiectasis.
Exclusion Criteria	
Required Medical Information	The patient has a diagnosis of cystic fibrosis that is confirmed by appropriate diagnostic or genetic testing OR the patient has a diagnosis of non-cystic fibrosis bronchiectasis. Pseudomonas aeruginosa is present in the patient's airway cultures OR the patient has a history of pseudomonas aeruginosa infection or colonization in the airways.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	TOPICAL TACROLIMUS
Drug Names	TACROLIMUS
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, Psoriasis on the face or body skin folds.
Exclusion Criteria	
Required Medical Information	1) The short-term or noncontinuous chronic use to treat moderate to severe atopic dermatitis (eczema) OR 2) The short-term or noncontinuous chronic use to treat psoriasis on the face or body skin folds
Age Restrictions	Tacrolimus 0.03% 2 years of age or older, Tacrolimus 0.1% 16 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	The patient experienced an inadequate treatment response, intolerance, or contraindication to at least one medium or higher potency topical steroid if Protopic will not be used on the face, body skin folds, genital area, armpit, or around the eyes.

Prior Authorization Group	TOPICAL TESTOSTERONES
Drug Names	ANDRODERM, ANDROGEL, ANDROGEL PUMP, AXIRON, FORTESTA, STRIANT, TESTIM, TESTOSTERONE, TESTOSTERONE PUMP, VOGELXO, VOGELXO PUMP
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Drug is being prescribed for hypogonadism in a male patient or a patient that self-identifies as male who had or currently has at least two confirmed low testosterone levels according to current practice guidelines or your standard male lab reference values.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	TRELSTAR
Drug Names	TRELSTAR MIXJECT
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, recurrent prostate cancer, intermediate or high risk prostate cancer in combination with radiation therapy, or very high risk prostate cancer with or without radiation therapy.
Exclusion Criteria	
Required Medical Information	If the patient has metastatic disease, node positive disease, or recurrent disease as defined as a biochemical failure after previous therapy, then no further information is required. If the patient has none of the abovementioned criteria and has intermediate or high risk stratification, then Trelstar must be used with external beam radiation therapy. If the patient has none of the abovementioned criteria and has very high risk stratification, Trelstar may be used with external beam radiation unless the patient is not a candidate for definitive therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	Use as neoadjuvant therapy prior to radical prostatectomy is not approvable.

Prior Authorization Group	TYKERB
Drug Names	TYKERB
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, metastatic CNS lesions.
Exclusion Criteria	
Required Medical Information	For advanced, recurrent, or metastatic HER2-positive breast cancer, Tykerb must be used in combination with 1) capecitabine or trastuzumab (without cytotoxic therapy) for patients who have received prior trastuzumab-containing regimen, OR 2) aromatase inhibitor (e.g., anastrozole, letrozole, exemestane) for postmenopausal women with hormone receptor positive disease. For metastatic CNS lesions, Tykerb must be used with capecitabine in patients with recurrent HER2-positive breast cancer.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	TYSABRI
Drug Names	TYSABRI
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Use as monotherapy. For Crohn's disease (CD), patient must have an inadequate response, intolerance or contraindication to one conventional CD therapy (eg, corticosteroid, azathioprine, mesalamine) and one TNF-inhibitor (eg, Humira, Cimzia).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	MS: Plan Year. CD: initial = 3 months, renewal = Plan Year.
Other Criteria	Upon renewal for CD, patient's condition must have improved or stabilized with Tysabri treatment.

Prior Authorization Group	UPTRAVI
Drug Names	UPTRAVI
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	NYHA Functional Class II or III symptoms. PAH (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than or equal to 5 Wood units OR pretreatment pulmonary vascular resistance is greater than 3 Wood units for members who are experiencing clinical deterioration/worsening on current PAH therapy at maximum tolerated doses.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	VALCHLOR
Drug Names	VALCHLOR
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Patient has received prior skin-directed therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	

Prior Authorization Group	VENCLEXTA
Drug Names	VENCLEXTA, VENCLEXTA STARTING PACK
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	VERSACLOZ
Drug Names	VERSACLOZ
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	History of clozapine-induced agranulocytosis or severe granulocytopenia. Dementia-related psychosis.
Required Medical Information	The patient is unwilling or unable to take tablets or capsules orally or is at high risk for non-compliance.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	VIBERZI
Drug Names	VIBERZI
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Known or suspected biliary duct obstruction or sphincter of Oddi disease or dysfunction. Alcoholism, alcohol abuse, or alcohol addiction, or a patient who drinks more than 3 alcoholic beverages per day. History of pancreatitis or structural diseases of the pancreas, including known or suspected pancreatic duct obstruction. Severe hepatic impairment (Child-Pugh class C). History of chronic or severe constipation or sequelae from constipation, or known or suspected mechanical gastrointestinal obstruction.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	VIMIZIM
Drug Names	VIMIZIM
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Diagnosis of mucopolysaccharidosis IVA (MPS IVA, Morquio A syndrome) was confirmed by an enzyme assay demonstrating a deficiency in N-acetylgalactosamine 6-sulfatase enzyme activity or by DNA testing.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	Appropriate medical support is readily available when Vimizim is administered in the event of anaphylaxis, severe allergic reaction, or acute respiratory failure.

Prior Authorization Group	VOTRIENT
Drug Names	VOTRIENT
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, uterine sarcoma, follicular, papillary, or Hurthle cell thyroid carcinoma.
Exclusion Criteria	
Required Medical Information	For renal cell carcinoma, the disease is relapsed or medically unresectable. Votrient will be used as a single agent. For soft tissue sarcoma, does not have an adipocytic soft tissue sarcoma or GIST. The patient has angiosarcoma or pleomorphic rhabdomyosarcoma. If so, Votrient will be used as a single agent. If not angiosarcoma or pleomorphic rhabdomyosarcoma, the patient has retroperitoneal/intra-abdominal sarcoma or extremity/superficial trunk sarcoma. If so, the disease is unresectable, progressive, or recurrent and Votrient will be used as a single therapy. For uterine sarcoma, the patient had stage I, II, III, or IV disease. If II, III, or IV, the medication will be used as a single agent. If the patient has stage I disease, the disease is medically inoperable and Votrient will be used as a single agent. For follicular, papillary, or Hurthle cell thyroid carcinoma, Nexavar is not an appropriate option for the patient. The disease is unresectable or metastatic. The disease is radioiodine-refractory. The disease is progressive or symptomatic.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	VPRIV
Drug Names	VPRIV
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concomitant therapy with miglustat (Zavesca)
Required Medical Information	Diagnosis of Gaucher disease was confirmed by enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by DNA testing. Patient has one or more of the following disease complications: anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	XALKORI
Drug Names	XALKORI
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, inflammatory myofibroblastic tumors, non-small cell lung cancer (NSCLC) with ROS1-positive tumors.
Exclusion Criteria	
Required Medical Information	For NSCLC, the tumor is ROS1- or ALK-positive AND the patient has recurrent or metastatic disease. For IMT, the tumor is ALK-positive. For all indications, Xalkori is being used as a single agent.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	XELJANZ
Drug Names	XELJANZ, XELJANZ XR
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Combination therapy with a potent immunosuppressant such as azathioprine or cyclosporine
Required Medical Information	Latent TB screening with either a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB) prior to initiating Xeljanz or previous biologic DMARD. For moderately to severely active rheumatoid arthritis (new starts only), member must meet both of the following requirements: 1) Member has an inadequate response to at least a 3-month trial of methotrexate (MTX) despite adequate dosing (i.e., titrated to 25-30 mg/week) or intolerance or contraindication to MTX, and 2) Member has experienced an inadequate response to at least a 3-month trial of any biologic DMARD (e.g., TNF-alpha inhibitor, Actemra, Kineret, Orencia, or Rituxan) or meets at least one of the following requirements: a) Member has an intolerance or contraindication to any biologic DMARD, b) Member has a history of a demyelinating disorder, congestive heart failure, chronic hepatitis B, or autoantibody formation/lupus-like syndrome.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	XENAZINE
Drug Names	TETRABENAZINE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, chronic tics associated with Tourette's syndrome, tardive dyskinesia, hemiballismus, chorea not associated with Huntington's disease.
Exclusion Criteria	Patients who are actively suicidal or have untreated or inadequately treated depression.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	XEOMIN
Drug Names	XEOMIN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, upper limb spasticity related to stroke.
Exclusion Criteria	Cosmetic use
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	XGEVA
Drug Names	XGEVA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For bone metastases from prostate cancer (solid tumor), patient has castration-recurrent disease. For giant cell tumor of the bone, patient has unresectable disease or surgical resection is likely to result in severe morbidity. For hypercalcemia of malignancy, condition is refractory to intravenous (IV) bisphosphonate therapy (eg, zoledronic acid, pamidronate) defined as albumin-corrected serum calcium level of greater than 12.5 mg/dL despite IV bisphosphonate therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Hypercalcemia of malignancy: initial = 2 months, renewals = Plan Yr. All other dx = Plan Yr.
Other Criteria	For hypercalcemia of malignancy renewal requests: patient has demonstrated a response to Xgeva therapy defined as albumin-corrected serum calcium level of 12.5 mg/dL or less. For bone metastases from solid tumors and giant cell tumor of the bone: patient will receive calcium and vitamin D supplementation as needed to treat or prevent hypocalcemia. Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

Prior Authorization Group	XIFAXAN
Drug Names	XIFAXAN
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, Irritable Bowel Syndrome without constipation.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	18 years of age or older for reduction in risk of overt hepatic encephalopathy (HE) recurrence.
Prescriber Restrictions	
Coverage Duration	Reduction in risk of overt hepatic encephalopathy (HE) recurrence- 6 mos, IBS w/o constipation-3 mos
Other Criteria	

Prior Authorization Group	XOLAIR
Drug Names	XOLAIR
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For allergic asthma, Xolair will be used in combination with other medications for long-term control of asthma. Patient will have a rapid-acting beta2-agonist available for rescue therapy. For initial therapy, must meet ALL of the following criteria: 1) has a diagnosis of moderate to severe persistent asthma, 2) has positive skin test (or blood test) to at least 1 perennial aeroallergen, 3) has baseline IgE level at or above 30 IU/mL, 4) asthma is inadequately controlled despite use of inhaled corticosteroid at the optimal dose, and 5) patient is optimizing the use of a long-acting inhaled beta2-agonist, leukotriene modifier, or theophylline at the optimal dose. For continuation therapy, patient must have improved asthma control while on Xolair. For chronic idiopathic urticaria, patient initiating Xolair therapy must meet ALL of the following criteria: 1) patient has been evaluated for other causes of urticaria, 2) patient has had itchy hives for at least 6 weeks, 3) patient has remained symptomatic despite H1-antihistamine treatment, and 4) the dose of antihistamine has been optimized. For continuation therapy, patient's symptom has been improved with Xolair treatment.
Age Restrictions	For CIU: 12 years of age or older. For allergic asthma: 6 years of age or older.
Prescriber Restrictions	For chronic idiopathic urticaria: allergist.
Coverage Duration	Plan Year
Other Criteria	Xolair will be administered in a controlled healthcare setting with access to emergency medications (e.g., anaphylaxis kit).

Prior Authorization Group	XTANDI
Drug Names	XTANDI
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	For metastatic, castration-resistant disease, the patient has been previously treated with Zytiga unless the patient has a contraindication, or intolerance, to Zytiga therapy. For disease that is not castration-resistant, Xtandi will be used in combination with androgen deprivation therapy. Xtandi will be used to enhance the effectiveness of radiation therapy, to supplement androgen deprivation therapy if the patient experienced inadequate testosterone suppression, or to prevent androgen flare in androgen deprivation therapy naive patients.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	XYREM
Drug Names	XYREM
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Taking alcohol or sedative hypnotic agents while taking Xyrem.
Required Medical Information	1) The drug is being prescribed for the treatment of cataplexy in a patient with narcolepsy OR 2) The drug is being prescribed for the treatment excessive daytime sleepiness in a patient with narcolepsy without cataplexy and 3) At least one CNS stimulant drug and one CNS wakefulness promoting drug have been tried and 4) The patient experienced an inadequate treatment response or intolerance to the CNS stimulant drug and CNS promoting wakefulness drug OR 5) the patient has a contraindication to a CNS stimulant drug or a CNS wakefulness promoting drug (NOTE: Examples of a CNS stimulant drug are amphetamine, dextroamphetamine, or methylphenidate. Examples of a CNS wakefulness promoting drug is modafinil or armodafinil. Coverage of modafinil or armodafinil or amphetamines or methylphenidates may require prior authorization).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	If the request is for the continuation of Xyrem, the patient experienced a decrease in daytime sleepiness with narcolepsy or a decrease in cataplexy episodes with narcolepsy.

Prior Authorization Group	YERVOY
Drug Names	YERVOY
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, recurrent melanoma, CNS metastases from primary tumor (melanoma).
Exclusion Criteria	
Required Medical Information	For unresectable or metastatic melanoma, Yervoy will be used as a single agent or in combination with nivolumab. For the adjuvant treatment of melanoma: 1) Yervoy will be used as adjuvant therapy following complete resection, including total lymphadenectomy, AND 2) the disease has pathologic involvement of regional lymph nodes of more than 1 millimeter. For CNS metastases from primary tumor (melanoma): 1) Yervoy was active against the primary tumor (melanoma), AND 2) the disease is recurrent.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	ZAVESCA
Drug Names	ZAVESCA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Patient has mild to moderate type 1 Gaucher disease. Diagnosis of Gaucher disease was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by DNA testing. Enzyme replacement therapy is not a therapeutic option (e.g., due to constraints such as allergy, hypersensitivity, or poor venous access).
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	ZELBORAF
Drug Names	ZELBORAF
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, melanoma with BRAF V600K mutation, CNS metastases from primary tumor (melanoma), NSCLC with BRAF V600E mutation.
Exclusion Criteria	
Required Medical Information	For melanoma, the tumor is positive for either BRAF V600E or V600K mutation. For CNS metastases, the patient has a diagnosis of melanoma AND Zelboraf was active against primary tumor (melanoma) AND Zelboraf will be used as a single agent. For non-small cell lung cancer (NSCLC), the patient has BRAF V600E mutation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	ZOLINZA
Drug Names	ZOLINZA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, mycosis fungoides, Sezary syndrome, multiple myeloma.
Exclusion Criteria	
Required Medical Information	For multiple myeloma: Zolinza will be used as salvage therapy in combination with bortezomib (Velcade).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	ZORBTIVE
Drug Names	ZORBTIVE
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Active malignancy, history of malignancy in the past 12 months, previous Zorbtive therapy for longer than 8 week
Required Medical Information	Zorbtive will be used in conjunction with optimal management of SBS.
Age Restrictions	
Prescriber Restrictions	Gastroenterologist or nutritional support specialist
Coverage Duration	Maximum 8 weeks total
Other Criteria	

Prior Authorization Group	ZURAMPIC
Drug Names	ZURAMPIC
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Severe renal impairment, end stage renal disease, kidney transplant recipient, or dialysis. Tumor lysis syndrome or Lesch-Nyhan syndrome. (Note: Per prescribing information, Zurampic (lesinurad) is contraindicated in patients with severe renal impairment (eClcr less than 30mL/min) and should not be initiated in patients with an eClCr less than 45 mL/min).
Required Medical Information	Zurampic (lesinurad) is being used in combination with a xanthine oxidase inhibitor (i.e., allopurinol or febuxostat).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	ZYDELIG
Drug Names	ZYDELIG
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	History of serious allergic reactions including anaphylaxis or toxic epidermal necrolysis.
Required Medical Information	For relapsed chronic lymphocytic leukemia, Zydelig is used in combination with rituximab. For relapsed follicular B-cell non-Hodgkin lymphoma and relapsed small lymphocytic lymphoma, patient has received at least two prior systemic therapies.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	ZYKADIA
Drug Names	ZYKADIA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D, recurrent ALK-positive NSCLC.
Exclusion Criteria	
Required Medical Information	Patient has recurrent or metastatic disease. The tumor is ALK-positive. Patient has progressed on or is intolerant to crizotinib.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	ZYPREXA RELPREVV
Drug Names	ZYPREXA RELPREVV
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Dementia-related psychosis.
Required Medical Information	1) Tolerability with oral olanzapine has been established AND 2) The patient has a history of noncompliance and/or refuses to utilize oral medications.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

Prior Authorization Group	ZYTIGA
Drug Names	ZYTIGA
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	
Required Medical Information	Patient has metastatic prostate cancer. Patient's disease is castration-resistant. Zytiga will be used in combination with prednisone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	